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The Effect of Adverse Childhood Experiences on Psychosocial Wellbeing

by

Gabrielle C. Yundt

Presented to the faculty of the

Graduate School of Clinical Psychology

George Fox University

in partial fulfillment

of the requirements for the degree of

Doctor of Psychology

in Clinical Psychology

Newberg, Oregon

December 6, 2019

The Effect of Adverse Childhood Experiences on Psychosocial Wellbeing

by

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has been approved

at the

Graduate School of Clinical Psychology

George Fox University

as a Dissertation for the Psy.D. degree.

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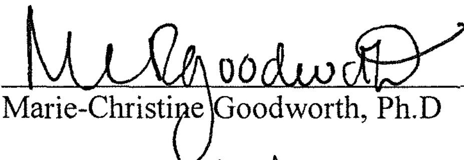

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The Effect of Adverse Childhood Experiences on Psychosocial Wellbeing.

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Abstract

As a result of adversity, trauma, or maltreatment, a child's primary defense is to engage in self-blame in order to maintain a belief in a safe world. Without intervention, these adaptive strategies may continue to shape the way survivors relate to themselves and make meaning out of negative events. This study hypothesized that participants with adversity in childhood have an increased likelihood of low self-compassion (indicating tendencies towards self-judgment, over-identification, and isolation). This study further hypothesized a positive correlation between posttraumatic growth, resilience and hardiness. Participants in this study were adults recruited from three online sites (social networking, online forum, and a local university); participants ranged in age from 18-64, sexually and ethnically diverse. The majority of participants were white, United States born, female, and were between the age of 18-24. Participants were surveyed using the Adverse Childhood Experience survey, Self-Compassion Scale- Short Form, Connor Davidson Resilience Scale, Hardiness Questionnaire, Posttraumatic Growth Inventory, and two one-item scales measuring religion and attachment. Results were analyzed using a

Pearson correlation and path analysis. Self-compassion was not significantly correlated to ACEs, and a strong correlation was observed between resilience and self-compassion. Resilience and posttraumatic growth had a moderate correlation, resilience and hardiness had a strong correlation, and there was no significant correlation observed between hardiness and posttraumatic growth. The results from the path analysis found that resilience mediates the relationship between adversity and the development of posttraumatic growth. Moreover, adversity in childhood had a small negative correlation to religion, resilience, self-compassion, and hardiness.

Keywords: Adverse Childhood Experiences, ACEs, Self-Compassion, Resilience, Posttraumatic Growth, trauma, Hardiness, childhood maltreatment, adversity

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I would like to give a special thank you to my research team, whose time, brainstorming and gentle guidance led to this study. To the authors, supervisors, professors, and peers whose passion and commitment to treating adversity has inspired me to find and hold onto hope- thank you. Specifically, I would like to thank Drs. Seegobin, Goodworth, and Kuhnhausen, whose mentorship, conversations over tea, and insight helped to foster the ideas and exploration outlined in the present study. Particularly noteworthy is the contributions made by Dr. Celeste Jones who aided in bringing my vision of a path analysis to reality.

I am very grateful and appreciative to all those who participated in my study. Your willingness to engage on these vulnerable topics gave me the insight needed to spread encouragement and understanding. This study proved to be a platform to allow me to feel deeply connected to your journey. I am proud and honored to have played a small role in helping to bring about self-awareness and cathartic relief even by simply completing the survey.

Lastly, to those recovering from the insults of childhood maltreatment- it is common to feel either that one is bad or damaged or to feel as though the events one has endured are insignificant. I hope that these findings prove to be useful to you in demonstrating the validity of this pain, the toll it takes on your well-being and the utter strength demonstrated by many people who are overcoming this experience. To those of you who have been made to feel hopeless in changing your circumstance, may you take courage in learning that through self-kindness, meaning-making, connection to others, and a sense of agency you are able to develop a more resilient mind and gain protection from the impacts of further damage or re-victimization. I am

standing with you; you are my inspiration and encouragement. May we empower one another and remember that we are not alone in our suffering.

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Chapter 1

Introduction

"Trauma really does confront you with the best and the worst. You see the horrendous things that people do to each other, but you also see resiliency, the power of love, the power of caring, the power of commitment, the power of commitment to oneself, the knowledge that there are things that are larger than our individual survival. And in some ways, I don't think you can appreciate the glory of life unless you also know the dark side of life."

-Bessel van der Kolk, M.D.

Understanding Developmental Trauma

The connections between early childhood maltreatment and health outcomes are well documented (Banyard, Hamby, & Grych, 2017 ; Felitti et al., 1998; Hillis, Anda, Dube, & Felitti, 2004; Traub, Boynton-Jarrett, Renee, & Berkowitz, 2016; Wolitzky-Taylor et al., 2017) and current research is now examining the details of the impact, as well as the nature of the connections between trauma and adult functioning and recovery. Courtois (2004) argues that the experiences of complex trauma, childhood maltreatment and/or extreme stress lead to such symptoms as: "alterations in the regulation of affective impulses, alterations in attention and consciousness, alterations in self-perception, alterations in perception of the perpetrator, alterations in relationship to others, somatization and/or medical problems, and alterations in systems of meaning" (p. 414). Spinazzola and his colleagues (2014) demonstrated that childhood maltreatment has an incremental effect; therefore, individuals with higher abusive experiences

have greater mental health disturbance. They also found that psychological abuse, compared to physical/sexual abuse or neglect, showed more deleterious impacts and exacerbated risk behaviors (i.e., verbal/physical aggression, reckless driving, over-consumption of food, drugs or alcohol and/or indiscriminate friendliness).

The Adverse Childhood Experiences (ACE) survey was developed as an inclusive survey using items from other validated and relevant scales to measure childhood maltreatment (i.e., neglect, physical, psychological and sexual abuse) and family dysfunction (i.e., domestic violence, separation/divorce, family member with: substance abuse, mental illness and/or incarceration). Participants were asked to answer for experiences that had occurred before the age of 18 years old to represent formational, developmental experiences. The survey consists of items from the Conflicts Tactics Scale (to measure psychological and physical abuse), Wyatt Sex History Questionnaire (to define contact sexual abuse), and 1988 National Health Interview Survey (to measure exposure to drug or alcohol abuse). Felitti and his colleagues (1998) found a strong relationship between the amount of exposure in childhood adversity and risk factors to leading causes of early death in adults. They found that individuals with a high ACE score were significantly more likely to develop addictions, disease and medical issues throughout the course of their life. These studies also uncovered the broad prevalence of high scores on the ACE scale despite socioeconomic status, ethnicity, age and gender (Felitti et al., 1998).

The Center of Disease Control and Prevention (n.d.), demonstrates the hierarchical relationship following childhood adversity. This pyramid depicts the process beginning with generational embodiment/historical trauma and social conditions/local context as factors leading to ACE. Expected consequences of ACEs include: disrupted neurodevelopment, social/cognitive/

emotional impairment, adoption of health-risk behaviors (i.e., overeating, smoking, sedentary lifestyle etc.), disease/disability/social problems, and early death. Studies regarding adverse childhood experiences have found a positive correlation of ACE scores with memory disturbances (Brown et al., 2007) and risk of suicide attempts (Dube et al., 2001). In addition, correlations have been found between ACEs and depressive disorders (Dube et al., 2001). As seen above, childhood trauma has been shown to be linked to a number of adult mental health and addiction challenges.

Researchers and psychologists can be intimidated and hesitant to ask about trauma or adverse experiences for fear of triggering or re-traumatizing the participant (Becker-Blease & Freyd, 2006). Though memories are vulnerable to alteration (Loftus, 2005) and repeated exposure to reminders of a trauma can have a re-traumatizing effect on an individual, asking and discussing the trauma does not pose a risk to the participant (Edwards, Dube, Felitti, & Anda, 2007). In fact, research has discovered that results are more likely to underestimate childhood maltreatment (Hardt & Rutter, 2004). Becker-Blease and Freyd (2006) suggests that, by failing to ask about trauma, we risk missing important components of participant's current functioning and predictors of later-life problems.

Self-Compassion as a Measure of Projected Life Outcome.

Neff and Vonk (2009) proposed the concept of self-compassion to understand and evaluate views of self, psychological well-being, and improved quality of life. They defined self-compassion as, "treating oneself with kindness, recognizing one's shared humanity, and being mindful when considering negative aspects of oneself" (p.23). Self-compassion, as they have conceptualized it, is composed of three parts-self-kindness (as opposed to judgment), a sense of

common humanity (as opposed to isolation), and mindfulness (as opposed to overidentification) (Neff, 2009). Studies on self-compassion have found that high self-compassion scores are predictive of feelings of self-worth, increased happiness, optimism, and curiosity (Hall, Row, Wuensch, & Godley, 2013). Higher reported self-compassion was also correlated with decreased anxiety, decreased depression and decreased fear of failure (Neff & Vonk, 2009). Neff (2009) found a negative correlation between self-compassion and social comparison, public self-consciousness, self-rumination, and need for cognitive closure.

Adverse Childhood Experiences and Self-Compassion

Whereas high ACEs scores have been correlated with later life disease and mental health vulnerabilities (Felitti et al., 1998), high self-compassion score in trauma-exposed populations has been shown to be related to decreased stress-induced inflammation (Breines et al., 2014) as well as decreases in depression and self-criticism (Kaurin, Schonfelder, & Wessa, 2018). This indicates the possibility of mediating some of the negative physical and mental health effects of childhood adversity through the practice of self-compassion.

Many efforts are already being given to the prevention of adversity in childhood through such programs as the Department of Human Services and Child Protective Services. In addition, following the ACEs study, there is an increase in attention to the health risk-behaviors and problems that arise as a result. The human mind is adaptive and has the ability to adjust to changes in perception, habits and understanding, known as neuroplasticity (Porges, 2015; Schore, 2013; Siegel, 2015). Therefore, neurodevelopmental effects of childhood adversity can be addressed through social, cognitive and emotional interventions. Given the neurobiological effects of increasing self-compassion, it is likely that most individuals with adverse childhood

experiences could benefit greatly from these patterns of relating to themselves (Diehl & Prout, 2002). As the field and study of self-compassion continues to grow and develop it will be even more vital, therefore, for therapist's and trauma survivors to implement self-compassion interventions into treatment and recovery.

In Vigna, Poehlmann-Tymam, & Koenig's study (2017) of the effects of self-compassion as a "resilience-promoting response" in gender and sexual minority adolescents, they found a small negative relationship between self-compassion and ACEs scores. Vigna and colleagues (2017) observed twice the occurrence of depressive symptomology and significantly higher anxiety symptomology for sexual and gender minority students. Additionally, self-compassion was found to be significantly negatively correlated with all variables (general peer victimization, bias-based bullying, ACEs, anxiety, and depressive symptoms).

Resilience Buffers the Impact of Adversity

Resilience has been defined in the literature in many different ways. Masten (2011, 2012) defined it as the ability to overcome adversity that may damage stability, viability or development. Resilience has also been defined as a characteristic of someone who is competent under stress, shows signs of recovery from trauma (Ungar, 2008) and an ability to maintain equilibrium and healthy adjustment (Bonanno, 2004) despite unlikely circumstances. Ultimately, at its broadest use of the word, resilience is successful coping with stress or adversity (Connor & Davidson, 2003).

Previously, resilience was understood as a concept of rare and remarkable occurrence among a select few individuals with marked traits allowing them to have an impenetrable shield and avoid the consequences of trauma and adversity (Masten, 2001). More recent research,

however, suggests that resilience may be a normative aspect of healthy development (Bonanno, 2004; Masten, 2001; Ungar, 2008). Moreover, these researchers believe that resilience is the development of protective factors that lead to a more successful recovery from adverse experiences (Masten & Narayan, 2012; Ungar, 2008). Researchers have questioned the utility of resilience as a measure of superior durability for some time (Bonanno, 2004; Masten, 2001; Raiche, 2017; Ungar, 2008). Masten (2001) suggests that, despite common belief, resilience is an ordinary, common experience and a part of normal human adaptation. Ungar (2008) argues that a person who makes the most out of the resources available to them should be considered resilient and that resiliency is simply the ability to perform well under stressful conditions.

Adversity and Resilience

Given that resilience is the adaptive and consistent functioning despite adversity, many studies on resillience have focused on resilience as an outcome developed in response to extreme stress. During a recent study with combat veterans, Raiche (2017) found a negative correlation between resilience and posttraumatic stress symptoms (PTSS) suggesting that resilience may mediate the impact of traumatic experiences. Philippe, Laventure, Beaulieu-Pelletier, Lecours, & Lekes (2011) additionally found that resilience mediated the relationship between childhood trauma and psychological symptoms of depression, anxiety and self-harm in a clinical outpatient population. Resilience was shown to significantly mediate the relationship between emotional abuse, physical neglect and emotional neglect and psychological symptoms (depression, anxiety and self-harm); it did not, however, mediate the effect of sexual and physical abuse on depression, anxiety and self-harm (Philippe et al., 2011). This study further determined that

resilience appears to protect against psychological symptoms for those experiencing severe traumas or who have not experienced a trauma.

Resilience and Self-Compassion

Recent studies have begun to explore the relationship between resilience and self-compassion (Bluth, Roberson, & Gaylord, 2015; Vigna et al., 2017). Individuals demonstrating resilience in the face of adversity also appear to demonstrate traits of self-compassion such as: mindfulness, common humanity, acknowledgement of their own limitations, as well as offering warmth and comfort to others (Vigna et al., 2017). Multiple researchers have proposed that high self-compassion leads to resilience; this occurs when self-compassion skills protect from stress due to the cognitive appraisal and physiological responses to these events (Bluth et al., 2015; Bruines et al., 2014; Vigna et al., 2017). Raiche (2017) demonstrated a significant correlation between resilience and self-compassion found in combat veterans. This may result due to perceived agency, greater competency, activism, and secure attachment relationships (Masten & Narayan, 2012; Ungar, 2008).

Protective Factors

Self-compassion and resilience may be influenced by the protective factors, environmental supports, and positive expectations. Stressful events, adversity and potentially traumatic events are mediated by an internal locus of control, resilience and can be strengthened through relationship security and social support (Benight & Bandura, 2004; Benight & Harper, 2002; Pooley, Cohen, & O’Connor, 2006, 2010; Pooley, Cohen, O’Connor, & Taylor, 2013). In a study conducted by Hazen & Shaver (1987), it was determined that approximately 56% of individuals identified as having a secure attachment. However, for children experiencing neglect

or childhood abuse by a significant adult, attachment may be seriously severed (Fisher, 2014). Siegel (2015) suggests that while abuse interferes with differentiation, secure attachment integrates the need for the child to be differentiated from the parent while "linking with them through compassionate communication" (p. 161). Siegel (2015) has observed a neurobiological impact of insecure attachment and unresolved trauma on the ability to make meaning of the environment and future relationships. Schore (2013) notes that these secure attachments build resilience through emotional communication and interactive affect regulation.

Brewer-Smith and Koenig (2014) reveal in a longitudinal study that survivors of childhood maltreatment demonstrate a relationship between religion/spirituality and stress resilience. Moreover, they suggest that the promotion of forgiveness, cathartic emotional release, and social support along with hope and comfort may lead to positive neurobiology, behavior and health outcomes. Faith and religious community may also be experienced as a place of positive vulnerability and connection for children in crisis (Gunnestad & Thwala, 2011).

Hardiness and Posttraumatic Growth

Similar phenomena have been noted in literature in the past using terms such as hardiness and posttraumatic growth. Resilience should be differentiated from these terms, however. Maddi (2013) similarly describes a "hardiness personality" as the explanation for an individual who demonstrates a pattern of attitudes and problem solving which "constitutes the existential courage and motivation to do the hard work of turning stressful circumstances from potential disasters into growth opportunities" (p. 9).

Hardiness, however, has some slight variations from resilience and is defined primarily on the basis that it is a personality trait of an individual rather than a response to an experience

(Kobasa, 1984). A hardiness measure will be included to explore the relationship between resilience and hardiness to examine state and trait possible differences and to explore if one is more likely to indicate better life outcomes. This is consistent with self-efficacy research (Pooley et al., 2013) indicating that a belief in personal agency over one's life decreases reactions to stress.

In addition, many researchers are beginning to consider the presence of posttraumatic growth in addition to resilience (Masten & Narayan, 2012; Meyerson, Grant, Carter, & Kilmer, 2011; Raiche, 2017; Tedeshi & Calhoun, 1996). Posttraumatic growth is characterized by five positive changes in functioning, including: appreciation of life, relationships with others, new possibilities in life, personal strength, and spiritual life (Tedeshi & Calhoun, 1996). Resilience is demonstrated by continued functioning post-traumatic event at a level comparable to their functioning prior to the adversity, whereas posttraumatic growth shows improved functioning and performance after an adverse experience occurs. Furthermore, Tedesci and Calhoun (1996) noted that they did not believe resilience and posttraumatic growth to be related as resilient individuals, by definition, do not show a change in functioning following adversity and stress, whereas individuals with PTG show improvements. By including this measure, this study intends to explore a subpopulation, beyond those demonstrating resilience, who may in fact develop greater psychological strength as a result of adversity or trauma. As the field of developmental trauma continues to unfold and describe common responses to early life stressors, we are better able to predict and intervene for these individuals (D'Andrea, Ford, Stolbach, Spinazzola, & Van der Kolk, 2012; Fisher, 2014; Siegel, 2015;).

Purpose of this Study

This study examined the relationship between childhood adversity, self-compassion, hardiness, posttraumatic growth and resilience. By uncovering this relationship, we are better able to conceptualize the patient's psychosocial circumstances inhibiting them from developing a healthy view of self. I proposed that, in addition to the neurological and biological responses to adverse childhood experiences, self-compassion is also injured, except when attachment, religion, resilience and hardiness are taken into account as mediating factors.

Results of this study may be a helpful tool for both survivors and clinicians working with survivors of childhood abuse. Understanding the deleterious effects these early experiences may have on the development of self-compassion may help to validate the psychological strain resulting from adversity. Finding religion, attachment, resilience and self-compassion as protective factors would help to provide evidence-based interventions to survivors in order to help aid in their recovery and protect them from further revictimization. Lastly, the findings of this study may support the integration of self-compassion into PTSD treatments and continued resilience-building interventions to at-risk populations (Raiche, 2017).

Hypotheses of the Present Study

Hypothesis 1: ACEs scores will negatively correlate with Self-Compassion ratings.

Hypothesis 2: Resilience scores will positively correlate with Self-Compassion scores.

Hypothesis 3: ACEs scores will negatively correlate with Resilience scores.

Hypothesis 4: Resilience, Hardiness and Posttraumatic Growth will positively correlate with each other.

Hypothesis 5: Resilience and self-compassion will mediate the associations between ACEs and posttraumatic growth.

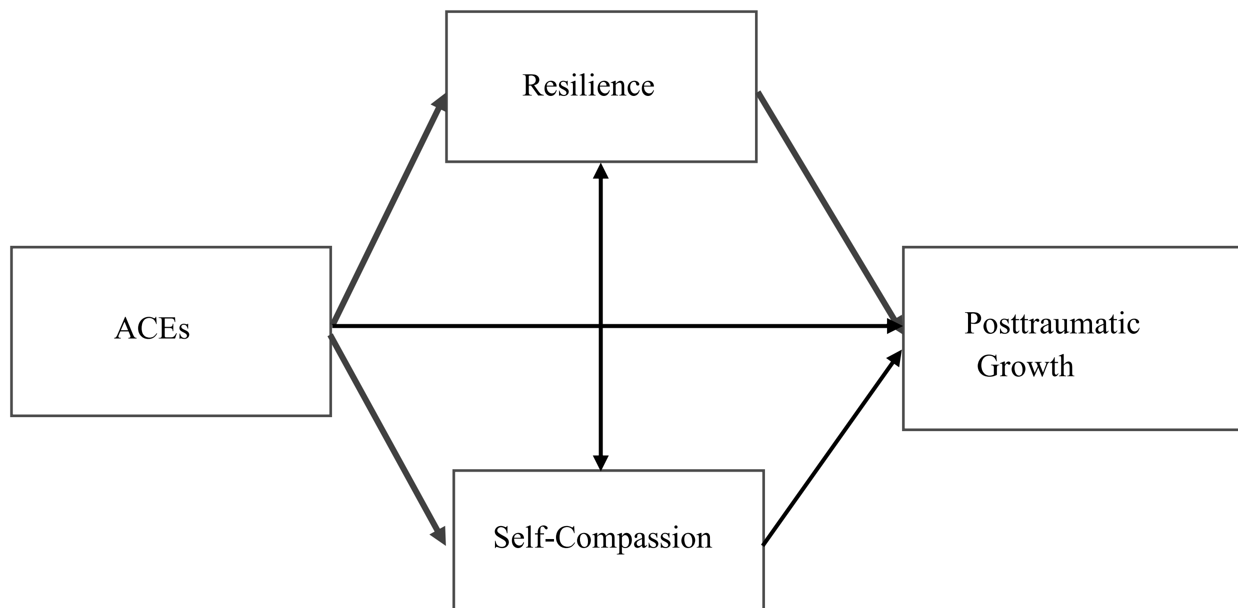

Figure 1. Model of hypothesized relationship between Adverse Childhood Experiences and Posttraumatic Growth (Hypothesis 5).

Chapter 2

Methods

This research is structured using a quantitative design to begin to examine the relationships between Adverse Childhood Experiences (ACEs), self-compassion, posttraumatic growth, hardiness, resilience, religion, and presence of a person to help during hard times.

Participants

There were 287 participants who began the survey; a total of 52 participants ended the survey pre-maturely, resulting in 235 completed surveys. Twenty-six participants discontinued after the demographics section, 3 after the ACEs study, 6 ended after the resilience scale, an additional 6 participants ended after self-compassion and one participant left the survey after hardiness. Of the 287 participants who initiated the survey 17% of respondents did not complete the full survey. With 7.3% of these respondents completing one or more questionnaires before exiting. Additionally, given that the Posttraumatic Growth Inventory asks participants to consider the impact of a trauma, crisis, or disaster, only participants who endorsed experiencing one or more of these were asked to complete the PTGI (48.8%).

Respondents were 81.29 % White, 12.59% Asian or Pacific Islander, 6.47% Hispanic or Latino, 3.24% Black or African American, and 1.08% American Indian (Table 1). The age of participants was skewed towards a young adult population with half the sample ranging in age from 18-24 years (50.18%), 34.66% between age 25-34, 10.47% age 35-44 and 1.81% 55-64 years (Table 1). Gender identities reported by participants include 28.06% males, 69.78%

females, 2.52% transgender and 1.44% non-binary (Table 1). Participants identified 21 countries of birth with 78.4 % from the United States, 4.2 % from Australia, 3.1% from the United Kingdom, and 3.1% from Canada (Table 1).

Table 1

Demographics of all Participants

		Frequency	Percentage
Ethnicity			
	American Indian or Alaskan Native	3	1.08
	Asian or Pacific Islander	35	12.59
	Black or African American	9	3.24
	Hispanic or Latino	18	6.47
	White/Caucasian	226	81.29
Age			
	18-24	139	50.18
	25-34	96	34.66
	35-44	29	10.47
	55-64	5	1.81
	65+	0	0
Assigned sex at birth			
	Male	69	24.82
	Female	209	75.18
Current gender identity			
	Male	78	28.06
	Female	194	69.78
	Transgender	7	2.52
	Non-binary	4	1.44
Country of Birth			
	USA	225	78.4
	United Kingdom (Great Britain, Northern Ireland, England, Scotland, Wales)	9	3.1
	Australia	12	4.2
	Poland	2	0.7
	Canada	9	3.1
	Finland	2	0.7
	Syria	1	0.3
	Sweden	1	0.3

Netherlands	1	0.3
Italy	1	0.3
Brazil	1	0.3
New Zealand	2	0.7
Argentina	2	0.7
North Marianas Islands	1	0.3
Peru	1	0.3
India	1	0.3
Chile	1	0.3
Belgium	1	0.3
Germany	1	0.3
Guatemala	1	0.3
Ethiopia	2	0.7

Materials

Adverse Childhood Experiences Scale (ACEs). The Adverse Childhood Experiences Scale (ACEs; Felitti et al., 1998) was used to evaluate the level of adversity experienced by our participants during childhood. Items in this scale range from experiencing a parent's divorce to instances of abuse in childhood. The ACEs scale is a 10-item yes/no questionnaire, with higher scores suggesting more adversity in childhood. For this study, Cronbach's alpha was .88. See Appendix A.

Self-Compassion Scale—Short Form (SCS-SF). The Self-Compassion Scale (SCS-SF; Raes, Pommier, Neff, & Van Gucht, 2011) will be used to measure how participants experience self-compassion. The SCS-SF is a 12-item measure, shortened from the original 26-item measure. This scale determines levels of self-compassion by examining ratings of self-kindness, self-judgment, common humanity, isolation, mindfulness and over-identified items. The SCS-SF uses a 5-point Likert scale ranging from *almost never* to *almost always.* For this study, Cronbach's alpha was .86. See Appendix A.

Connor-Davidson Resilience Scale (CD-RISC). The Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003) is a 25-item questionnaire used to measure the resilience of the participants. The CD-RISC uses a 5-point Likert scale ranging from *absolutely false* to *true almost all of the time*. The internal consistency reliability coefficient is .89 and the test-retest reliability coefficient is .87 (Connor & Davidson, 2003). For this study, Cronbach's alpha was .91. See Appendix A.

Hardiness Questionnaire. The Hardiness Questionnaire is a self-report measure used to measure trait-level stress resistance (Bardone, 1995). The measure consists of 12 items, the participant is asked to rank each item on a 4-point likert scale (*Strongly disagree, disagree, agree* or *strongly agree*). For this study, Cronbach's alpha was .83. See Appendix A.

Posttraumatic Growth Inventory (PTGI). The Posttraumatic Growth Inventory is a 21-item inventory in which the participant ranks each item based on a 5-point likert scale indicating the degree to which they feel the statement of potential growth is true of their experience following the crisis (Tedeschi & Calhoun, 1996). For this study, Cronbach's alpha was .92. See Appendix A.

One-Item measures. As a way of considering potential covariants such as attachment and religious beliefs, two one-item questions were added to determine these influences. A one-item questionnaire asking the level of importance of religion has been shown to be as effective as commonly used full scales (Gorusch & McFarland, 1972). Additionally, participants were asked, "Was there someone in your life who helped teach you self-compassion or who helped you through hard times?" to determine the presence of a secure attachment figure. This helps to determine the level of support for social and emotional well-being. See Appendix A.

Procedure

Following IRB approval, participants were recruited through electronic convenience methods including: undergraduate psychology students at George Fox University, a Reddit "subreddit" geared towards academic studies, and Facebook. Participants filled out measures through survey monkey.

Consent forms were administered along with surveys through an electronic source. All data collection was done anonymously, thus insuring the participants confidentiality in this process. See Appendix A and Appendix B.

Chapter 3

Results

Data was analyzed by using the IBM Statistical Package for the Social Sciences Statistics, version 26 (SPSS 26). Descriptive statistics and a Pearson Correlations of all variables was run to assess the general variance and relationship of the variables. In addition, a path model was created with the SPSS add-on package AMOS, used to determine the predictability of the correlations between variables.

Preliminary Analyses

Preliminary analyses were conducted in order to test the assumptions of a path analysis. As seen in Table 2, skewness and kurtosis values were within acceptable limits for all variables. Resilience, post-traumatic growth, self-compassion, religious importance, and hardiness was normally distributed. The mean ACEs scores across participants was 2.77 (*SD* = 2.73). ACEs was non-normally distributed, with a moderate skewness of .90 (*SE* = .15) and kurtosis of -.11 (*SE* = .31). This is expected, given that most participants have not experienced adversity in childhood. The presence of an attachment figure among participants ranged from 1 (“no”) to 2 (“yes”) with a mean of 1.26 (*SD* = .44) indicating that most participants did not have a significant attachment figure during development. Having a significant person during childhood was non-normally distributed, with a high skewness of 1.13 (*SE* = .16) and kurtosis of -.73 (*SE* = .32), however, this variable was not included in the path analysis.

Table 2

Descriptive Statistics

Measure	N	Mean	SD	Skewness	Kurtosis	Cronbach Alpha
Religion	235	4.63	3.11	.07	-1.57	--
Person	235	1.26	.44	1.13	-.73	--
ACEs	251	2.77	2.73	.9	-.11	.83
CDRISC	248	63.75	15.49	-.41	.18	.93
PTGI†	140†	54.23	25.83	-.37	-.76	.95
Hardiness	236	1.69	4.44	-.07	-.09	.43
SCS-SF	242	3.27	.64	-.45	.53	.76

Note. Religion and Person (Attachment figure) are measured from one-item questions. ACEs = Adverse Childhood Experiences survey, CDRISC = Connor-Davidson Resilience Scale, PTGI = Posttraumatic Growth Inventory, and SCS-SF = Self-Compassion Survey-Short Form. †Only individuals who endorsed experiencing a trauma, crisis or disaster were asked to complete the PTGI

Hypotheses Testing

Hypothesis 1. For hypothesis 1 we expected to find a negative correlation between ACEs and self-compassion. As seen in Table 3, the correlation between childhood adversity and self-compassion was non-significant ($r(242) = -.12, p = .07, n.s.$).

Hypothesis 2. The second hypothesis anticipated a positive correlation between resilience and self-compassion. As observed in the Table 4, this was confirmed and a strong significant positive correlation was observed between self-compassion and resilience, ($r(236) = .60, p = .01$).

Table 3

Coefficient of Determination

Model	*R*	*R Squared*	*Adjusted R Square*	*Standard Error*
1	.65	.42	.39	.51

Note. Predictors: (Constant), ACESTota, PTGITotal, Was there someone in your life who helped teach you self-compassion or who helped you through hard times? HQtotal, Religion, CDRISCTotal. Self-compassion was used as the dependent variable.

Table 4

Pearson Correlations

	Measure	*1*	*2*	*3*	*4*	*5*	*6*	*7*
1	Religion	--						
2	Person	-.25**	--					
3	ACEs	-.15*	.17**	--				
4	CDRISC	.44**	-.22**	-.19**	--			
5	PTGI	.39**	-.31**	.03	.46**	--		
6	SCS-SF	.18**	-.21**	-.12	.60**	.43**	--	
7	Hardiness	.22**	-.17**	-.21**	.53**	.14	.42**	--

Note. Religion and Person (Attachment figure) are measured from one-item questions. ACEs = Adverse Childhood Experiences survey, CDRISC = Connor-Davidson Resilience Scale, PTGI = Posttraumatic Growth Inventory, and SCS-SF = Self-Compassion Survey-Short Form.
$^* p < .05$; $^{**} p < .01$

Hypothesis 3. The third hypothesis predicted a negative correlation between ACEs and resilience. This was confirmed and a significant small negative correlation was observed, $(r(245) = -.19, p = .01)$.

Hypothesis 4. Hypothesis four predicted a positive correlation between resilience, hardiness and posttraumatic growth. As observed in Table 4, resilience and posttraumatic growth were found to have a moderate significant positive correlation, ($r(137) = .46, p = .01$). As shown in Table 4, hardiness and posttraumatic growth was non-significant ($r(138) = .14, p = .095, n.s.$). Table 4 shows that resilience and hardiness had a strong significant positive correlation ($r(233) = .53, p = .01$).

Hypothesis 5. Our fifth hypothesis expected to find resilience and self-compassion as mediators of the association between ACEs and posttraumatic growth. As seen in Figure 2, a significant indirect path was observed with resilience as a mediator between the relationship between ACEs and posttraumatic growth. No significant direct relationship was observed between ACEs and posttraumatic growth. Furthermore, as shown in Table 4, a moderate significant relationship was observed between posttraumatic growth and self-compassion ($r(140) = .43, p = .01$). Figure 2 further demonstrated that the less adversity an individual experiences, the more self-compassion someone is likely to have as an adult.

The linear regression equations between self-compassion and resilience is $y = 1.71 + 0.02x$, between posttraumatic growth and self-compassion is $y = 2.7 + 0.01x$. Next, a Sobel Test of Mediation was used to explore resilience and self-compassion as mediators of the relationship between ACEs and posttraumatic growth (see Figure 2 for the path model, Table 3 for r^2, and Table 4 for estimates). Resilience was found to be a significant mediator ($z = -2.54$ ($SE = .25$), $p = .01$). Self-compassion was not found to be a significant mediator ($z = -1.58$ ($SE = .17$), $p = .11$, $n.s.$).

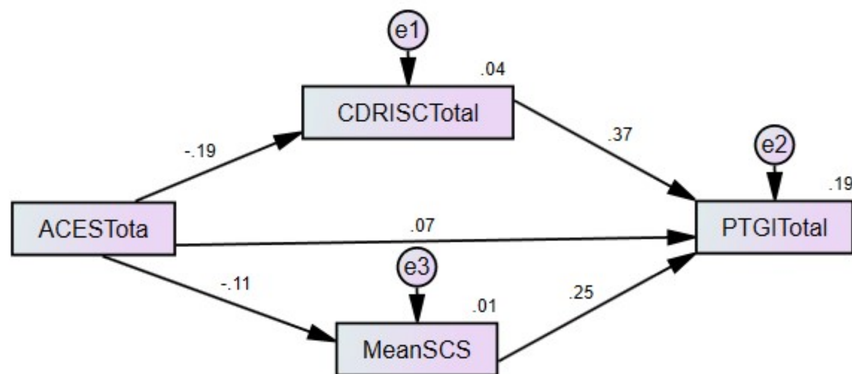

Figure 2. Path analysis

Note: e1, e2, and e3 represent additional variables not accounted for by the variables in this model. Statistics noted in this model represent R^2. ACESTota= the total score of Adverse Childhood Experience, CDRISCTotal= Total score of Connor-Davison Resilience Scale, MeanSCS= the overall score for Self-Compassion Survey- Short Form and PTGITotal= total score for Posttraumatic Growth.

Additional Analyses

A Pearson correlation (Table 4) further showed that ACEs had a small negative correlation with religion ($r(235) = -.15, p = .05$) and hardiness ($r(235) = -.21, p = .01$), as well as a small positive correlation with a significant attachment figure ($r(231) = .17, p = .01$). Furthermore, religion showed significantly correlated relationships with most variables, including: a moderate correlation to resilience ($r(231) = .44, p = .01$), posttraumatic growth ($r(139) = .39, p = .01$), and a small correlation to having a significant attachment figure ($r(235) = .25, p = .01$), hardiness ($r(233) = .22,\ p = .01$), and self-compassion ($r(235) = .18,\ p = .01$). Having an attachment figure present in development was observed to have a significant correlation to several variables. Correlations to an attachment figure include: a small

positive correlation with ACEs ($r(235) = .17, p = .01$), small negative correlation to hardiness ($r(233) = -.17, p = .01$), moderate negative correlation to resilience ($r(231) = -.22, p = .01$), self-compassion ($r(235) = -.21, p = .01$), and post traumatic growth ($r(139) = -.31, p = .01$). Additionally, a moderate positive correlation was observed between self-compassion and hardiness ($r(236) = .42, p = .01$).

Table 5

Regression Table

Variable	*B*	*SE B*	*β*	*t*	*p*
Self-Compassion	2.108	.276	--	7.642	.00
CDRISC	.014	.00	.33	3.51	.00
Religion	-.02	.02	-.10	-1.29	.20
Person	-.07	-.10	-.05	-.73	.46
PTGI	.01	.00	.26	3.24	.00
Hardiness	.04	.01	.27	3.23	.00
ACEs	.01	.02	.06	.86	.39

Note. Religion and Person (Attachment figure) are measured from one-item questions. ACEs = Adverse Childhood Experiences survey, CDRISC = Connor-Davidson Resilience Scale, PTGI = Posttraumatic Growth Inventory, and SCS-SF = Self-Compassion Survey-Short Form. The symbols in the above table represent unstandardized beta (*B)*, the standard error for the unstandardized beta (SE *B*), the standardized beta (β), the *t* test statistic (*t)*, and the probability value (*p*). The dependent variable is Self-Compassion Scale.

Chapter 4

Discussion

Discussion of the Sample

One of the goals of this study was to provide the most inclusive pool of participants as possible. It is noteworthy that the sample population is skewed to predominantly represent the experience mostly of young adults, identifying as females who are White/Caucasian and United States born.

According to Poushter, Fetterolf, & Tamir (2019), worldwide studies across 21 countries found that religion is rated to be important to approximately 46% of people. This aligns with the above findings in Table 4. It should be noted that this sample was normally distributed, but showed a significant negative kurtosis indicating that respondents were equally represented across the endorsement of religious importance.

In the present study, 63% of respondents identified the presence of an attachment figure (See Table 2). Felitti et al. (1998) found that 52% of participants endorsed having at least one adversity in childhood and 25% identified having two or more ACEs. The present study found that of 251 participants who completed the ACEs, 73.7% endorsed experiencing one or more adversity and 56.2% identified having two or more ACEs. It is noteworthy that the present study observed a population with much greater exposure to adversity in childhood. Additionally, this sample demonstrated a significant skew and is non-normally distributed, however, this is reflected of previous studies in which the majority of individuals experienced zero adverse childhood experiences.

In Connor & Davidson (2003) study, they found that the overall sample had an average CDRISC score of $M = 63.87$ ($SD = 16.83$). The present study found very similar results (see Table 2). One meta-analysis found that Posttraumatic Growth scores appear to range from $M = 33.80$ ($SD = 15.49$) to $M = 68.08$ ($SD = 24.95$) (Steffens & Andrykowski, 2015). This aligns with the findings of this study shown in Table 2. According to Raes et al. (2011), average self-compassion scores are $M = 3.0$ ($SD = 1.5$), this is relatively similar to our sampled population (see Table 2).

Discussion of the Hypotheses

Hypothesis 1. The first hypothesis stated that there will be a negative correlation between Adverse Childhood Experiences and self-compassion. Findings of this study did not support this assumption and no significant relationship was observed between ACEs and Self-Compassion. While extreme neglect in childhood is associated with poor brain development and behavioral outbursts (Center on the Developing Child, 2007), researchers have observed that trauma and stress are experienced differently by different people and not all potentially traumatic events (PTE) will cause PTSD or dysfunction (Pine, Costello, & Masten, 2005). In addition, positive coping and protective factors are believed to alter an individual's treatment of themselves and appraisal of their previous circumstance over time. Thus, events that may have occurred 10-30 years in the past may not impact individuals' view of themselves as much as it may have in their childhood. It may also be that while some of these individuals have experienced multiple adversities in life, the independence gained in adulthood has provided the distance to transform their narrative.

Hypothesis 2. The second hypothesis anticipated a positive correlation between resilience and self-compassion. The present research found that resilience and self-compassion had a strong significant correlation (Table 4). This supports findings that self-compassion was associated with resilient people (Bluth et al., 2015; Breines et al., 2014; Raiche, 2017; Vigna et al., 2017). Additionally, Table 4 showed a correlation between resilience and self-compassion.

Hypothesis 3. In the third hypothesis, it was expected that Adverse Childhood Experiences would negatively correlate with resilience. Findings from survey results confirmed this hypothesis and showed a statistically significant small negative correlations (see Table 4). This supports research findings that contrary to popular belief, children are not more resilient than adults (Perry & Szalavitz, 2006). Alternatively, it can be argued that children are more sensitive to adversity and trauma and require more support in overcoming these impacts and making sense of these events. Without significant meaning-making, support and explanation from adults, children may grow up to have a decreased ability to endure stress and adversity later in life (Spinazzola et al., 2014). It may be that these adult children of adverse backgrounds have endured neurological impairment from the stress, loneliness, and/or terror endured during development (Center on the Developing Child, 2007). It may be attributed to difficulty understanding these events from childhood in the context of their life and may lead to misattributing these experiences.

Hypothesis 4. The fourth hypothesis anticipated positive correlations between resilience, hardiness and posttraumatic growth. As research has used these synonymously or favoring one over the other as an explanation for individuals who appear to be healthy despite significant stress, adversity or trauma. This study confirmed a moderate positive correlation between

resilience and posttraumatic growth as well as a strong positive correlation between hardiness and resilience, but did not confirm a positive correlation between posttraumatic growth and hardiness. This indicates that resilient people are more likely to demonstrate hardiness and posttraumatic growth in the face of stress or trauma, but hardy people are no more likely to demonstrate growth after a traumatic event than non-hardy people.

Hardiness is characterized by control, commitment and challenge and demonstrates a negative correlation to physical illness in the face of high stress (Kobasa, 1979). Posttraumatic growth demonstrates ability to show increased performance after a traumatic experience due to meaning-making and a sense of connection (Tedeschi & Calhoun, 1996). Although Tedesci and Calhoun (1996) believe you cannot be both resilient and have PTG, however, someone may show resilience to many/most adversities in their life but in the face of a specific trauma, crisis, or disaster have an increased chance of demonstrating posttraumatic growth following that event. Given the observed relationship, it may be that both individuals are resilient in the sense that both groups do not suffer significant social, physical or psychological setbacks as a result of stress, trauma or adversity. Individuals with PTG should be distinguished from those with resilience as they do show a significant change in psychological and behavioral health in a positive regard.

Hypothesis 5. The fifth hypothesis predicted that resilience and self-compassion will mediate the relationship between Adverse Childhood Experiences and Posttraumatic Growth. We were not able to confirm a direct relationship between PTG and ACEs, however, resilience was observed to mediate the relationship between ACEs and PTG.

As discussed in regards to Hypothesis 1, the absence of this correlation between ACEs and PTG may be best attributed to the diversity of experience and internalization of stress, trauma, or disaster based on a wide variety of factors (i.e., protective factors, genetic factors, and temperament). Whereas the meaning-making and self-kindness practiced with resilience and self-compassion may offer a higher likelihood of positive attribution and growth following a traumatic event.

Discussion of additional analyses. The higher the adversity experienced in childhood, the lower religious importance and hardiness and the higher likelihood of a significant attachment figure (Table 4). The degree to which religion was seen as important was related to increased resilience, posttraumatic growth, the presence of an attachment figure, hardiness and self-compassion. Having a significant attachment figure was further related to hardiness and posttraumatic growth. Self-compassion was also related to high posttraumatic growth and hardiness.

Limitations

Fatigue is a common contributions to attrition within surveys, however, nearly half of participants who did not complete the full survey discontinued prior to completing the first page. Since the survey begins with the Adverse Childhood Experiences, some participants may have been disinclined to complete this survey given the discomfort that reporting childhood adversities may evoke. It should be mentioned that this present study utilized convenience sampling methods through targeted online channels including a sample of undergraduate students at a local university, Facebook, and Reddit. This present study is not representative of the whole population given that a majority of participants were young (between the ages of 18-24), white,

females, and/or born in the USA. It is likely that, given the medium the survey was presented, this is the population most likely to have access to this survey. Additionally, the self-selection often observed in convenience sampling may draw individuals whose backgrounds are personally significant to the variables mentioned, thus attracting higher rates of ACEs than reflected in the general public.

Furthermore, a number of countries were represented in this study. These populations are not evenly represented given that many countries only had one participant and the majority of respondents were from the United States, United Kingdom, Australia, and Canada. This poses a limitation given that one respondent from a country is not enough to have data variance or draw conclusions. In addition, participants were not asked to identify one specific traumatic event when completing the PTGI as is recommended to yield responses to specific events.

Implications

While experiences of some childhood maltreatment and trauma may lead to self-negation and psychological difficulty, this present study has demonstrated that experiencing adversity in childhood does not lead to low self-compassion or posttraumatic growth. Further, the relationship between adversity in childhood and resilience and hardiness was a small negative correlation. Alternatively, this study found that individuals who have high self-compassion, hardiness and religious beliefs are more likely to exhibit resilience. In addition, individuals with high resilience, self-compassion, and religious beliefs are more likely to experience posttraumatic growth following a trauma, crisis, or disaster.

Future Directions

Future studies should continue to explore the relationships between self-compassion, posttraumatic growth, resilience and childhood trauma. Studies have shown that being exposed to a traumatic event does not necessarily lead to clinically significant symptoms (National Institute of Mental Health, n.d.), however, research has demonstrated that repeated, complex and chronic traumatic experiences significantly increase the likelihood of pathology (Spinazzola et al., 2014). Additional trauma studies may benefit from exploring the significance of complex or chronic traumatic experiences in psychosocial outcomes. Trauma studies may also take a focused look by selecting a single group who have endured a specific traumatic experience to complete the PTGI, SCS-SF, and CDRISC.

In addition, future studies may choose to use a full religious scale and attachment questionnaire to measure the significance of these variables in predicting resilience and posttraumatic growth. Many variables contribute to the outcomes of adversity that deserve further exploration including: genetics, prior mental health diagnosis, health conditions, social support, intelligence, and substance use to name a few. Furthermore, future studies may benefit from exploring the international use of these measures. It may be of interest to researchers, given a larger and/or more varied sample to explore the different relationships between childhood adversity and psychosocial well-being.

Moreover, future studies may choose to examine from a more diverse age bracket to determine if there may be a cohort difference in responses to adversity and trauma. Given the advances in technology and globalization of our world- have we learned to adapt easier with more information at our disposal? Or has this become a barrier in resilience as some suggest,

leaving us more isolated? Gathering from a participant pool with a greater male-to-female population should be explored to see if there are significant differences in experience.

Lastly, studies on resilience and psychosocial well-being would benefit from considering additional markers of wellness and success in the face of challenging circumstance. For example, grit may be used to describe similar examples of individuals demonstrating strength, perseverance despite obstacles and setbacks. Grit typifies the kind of internal motivation needed to succeed in academics, physical feats, and business. Angela Duckworth and her colleagues (2007) describe grit as someone possessing uncommon perseverance and conscientiousness such that they tend to create long-term goals and don't stray from this objective despite setbacks.

Conclusions

This study utilized a retrospective, self-report method to determine the relationship between adversity in childhood and later life psychosocial characteristics of well-being including: resilience, hardiness, self-compassion, and posttraumatic growth. There are many common contributors to healthy coping, recovery and resilience following adversity, stress or trauma. For this reason we also used a one-item measure to consider the role of religion and attachment in predicted outcomes after adversity.

This study demonstrated several positive relationships in regard to psychological outcomes after childhood maltreatment or adverse experiences. First, self-compassion appears to lead to both increased resilience and increased likelihood of posttraumatic growth. Adverse Childhood Experiences (ACEs) was not predictive of resilience, posttraumatic growth, or self-compassion. However, experiencing these adversities have a small negative relationship to religion, resilience, and hardiness. This means that simply having adversity in childhood does not

directly impact your psychological or social health, but may give you a lesser propensity towards religious expression and an ability to withstand stress or adversity.

Overall, these findings indicate that self-talk and inner narrative is a significant element in mediating the effects of adversity. Our ability to attribute meaning and purpose to life's challenges give us an improved ability to navigate through them. Curiously, having an attachment figure was negatively correlated to both resilience and PTG. It may be that individuals who have a significant attachment in childhood were more protected from a need to develop resilience or meaning-making coping skills during adversity. Alternatively, it may be that individuals who had an adult to help them through hard times possessed sufficient support and protective factors so as to experience stressful and potentially traumatic events (PTE) to a lesser degree.

Given previous research on self-compassion, resilience, hardiness and attachment, psychosocial well-being is worthy of further research and therapeutic implementation. As the present study demonstrates, childhood adversity may slightly disadvantage individuals towards less hardiness or resilience thus experiencing some degree of setback when faced with adversity or high stress later in life. Adversity in childhood was not, however, found to be predictive of later life psychological well-being. These are important findings for those who have come from disadvantaged, and/or challenging backgrounds in which they experienced or were exposed to neglect, verbal, physical, and/or sexual abuse, parental domestic violence, parental divorce, family mental health, family substance use, and/or family incarceration.

It is also encouraging to mental health workers, mentors and coaches who may play a vital role in the lives of individuals who may have experienced one or more of the above

adversities in childhood. Though, these individuals and those who care for them cannot undo the circumstances of their childhood, teaching and encouraging these individuals to practice hardiness, self-compassion, and resilience may have significant long-term impacts on them. Specifically, in conceptualizing stressful, adverse or traumatic events in ways that support a commitment to self, meaningfulness, and internal control will support hardiness and satisfaction at work and in interprofessional relationships.

By practicing self-compassion demonstrated in self-kindness, common humanity, and mindfulness, one can expect to increase their ability to overcome stressful, traumatic and adverse events. Both hardiness and self-compassion are, in part, characterized by meaning-making and a connection to something greater. For some, this is experienced in significant relationships, religious beliefs, and other protective factors. These improvements can be expected to yield resilience and a decreased impact both psychologically and physiologically from stressful events.

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Appendix A
Scales and Questionnaires

Resilience scale CD-RISC

For each statement give the response that best describes your experience: **not true at all** (0), **rarely true** (1), **sometimes true** (2), **often true** (3), **true nearly all of the time** (4)

	Not true				True
1 Able to adapt to change	0	1	2	3	4
2 Close and secure relationships	0	1	2	3	4
3 Sometimes fate or God can help	0	1	2	3	4
4 Can deal with whatever comes	0	1	2	3	4
5 Past success gives confidence for new challenge	0	1	2	3	4
6 See the humorous side of things	0	1	2	3	4
7 Coping with stress strengthens	0	1	2	3	4
8 Tend to bounce back after illness or hardship	0	1	2	3	4
9 Things happen for a reason	0	1	2	3	4
10 Best effort no matter what	0	1	2	3	4
11 You can achieve your goals	0	1	2	3	4
12 When things look hopeless, I don't give up	0	1	2	3	4
13 Know where to turn for help	0	1	2	3	4
14 Under pressure, focus and think clearly	0	1	2	3	4
15 Prefer to take the lead in problem solving	0	1	2	3	4
16 Not easily discouraged by failure	0	1	2	3	4
17 Think of self as a strong person	0	1	2	3	4
18 Make unpopular or difficult decisions	0	1	2	3	4
19 Can handle unpleasant feelings	0	1	2	3	4
20 Have to act on a hunch	0	1	2	3	4
21 Strong sense of purpose	0	1	2	3	4
22 In control of your life	0	1	2	3	4
23 I like challenges	0	1	2	3	4
24 You work to attain your goals	0	1	2	3	4
25 Pride in your achievements	0	1	2	3	4

Adverse Childhood Experience (ACE) Questionnaire Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** ... Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 ________

2. Did a parent or other adult in the household **often** ... Push, grab, slap, or throw something at you?
or **Ever** hit you so hard that you had marks or were injured?
Yes No If yes enter 1 ________

3. Did an adult or person at least 5 years older than you **ever**... Touch or fondle you or have you touch their body in a sexual way?
or
Try to or actually have oral, anal, or vaginal sex with you?
Yes No If yes enter 1 _________

4. Did you **often** feel that ... No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 ________

5. Did you **often** feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 _________

6. Were your parents **ever** separated or divorced?
Yes No If yes enter 1 _________

7. Was your mother or stepmother: **Often** pushed, grabbed, slapped, or had something thrown at her?

or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

Yes No If yes enter 1 ________

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes No If yes enter 1 ________

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

Yes No If yes enter 1 ________

10. Did a household member go to prison?

Yes No If yes enter 1 ________

Self-Compassion Short Scale

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never				Almost always
1	**2**	**3**	**4**	**5**

_____1. When I fail at something important to me I become consumed by feelings of inadequacy.
_____2. I try to be understanding and patient towards those aspects of my personality I don't like.
_____3. When something painful happens I try to take a balanced view of the situation.
_____4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
_____5. I try to see my failings as part of the human condition.
_____6. When I'm going through a very hard time, I give myself the caring and tenderness I need.
_____7. When something upsets me I try to keep my emotions in balance.
_____8. When I fail at something that's important to me, I tend to feel alone in my failure
_____9. When I'm feeling down I tend to obsess and fixate on everything that's wrong.
_____10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
_____11. I'm disapproving and judgmental about my own flaws and inadequacies.
_____12. I'm intolerant and impatient towards those aspects of my personality I don't like.

Hardiness Questionnaire

Are you tough when life gets rough? This simple quiz can give you an idea of how stress-hardy you are. Indicate how strongly you agree or disagree with each statement, using this scale:
0=strongly disagree 1=mildly disagree 2=mildly agree 3= strongly agree

A. ____ Trying my best at work makes a difference.

B. ____ Trusting to fate is sometimes all I can do in a relationship.

C. ____ I often wake up eager to start on the day's projects.

D. ____ Thinking of myself as a free person leads to great frustration and difficulty.

E. ____ I would be willing to sacrifice financial security in my work if something really challenging came along.

F. ____ It bothers me when I have to deviate from the routine or schedule I've set for myself.

G. ____ An average citizen can have impact on politics.

H. ____ Without the right breaks, it is hard to be successful in my field.

I. ____ I know why I am doing what I'm doing at work.

J. ____ Getting close to people puts me at risk of being obligated to them.

K. ____ Encountering new situations is an important priority in my life.

L. ____ I really don't mind when I have nothing to do.

Post Traumatic Growth Inventory

Indicate for each of the statements below the degree to which this change occurred in your life as a result of the crisis/disaster, using the following scale.

0 = I did not experience this change as a result of my crisis. 1 = I experienced this change to a very small degree as a result of my crisis. 2 = I experienced this change to a small degree as a result of my crisis. 3 = I experienced this change to a moderate degree as a result of my crisis. 4 = I experienced this change to a great degree as a result of my crisis. 5 = I experienced this change to a very great degree as a result of my crisis.

Possible Areas of Growth and Change	***0***	***1***	***2***	***3***	***4***	***5***
1. I changed my priorities about what is important in life.						
2. I have a greater appreciation for the value of my own life.						
3. I developed new interests.						
4. I have a greater feeling of self-reliance.						
5. I have a better understanding of spiritual matters.						
6. I more clearly see that I can count on people in times of trouble.						
7. I established a new path for my life.						
8. I have a greater sense of closeness with others.						
9. I am more willing to express my emotions.						
10. I know better that I can handle difficulties.						

11. I am able to do better things with my life.						
12. I am better able to accept the way things work out.						
13.I can better appreciate each day.						
14. New opportunities are available which wouldn't have been otherwise.						
15. I have more compassion for others.						
16. I put more effort into my relationships.						
17. I am more likely to try to change things which need changing.						
18.I have a stronger religious faith.						
19. I discovered that I'm stronger than I thought I was.						
20. I learned a great deal about how wonderful people are.						
21.I better accept needing others.						

One- Item Questions:

1. Select the number that indicates how important your religion is to you 1 (Not at all; have no religion); 2; 3; 4; 5; 6; 7; 8; 9 (Extremely important; my religious faith is the center of my entire life).

2. Was there someone in your life who helped teach you self-compassion or who helped you through hard times?

Appendix B

Consent Forms

INFORMED CONSENT TO ACT AS A PARTICIPATE IN A RESEARCH STUDY

You are invited to participate in a research study of adverse childhood experiences. This research will examine relationships between adverse childhood experiences, self-compassion, posttraumatic growth, hardiness, and resilience. The following survey will consist of a demographics form followed by five questionnaires and two one-item questions related to religiosity and attachment.

To qualify for this research, one must be 18 years of age or older and may be of any gender, or ethnicity.

All information you provide will remain confidential and will not be associated with your identifying information. At any time, you have the freedom to withdrawal or not respond, but for adequate data collection, it will be greatly appreciated for your full participation. Your participation in this study will require approximately 20-35 minutes.

As a token of appreciation, you will be given the option to enter in a raffle for a $50 gift card. If you choose to enter the raffle, an email address is required and will only be used to contact you for incentive purposes.

If you have any further questions concerning this study, please feel free to contact us through phone or email: Gabrielle Yundt at gyundt12@georgefox.edu or Winston Seegobin at wseegobin@georgefox.edu, (503) 554-2370.

By clicking “OK” and “NEXT,” you certify that you have read the preceding information, understand it’s content, and agree to the terms above.

Appendix C

Curriculum Vitae

Education

Psy.D. George Fox University, Clinical Psychology (April 2021)
Dissertation: The Effect of Adverse Childhood Experiences on Psychosocial Wellbeing
Multicultural Committee member, 2017

M.A. George Fox University, Clinical Psychology *April 2018*
Advisor: Winston Seegobin, Psy.D.

B.S. Oregon State University, Psychology Major *June 2016*

Clinical and Work Experience

Doctoral Psychology Extern *August 2019-current*
Portland Mental Health & Wellness
Supervisor: Brad Sanchez, Psy.D.
Role: Outpatient Therapist, Intake Specialist

- Population: families and adults from rural and low-income populations (primarily OHP clients), across a range of clinical presentations including: trauma, Depression, Anxiety.
- Duties: Conducting diagnostic intakes, treatment development, conducting psychological assessments, and providing individual and family therapy to offer psychoeducation, reduce distress, decrease attachment difficulties, and increase emotional intelligence.

Mental Health Therapist/Practicum Student *August 2018-July 2019*
Morrison Child & Family Services
Supervisor: Beth French, Psy.D.
Role: Therapist/Intern, Intake Specialist

- Population: Children and adolescents (6-19) from rural and low-income populations (primarily OHP clients), across a range of clinical presentations including: trauma, Depression, Anxiety, ODD, ADHD, Tic Disorder and Bereavement.
- Duties: Conducting diagnostic intakes, treatment development, conducting psychological assessments, collaborating with DHS caseworkers and providing individual and family therapy to offer psychoeducation, reduce familial distress,

decrease attachment difficulties, and increase emotional intelligence in both parent and child.

Counseling Minister Grace City Church Portland *July 2018- Present*
Supervisor: Nancy Thurston, Psy.D., ABPP
Role: Church Staff member, Therapist, Evaluator, and Consultant

- Population: Primarily young adults (25-34), uninsured/out-of-pocket on a sliding scale, members of a non-denominational church with clinical issues involving: sex addiction, trauma, Personality Disorder, marital difficulties, family of origin problems, Substance Use, and problems related to parenting.
- Duties: Program development, accounting, patient coordination, providing psychological assessment, consultation to the church leadership and Individual therapy with adults from a psychodynamic orientation to address relational, attachment, and personality concerns through a spiritual and dynamic perspective by increasing insight and reflection on the therapeutic relationship and re-enacted relational patterns.

On-Call Clinical Responder Trillium Family Services *May 2018-Present*
Role: Qualified Mental Health Professional (QMHP); Children's Emergency Safety Intervention Specialist (CESIS)

- Population: children and adolescents 6-18 years old at secure inpatient, subacute and residential level of care with a range of acute behavioral and mental health difficulties, and diverse identity markers (i.e. gender identity, sexual orientation, ethnicity, SES)
- Duties: Crisis intervention, risk screening, supervision of the use of non-violent crisis interventions including approving the use of manual restraints, seclusion, maintaining safety throughout the campus and providing consultation to skills trainers and supervisors by promoting client's emotional health and psychoeducation throughout the facility.

Behavioral Health Crisis Consultant George Fox University *January 2018-Present*
Supervisors: Mary Peterson, Ph.D., ABPP/CL, William Buhrow, Psy.D., Luann Foster, Psy.D.
Role: Behavioral Health Crisis Consultant (BHCC); Qualified Mental Health Professional (QMHP)

- Population: Children and adults from a range of clinical presentations including: Anxiety, Depression, Psychosis, Schizophrenia, Bipolar and Chronic Pain.
- Duties: Case management and conducting risk screening assessments in order to provide consultation to the Attending Physician in the Emergency Department regarding patient care, assisting in safety planning, arranging a discharge plan, coordinating with multiple health care providers and family members, and/or arranging for respite care or hospitalization.

School Psychologist/Intern Yamhill-Carlton Intermediate School *August 2017-June 2018*
Supervisor: Elizabeth Hamilton, Ph.D.; Laura Geczy-Haskins, Psy.D.; Arielle Marston, M.A.

Role: Play therapy with children and adolescents (ages 10-14) to explore emotions, coping patterns and interpersonal relationships, and conducting psychoeducational assessments to determine eligibility for specialized education

Simulated Psychotherapy, George Fox University, Newberg *February 2017-April 2017*
Advisor: Glena Andrews, Ph.D.; Molly Winterrowd, M.A.

Role: Doctoral Student

- Population: 1st year college students
- Duties: Met with two freshman students for 10 sessions to provide Person-Centered individual therapy to explore conditions of worth and utilize the therapeutic relationship to promote congruence, empathic understanding and establish unconditional positive regard.

Skills Trainer Trillium Family Services *November 2014-October 2016, May-August 2017*

Role: Intensive DBT staff, Medical Assistant

- Population: Adolescents (age 12-18) with anxiety, depression, trauma, personality and eating disorders
- Duties: Milieu therapy intervention, coordinated conflict resolution and crisis intervention, primary lead staff in charge of managing staff duties and organizing activities to promote client's emotional health, psychoeducation, administration of medication and coordination with clinical teams (therapists, psychiatrist, nurses, supervisors and skills trainers).

Other Work Experience

Teaching Assistant George Fox University *August 2019-current*

Professor: Winston Seegobin, Psy.D.

Role: TA for Religious Diversity

- Population: 3rd year Psy.D. students
- Duties: Providing oversight and assistance of student papers, consultation with students

Teaching Assistant George Fox University *January-May 2019*

Professor: Joel Gregor, Psy.D.

Role: TA for History & Systems of Psychology

- Population: 2nd year Psy.D. students
- Duties: Providing oversight and assistance of student papers, assisting and support of the professor in reviewing lectures and ensuring student access to resources.

Teaching Assistant George Fox University *August-December 2018*

Professor: Elizabeth Hamilton, Ph.D.

Role: Primary TA for Psychopathology

- Population: 1st year Psy.D. students.
- Duties: Editing and grading case study reports, meeting with students to provide feedback and guidance in making accurate diagnoses. Reviewing and providing recommendations to the professor regarding recent research, podcasts, or videos that may aid in the lecture.

Caregiving Assisted Living Facility, Private Caregiving *November 2014-August 2015*

Role: Caregiver, Medical Assistant

- Population: Geriatric and physically disabled residents
- Duties: Care and medication administration and coordination with pharmacist, doctor, nurse, supervisor and care team; assistance with daily living activities (toileting, bathing, feeding, and changing); emergency intervention and coordination; support during end-of life transitions (soothing, providing comfort, coordinating with hospice, family members and emergency personnel).

Research Experience

Research Vertical Team Member *March 2016-Present*

Advisor: Winston Seegobin, Psy.D.

Supplemental Research, George Fox University, Newberg

- Tattooed Psychologists: A discussion of meaning, professionalism and self-disclosure *January-August 2018*
    - *Role*: Assistance with qualitative research coding for interrater reliability, creating and presenting poster at APA
    - *Advisor:* Winston Seegobin, Psy.D.
    - *Lead Researcher:* Elizabeth Hoose, M.A.

- A Program Evaluation of the Hope House *March 2017*
    - *Role*: Assistance with qualitative research coding for inter-rater reliability
    - *Advisor:* Winston Seegobin, Psy.D.
    - *Lead Researcher:* Andrea Hartman, M.A.

- Prayer and Trauma *October 2016-May 2017*
    - *Role*: Assistance running EEG experiment, EEG interpretation, coordinating with participants, lead researcher and research advisor
    - *Advisor:* Glena Andrews, Ph.D., MSCP, ABPP
    - *Lead Researcher*: Laura Hoffman, M.A.

Posters and Presentations

Tattooed Psychologists, Poster August 2018
Presented at: American Psychological Association Convention
Advisor: Winston Seegobin, Psy.D.
Lead Researcher: Elizabeth Hoose, M.A.
Role: 2nd author, assistance developing poster, and presenting

A Program Evaluation of the Hope House, Poster August 2018
Presented at: American Psychological Association Convention
Advisor: Winston Seegobin, Psy.D.
Lead Researcher: Andrea Hartman, Psy.D.
Role: 5th author

Certificates and Additional Training

Diversity Scholarship, George Fox University *August 2016-Present*

Child and Adolescent Assessment Course, George Fox University *May-July 2018*
Professor: Elizabeth Hamilton, Ph.D.

Attachment in Therapy Certificate, George Fox University *March-April 2018*
Professor: Brooke Kuhnhausen, Psy.D.

Children's Emergency Safety Intervention Specialist Certificate September 2018
Trillium Family Services

Gender and Sexuality Course, George Fox University *September-November 2018*
Professor: Brooke Kuhnhausen, Psy.D.

Projective Assessment Course, George Fox University *August-December 2018*
Professor: Nancy Thurston, Psy.D., ABPP

Fundamentals in Psychoanalysis Course, Oregon Psychoanalytic Center *September 2019-Present*
Instructors: Zoe Crawford, LCSW, Ann Dart, LCSW
Julie Rosenberg, MD, and Kate Blumner, MD

Skills

Language: Basic Spanish, Basic Sign Language
Computer: TIER**,** EVOLV, Epic, SPSS, Microsoft Word, Microsoft Excel, GoogleDrive, Time2Track, QuickBooks, TherapyNotes

Wilderness: Certified Adventure Trip Leader, June 2016

Memberships

-American Psychological Association, (APA) member since 2016

- *Division 7:* Developmental Psychology, member since 2019
- *Division 39:* Psychoanalysis, member since 2019
- *Division 56:* Trauma Psychology, member since 2019
- Sections-
    - *Section 353:* Concerns of Hispanic Women/Latinas, member since 2019
    - *Section 355:* Psychology of Asian Pacific American Women, member since 2019
    - *Section 371:* Section on Child Maltreatment, member since 2019

-**American Psychological Association of Graduate Students**, (APAGS) member since 2016

-**Association of Psychologists in Academic Health Centers**, (APAHC) member since 2018

-**Oregon Psychoanalytic Center**, (OPC) member since 2018