2021

Understanding Resilience Among Individuals with Adverse Childhood Experiences (ACEs)

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Walden University
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Abstract

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by

Meghan Larson

MSW, University of Georgia, 2005

BSW, Union University, 2004

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Social Work

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August 2021

Abstract

Adverse childhood experiences (ACEs), such as abuse, neglect, and dysfunction in a child's home are considered a public health crisis due to their correlation to health disparities and psychosocial problems in adulthood such as substance use, relationships, education, and maintaining employment. However, some individuals are resilient and demonstrate the ability to adapt and function well despite experiencing adverse events. To better understand resilience when ACEs are present, I conducted a basic qualitative research study to explore the lived experiences of individuals in Tennessee with elevated ACE and resilience scores. A purposeful sample of 12 participants who scored high on ratings of ACE and resilience participated in in-depth interviews, ranging from 24-140 minutes, about their experiences with resilience. Framed by Bronfenbrenner's ecological systems theory and resilience theory, thematic analysis was employed. Seven themes emerged from the data: (a) giving back, (b) faith and spirituality, (c) influence of strangers, (d) buffer within household, (e) system resources as barriers, (f) limited resource access for participants of color, and (g) generational factors. These themes suggest that protective factors at various system-levels foster resilience and demonstrate the need for trauma informed services across systems including education, mental health, faith based, law enforcement, and social services. Findings may be used to inform effective intervention strategies when developing practices and programs that address ACEs and build resilience.

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Dedication

I dedicate this dissertation to my husband, Mark, for his continuous encouragement and support to pursue my dreams, and to my sons, Andrew and Gabriel, who have been my inspiration. May you each courageously live out God's calling and destiny for your life.

Acknowledgments

I am grateful to have reached this milestone by the grace of God and support from dear family, friends, and colleagues. Walden University faculty and staff, especially my dissertation committee members, have provided valuable guidance throughout this lengthy process, for which I am extremely appreciative. Also, I want to give a heartfelt thank you to my research participants whose voices of honesty, vulnerability, and resilience made this research possible.

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Chapter 1: Introduction to the Study

Introduction

Adverse childhood experiences (ACEs) were first researched by Felitti et al. (1998b), who discovered that over half (52%) of the patients using the Kaiser Permanente health plan had experienced at least one type of abuse, neglect, or household dysfunction within the first 18 years of life, and 6.2% experienced four or more. According to the data from the Behavioral Risk Factor Surveillance System retrieved from 23 states within the United States, 61.55% of adults reported having experienced at least one ACE and 24.64% reported having experienced three or more ACEs (Merrick et al., 2018). These findings demonstrate the effect of ACEs on adults in the United States. Moreover, there is a substantial body of literature that indicates a relationship between ACEs and lifestyle choices or health-related behaviors across the lifespan (Bellis, Hughes et al., 2017; Felitti et al., 1998b; Iniguez & Stankowski, 2016; Larkin et al., 2014; Salinas-Miranda et al., 2015). Adverse childhood experiences are considered a public health crisis as they are associated with health disparities over the course of a person's life (Halfon et al., 2014; Salinas-Miranda et al., 2015; Wade et al., 2014), along with being associated with adult morbidity and mortality (Merrick et al., 2018). However, despite adversity, some individuals are resilient, having the ability to adapt and function well (Borge et al., 2016).

I conducted a qualitative study to explore the lived experiences among individuals in Tennessee with elevated ACE and resilience scores. My research is important to provide understanding of resilience in light of ACEs and because findings may be used to improve service delivery and public health outcomes. In this chapter, I provide

introductory information on the topic, along with the problem and question my research addressed, the conceptual framework, the purpose and significance of the study, and the scope of the research.

Background

Relationship Between Adverse Childhood Experiences and Resilience

As previously mentioned, Felitti et al. (1998b) conducted the first ACE study that brought validity to the notion that abuse and household dysfunction in childhood impacts long-term health and quality of life. Research on the topic has continued in years since the original ACE study, and more is known about the relationship between ACEs and lifestyle choices or health related behaviors across the lifespan (Bellis, Hughes et al., 2017; Felitti et al., 1998b; Iniguez & Stankowski, 2016; Larkin et al., 2014; Salinas-Miranda et al., 2015). Researchers have described an association between the dose-dependent relationship of ACEs and perceived resilience in children and discussed specific internal and external protective factors that contribute to resilience, such as self-efficacy, optimism, autonomy, and safe, stable, nurturing relationships (Heard-Garris et al., 2018). Iniguez and Stankowski (2016) stated research on ACEs yields evidence to support claims that "resilience resources and well-timed interventions to promote resilience can ameliorate the negative effects of ACEs" (p. 132). Logan-Greene et al. (2014) examined the correlation between ACEs and poor health among cohort groups, as well as patterns between resilience resources moderating ACEs even into upper years of life. Further, Borge et al. (2016) reviewed resilience science discoveries on the adaptive process, recognizing that despite exposure to adversity, some individuals can function

well. My research contributes knowledge on experiences of resilience when five or more ACEs are present.

Long-Term Effects of Adverse Childhood Experiences

Specific types of adversity individuals experience and the long-term effects of ACEs vary. ACE studies in some geographical areas have found high rates of physical abuse among participants (Fuller-Thomson & Sawyer, 2012), whereas other studies have found high rates of emotional abuse (Iniguez & Stankowski, 2016) and community violence (Wade et al., 2016). Child maltreatment is a significant public health problem causing financial burden and necessitates prevention and intervention (Fang et al., 2012). Based on the number of reports, approximately two million children are referred to child protective services due to maltreatment in the United States annually (Schofield et al., 2013). An exact number of children who experience maltreatment is unknown due to underreporting (Fang et al., 2012; Schofield et al., 2013). It is particularly important to examine ACEs and trauma exposure in low-income or impoverished areas because families under economic distress are more likely to experience caregiving challenges (Sprang et al., 2013). The National Survey of Children's Health found Tennessee to be in the highest quartile of states for economic hardship (Sacks et al., 2014). According to the U.S. Census Bureau (2017), 17.6 percent of Tennesseans live in poverty. Not only does poverty lead to poor living conditions, but it also contributes to lifestyle choices, low access to health care or preventative care, lack of insurance (Smith & Holloman, 2011), lower incomes, and lower educational status (McCall-Hosenfeld et al., 2014). The lasting effects of adverse experiences can create physical, behavioral, mental, financial, legal,

and social problems (Fang et al., 2012). Therefore, ACEs and the ripple effect ACEs perpetuate (Harper-Browne, 2014) make interventions toward positive social change a necessity.

State Specific Initiatives

In 2017, an initiative entitled Building Strong Brains Tennessee was implemented in the state to educate the public and professionals about brain architecture, toxic stress, ACEs, and resilience (Tennessee Department of Children's Services, 2018). Daugherty and Poudel (2017) measured the level of public awareness about ACEs, sources of adversity, the potential impact of ACEs, and level of support for efforts to mitigate ACEs through interviews with 922 Tennessee residents. Findings demonstrated that over half of the individuals interviewed (55.6%) were not at all familiar with ACEs, although interviewees reported a high level of support for the Building Strong Brains Tennessee initiative (Daugherty & Poudel, 2017). Since 2017, Building Strong Brains Tennessee trainings have occurred in 83 of the 95 counties in the state (Tennessee Commission on Children and Youth [TCCY], 2020). According to Daugherty and Poudel (2017), a majority of survey participants agreed that abuse, violence in the home, and substance use are to be considered ACEs, and that malnourishment, separation from parents, and racial and cultural discrimination would be considered ACEs as well.

As supplemental means to increase public awareness of ACEs, WTCE Public Broadcasting Service in Tennessee produced a six-part series on ACEs entitled "Adverse Childhood Experiences: A Public Health Issue - Building Strong Brains Tennessee" (WTCE, 2018). The series regularly airs on PBS stations throughout the state and is

available for viewing online. It is through the implementation of such programs that state and local leaders have taken innovative strides to improve awareness of ACEs and resilience. Further research on resilience among Tennesseans can be used to inform the development of practices across systems that will promote resilience and influence positive social change.

Problem Statement

Based on the prevalence of ACEs and their influence on health disparities, ACEs are considered a public health crisis and present a need for a wide range of interventions (Halfon et al., 2014; Salinas-Miranda et al., 2015; Wade et al., 2014). Experiences of abuse, neglect, and dysfunction in the home have often led to poor health outcomes (Bellis, Hughes et al., 2017; Felitti, 2002). For example, individuals who have experienced four or more ACEs were found to have an increased risk for smoking, alcoholism, drug abuse, depression, as well as self-reported poor health, high number of sexual partners, sexually transmitted disease, and at least one suicide attempt (Centers for Disease Control and Prevention, 2016; Felitti et al., 1998b; Sacks et al., 2014). Other life experiences such as toxic stress, discrimination, low socioeconomic status, and racial segregation can also negatively affect health (Halfon et al., 2014; Wade et al., 2016). While ACE research provides a foundation for understanding and addressing health issues and outcomes (Larkin et al., 2014), I have not found scholarly literature that evaluates the lived experiences of individuals with both ACEs and resilience. In-depth research on experiences of resilience when ACEs are present can improve understanding and ultimately improve public health outcomes, as growth and development occur within

a cultural and systemic context (Bronfenbrenner, 1979; Davis et al., 2015; Larkin et al., 2014) and behaviors can be intergenerational (Iniguez & Stankowski, 2016).

Purpose

The purpose of this study was to explore the lived experiences among individuals living in Tennessee with elevated ACEs and resilience. I used a basic qualitative inquiry to discover aspects that contribute to experiences of resilience. While the literature on ACEs provides a foundation for understanding and addressing health issues and outcomes (Larkin et al., 2014) and a plethora of research on the topic of resilience aids understanding, my research contributes knowledge specific to the phenomenon of resilience in relation to ACEs. Additionally, the research provides understanding about resources that individuals have found to be helpful or wished they had available to them when addressing ACEs and fostering resilience. In addition, assessing ACE resources is important because of the strategic measures taken in Tennessee to educate public and private sectors about ACEs and resilience.

Research Question

RQ: What are the lived experiences among individuals in Tennessee with elevated ACEs and resilience?

Theoretical Foundation and Conceptual Framework

Two theories compose the theoretical base for this study. The first, Bronfenbrenner's ecological systems theory, addresses human behavior and development occurring within the context of systems influence (Masten, 2016). Bronfenbrenner (1979) proposed that use of the ecological theory is beneficial toward understanding human

development due to the importance of a person's behavior and interactions in their natural environments. Interrelated systems or layers of the environment include the micro, mezzo, and macro levels, which contribute to the understanding of the whole person, as well as influence development (Bronfenbrenner, 1979; Cheng & Solomon, 2014; Masten, 2016). The second, resilience theory, provides a theoretical explanation of positive adjustment in the aftermath of trauma (Joseph & Linley, 2006; Masten, 2016). Masten (2016) defined resilience from a system's perspective as "the capacity for successful adaptation to disturbances that threaten system function, viability, or development" (p. 298). The combined theoretical approach provides a framework for understanding both human development and human potential, which are dependent on the function and interaction of systems in a person's life (Masten, 2016). Further details are outlined in Chapter 2.

Nature of the Study

In this study, I attempted to understand the phenomenon of resilience for individuals in Tennessee who report high ACE and resilience scores. I conducted a basic qualitative research study using purposive sampling to explore lived experiences of resilience. A screening profile was completed by all study participants to determine who met the criteria to participate based on ACE and resilience self-rating scales. Individuals were eligible to participate if they lived in Tennessee for more than 10 years, had an ACE count of four or greater, and had a resilience score within the highest two quartiles. Demographic information gathered included age, gender, race/ethnicity, education level, number of years residing in Tennessee, and urban or rural residence. Due to the

complexity of the resilience phenomenon, the qualitative research tradition allowed for semistructured interviews using open-ended questions to inquire about protective factors, personal characteristics, responses to stress, resources utilized, and relationships that may contribute to a person's experience of resilience. Additional detail on the nature and method of the study is provided in Chapter 3.

Definitions

Adverse childhood experiences (ACEs): Individual experiences of varied types of abuse, neglect, and household dysfunction within the first 18 years of life including physical abuse and neglect, emotional abuse and neglect, sexual abuse, domestic violence, substance abuse in the home, mental illness of a parent, separation or divorce of parents, and incarceration of a parent (Felitti et al., 1998b). Recent research has also considered experiences of discrimination, poverty, and community violence to be ACEs (Halfon et al., 2014; Wade et al., 2016).

Protective factors: Internal and external aspects of a person's life that mitigate negative functioning or risk (Howard et al., 1999; Sabina & Banyard, 2015; Werner, 1989), including a person's risk for developing a health condition or early death (Braveman & Gottlieb, 2014). Protective factors promote resilience (Sabina & Banyard, 2015) and can be used to explain why people with risk factors do not develop behaviors associated with those risk factors (Polaschek, 2017). Polaschek (2017) discussed an example when stating that high intelligence may protect, while low intelligence can increase risk of maladaptive behavior. Protective factors include social support, self-esteem, self-efficacy (Braveman & Gottlieb, 2014), optimism, hope, education,

religiosity and spirituality (Sabina & Banyard, 2015), genetics and biological underpinnings, economic resources, social resources, personality, caregiver bond, healthy attachment relationships, emotional regulation skills, goal-orientation or the capacity to visualize the future, and intrinsic motivation (Southwick et al., 2014).

Resilience: The "capacity of a system for successful adaptation to disturbances that threaten system function, viability, or development," and a person's capacity for successful adaptation depends on many systems, not merely a singular trait or resource (Masten, 2016, p. 298). Because resilience may include biological, psychological, social, and cultural factors, it is important to clarify whether the term resilience is used to refer to a trait, process, or an outcome (Southwick et al., 2014). Southwick et al. (2014) defined resilience as "a process to harness resources to sustain well-being" (Southwick et al., 2014, p. 4), and "a stable trajectory of healthy functioning after a highly adverse event" (p. 2) that may be experienced across multiple domains in life, such as workplace, health, and interpersonal relationships. For purposes of this study, resilience was defined as the ability to adapt, acquire resources, and maintain healthy functioning to sustain well-being.

Assumptions

There was the assumption that participants were honest when completing the screening information, which indicated whether the participant met the study criteria. I assumed that participants were open during the interview and told the truth about their experiences. Also, I assumed that each participant could relate to the phenomenon of resilience based on the screening data.

Limitations

Data gathered through interviews can be distorted by bias, participant perceptions of the interviewer, lack of awareness, or emotions (Patton, 2015). Also, because participants were asked to recount experiences from their past, they may have exhibited selective recall due to the discomfort of disclosure or simply forgetting (Rubin & Rubin, 2012). Additionally, my personal experience with the resilience phenomenon may have influenced bias during the collection, analysis, and interpretation of data. The limitation of bias is discussed further in Chapter 3. Lastly, there are limitations of transferability due to the specifications of the study sample and the uniqueness of the participant responses that may not transfer to other contexts and settings.

Scope and Delimitations

The purpose of this study was to explore the lived experiences among individuals living in Tennessee with elevated ACE and resilience scores. Eligible participants met specific sample criteria based on carefully selected ACE and resilience screening tools and demographic information. Participants were required to be 18 years of age or older and speak English. It was important that the participants lived within the state of Tennessee for 10 or more years so that interview responses about the macrosystem would yield knowledge relevant to the resources available within the state. Also, participants could not be a student or client of mine. Each eligible participant needed to have a high number of challenges during childhood and a high resilience score, both of which were determined through responses on the screening survey and scored by me. The recruitment process involved emailing an invitation to adults in Tennessee, including personal and

professional contacts of mine, as well as to individuals associated with the TCCY, which is an organization whose mission is to lead systems improvement for all children and families through data-driven advocacy, education, and collaboration. Therefore, recruitment captured some members of the population and not others. Ten of the 12 participants had prior knowledge about resilience and ACEs through their professional work and associations.

Significance of the Study

My research contributes knowledge about the lived experiences among individuals in Tennessee with elevated ACEs and resilience. As previously stated, ACEs are considered a public health crisis and present a need for a wide range of interventions (Halfon et al., 2014; Salinas-Miranda et al., 2015; Wade et al., 2014). Therefore, themes discovered in my research can be used to inform the development of programs and resources to help mitigate ACEs and promote resilience across systems such as education, healthcare, parenting, economic assistance, public housing, quality childcare, and community safety through programs that work to prevent and intervene with issues of child abuse, substance abuse, and domestic violence. Also, research on resilience can influence positive social change related to trauma-informed care, mental and behavioral health services, restorative justice, suicide prevention, and social and emotional learning. Because ACEs are common and outside of a child's control, a cultural shift is needed from a place of judgement that asks, "What's wrong with you?" to one of understanding that asks, "What happened to you?" or "What do you need?" (Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration,

2019). Research on the topic of resilience among Tennesseans can be used to inform a shift in culture in which practices across systems promote resilience.

Summary

Adverse childhood experiences are considered a public health crisis (Halfon et al., 2014; Salinas-Miranda et al., 2015; Wade et al., 2014) and often lead to poor health outcomes (Bellis, Hughes et al., 2017; Felitti, 2002). Despite exposure to adversity, some individuals may be resilient and function well (Borge et al., 2016). Resilience may be more common than expected (Southwick et al., 2014). To better understand the phenomenon of resilience when ACEs are present, I explored the lived experiences among individuals in Tennessee with elevated ACEs and resilience. Findings from this study may be used to inform resilience intervention strategies when developing practices and programs that aim to bring about positive social change.

Chapter 2: Literature Review

Introduction

ACEs are common, predictive of long-term health and well-being (Dong et al., 2003; Felitti et al., 1998b), and considered to be a public health crisis (Bethell et al., 2017) as they are associated with health disparities over the course of a person's life (Halfon et al., 2014; Salinas-Miranda et al., 2015; Wade et al., 2014), along with being associated with adult morbidity and mortality (Merrick et al., 2018). Specific types of adversity that individuals experience vary, including child maltreatment such as abuse and neglect, and household dysfunction such as substance abuse and domestic violence (Dong et al., 2003; Felitti et al., 1998b; Sacks et al., 2014). While the lasting effects of ACEs can create physical, behavioral, mental, financial, legal, and social problems for some (Fang et al., 2012; Harper-Browne, 2014), other individuals are resilient and continue functioning well despite adversity.

The purpose of this study was to explore the lived experiences among individuals in Tennessee with elevated ACEs and resilience. In this chapter, I discuss my literature search strategy and theoretical foundation for the study, as well as present a review of the literature on the topics of ACEs and resilience. Then, I summarize the main themes found in the literature and further discuss how my research fills a gap in the literature as a contribution to the knowledge on resilience in individuals who experienced ACEs.

Literature Search Strategy

I conducted a comprehensive literature review using the following databases and websites: SocINDEX, Academic Search Complete, Healthcare.gov, MEDLINE (Ebsco),

PsychINFO, Google Scholar, and Thoreau. Search terms used with each database included *adverse childhood experiences, trauma exposure, resilience, community,* and *post-traumatic growth*. When searching for articles on these terms, I used filters to find peer reviewed research published from 2013 to 2019. I reviewed and organized articles in an annotated bibliography format. Then, I used the findings from this literature search to conduct a comprehensive and critical analysis of the literature.

Theoretical Foundation

Bronfenbrenner's Ecological Systems Theory

The ecological systems theory introduced by Bronfenbrenner (1979) highlights understanding human development. Development is defined by Bronfenbrenner (1979) as "lasting change in the way in which a person perceives and deals with his environment" (p. 3). Bronfenbrenner likens the ecological system to a set of Russian dolls, as the innermost doll is encompassed by and nestled within its additional layers. This theory has provided an explanation of individuals' behaviors and emphasized that to understand the whole individual one must consider their environment and experiences (Davis et al., 2015; Larkin et al., 2014; Watling-Neal & Neal, 2013).

Interaction patterns between systems may help identify predictors of behavior and opportunities for intervention (Watling-Neal & Neal, 2013). Interrelated systems or layers of the environment include five unique layers: the microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Cross, 2017). The microsystem is "a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics" (Bronfenbrenner,

1979, p. 22). Here, the individual is directly engaged with others (Watling-Neal & Neal, 2013). The mesosystem refers to two or more settings in which the person experiences interactions in their home, a peer group, school, work, or neighborhood (Bronfenbrenner, 1979). The theorist, Bronfenbrenner (1979), posited that if third parties such as family, friends, and neighbors are absent or play a disruptive role in a person's life, the individual's developmental process is interrupted. Next, the exosystem consists of settings in which the person does not actively participate but is affected by, such as a parent's workplace or a sibling's extracurricular activities (Bronfenbrenner, 1979). The macrosystem refers to a larger context where the other systems exist and are influenced, such as culture, subculture, and beliefs (Bronfenbrenner, 1979; Watling-Neal & Neal, 2013). Lastly, the chronosystem consists of external developmental influences or changes in patterns of social interaction that affect the individual (Watling-Neal & Neal, 2013). These levels of a person's ecological system contribute to the understanding of the whole person, as well as influence development (Bronfenbrenner, 1979; Cheng & Solomon, 2014; Masten, 2016).

Since its origination in the late 1970s, Bronfenbrenner's ecological systems theory has become a widely adopted theory by social scientists (Watling-Neal & Neal, 2013). The theory has been used to explain various constructs such as social identity development, peer influences, social network dynamics, patterns of interaction, and how specific characteristics of an environment may influence behaviors (Cross, 2017). Bronfenbrenner's ecological systems theory addresses human behavior and development occurring within the context of systems (Masten, 2016) and substantiates that child

development is influenced by the child's environment, including aspects of relationships, culture, and community (Heard-Garris et al., 2018). It also reinforces the idea that external factors such as safe, supportive, nurturing relationships and environments shape human development and health outcomes (Heard-Garris et al., 2018).

Researchers have used the ecological systems theory to better understand the interrelated influences of systems. For instance, Fusarelli (2015) referred to Bronfenbrenner's ecological system's theory framework to examine the impact and interrelatedness of systems through analysis of national social policies, child well-being, and educational attainment. Bronfenbrenner's ecological systems theory was applied in this study to aid in the understanding of systems' influence on individuals' experiences of resilience despite childhood adversity. This theory is relevant to my research due to participants' experiences having occurred within the context of family, school, work, peer group, and community.

Resilience Theory

Resilience science originated during the 1970s and 1980s in the work of Garmezy, Rutter, and Werner (as cited in Howard et al., 1999; Johnson & Wiechelt, 2004; Masten, 2016). In the late 1970s, Werner, Bierman, and French published the Kauai Longitudinal Study, a hallmark resilience study and interdisciplinary investigation of infants born in 1955 in Kauai, Hawaii (as cited in Werner, 1989). The population was studied at birth, infancy, early and middle childhood, late adolescence, and adulthood to examine the long-term consequences of perinatal and prenatal complications, conditions in which the child was raised, development, and adaptations (Johnson & Wiechelt, 2004).

Researchers found that children raised in poverty have a greater risk for poor health and developmental outcomes (Johnson & Wiechelt, 2004). Additional findings from this study identified several internal and external resilience factors. Internal factors included activity level, sociability, intelligence, communication skills, internal locus of control, emotional support, and affection among family members (Werner, 1989). External factors were support systems found at school, work, and church (Werner, 1989). Overall, resilience theory provides a theoretical explanation for positive adjustment in the aftermath of trauma or adversity (Joseph & Linley, 2006; Masten, 2016), is focused on strengths rather than weaknesses (Johnson & Wiechelt, 2004), and is used to explain the phenomenon of how human capacity allows for individuals to survive and thrive during and after experiencing life's challenges (Masten, 2016).

The constructs of resilience theory have expanded due to an increase of scientific study, its evolving definition, and association with developmental science and systems theory (Masten, 2016). Origins of resilience science aid understanding and explanation of why some children or siblings fare better than others when exposed to the same adversity and risks (Masten, 2016). Resilience, as defined by Masten (2016), is "the capacity for successful adaptation to disturbances that threaten system function, viability, or development" (p. 298). Interactions between systems may create pathways of influence toward a person's healthy adaptation during or following adversity (Masten, 2016). Thus, a person's capacity for successful adaptation depends on many systems, not merely a singular trait or resource.

Alternative definitions of resilience include the ability to "withstand difficulties" or rebound from significant difficulties (Heard-Garris et al., 2018, p. 204), "a stable trajectory of healthy functioning after a highly adverse event" (Southwick et al., 2014, p. 2), and "a process to harness resources to sustain well-being," (Southwick et al., 2014, p. 4). Hence, resilience is more than the presence of health or absence of pathology. Though there has been no consensus on the definition of resilience, there are specific traits that have been determined to be protective and lead to resilient outcomes, including problem solving abilities, self-efficacy, optimism, autonomy, self-regulation, and supportive relationships (Heard-Garris et al., 2018). Southwick et al. (2014) noted the importance of clarifying whether the term resilience is used to refer to a trait, process, or an outcome; suggesting that resilience is a continuum across multiple domains in life, such as workplace, health, and interpersonal relationships.

A factor is considered to be protective if it buffers or mitigates a risk factor (Howard et al., 1999; Werner, 1989). Protective factors include both internal and external aspects of a person's life (Howard et al., 1999; Johnson & Wiechelt, 2004), such as effective parenting, connections to other competent adults, intellectual skills, self-efficacy, self-worth, hopefulness, religious or faith affiliations, socioeconomic advantages, good schooling, and other community assets (Masten, 1994); whereas risk factors are aspects that can interrupt development and functioning, which may yield poor outcomes and distress (Johnson & Wiechelt, 2004). Some common risk factors frequently studied are poverty, family instability, low education level, single parenthood, and health or physical problems (Felitti et al., 1998b; Johnson & Wiechelt, 2004). Just as risk factors

are not uniform, yet have a cumulative effect, this is also the case with protective factors (Howard et al., 1999; Johnson & Wiechelt, 2004).

Protective factors may promote resilience and reduce a person's risk for developing a health condition or experiencing early death (Braveman & Gottlieb, 2014). Additional protective factors to those mentioned previously include social support, self-esteem, (Braveman & Gottlieb, 2014), genetics and biological underpinnings, economic resources, social resources, personality, caregiver bond, healthy attachment in relationships, emotional regulation skills, goal-orientation or the capacity to visualize the future, and intrinsic motivation based on mastery system (Southwick et al., 2014). Joseph and Linley (2006) also noted self-efficacy to be a predictor of growth as well as a person's coping style, spirituality, and personality, such as being an extravert and having a positive attitude. It is possible that an individual may exhibit growth in relationships, views of self, and changes in life philosophy following trauma (Joseph & Linley, 2006).

As part of the Kauai Longitudinal Study, Werner and Smith (2001) discovered the following common factors among children contributed to resilience: at least one close relationship with a role model or a healthy attachment to a caregiver; has an easy temperament, affectionate, responsive, and good-natured; have many friends and interests during grade school; and have better than average language and reasoning skills. While we know some of the factors that lead to resilience, researchers agree that the phenomenon of resilience can be attained by various pathways and cannot be reduced to individual traits or characteristics (Howard et al., 1999; Johnson & Wiechelt, 2004; Masten, 2016). Overall, the data on resilience demonstrates that despite risks, people "can

overcome adverse environmental circumstances to experience healthy lives" (Johnson & Wiechelt, 2004, p. 662). The resilience theory is relevant to my research that will explore the experiences of individuals who have been exposed to ACEs and have high resilience scores.

Researchers advised that any new work related to resilience involve an ecological approach (Howard et al., 1999; Masten, 2016). Masten (2016) concluded that resilience may be generalized across system levels, as adversities may occur at various levels within a person's ecosystem. Interaction between systems may create pathways of influence through which a person may have healthy adaptation during or following adversity (Masten, 2016). The combined theoretical approach of ecological systems and resilience theories provides a framework for understanding the influence of interaction between systems in a person's life and human development (Masten, 2016).

Heard-Garris et al. (2018) utilized Bronfenbrenner's ecological system's theory along with resilience theory to study the relationship between ACEs and parent-perceived resilience in children through examination of the child, family, and community level factors associated with child resilience. In their study, Heard-Garris et al. (2018) found a dose-dependent relationship between ACEs and resilience, meaning a person's ACEs will influence the capacity to withstand, adapt, or rebound from adversity. Similar to Heard-Garris et al. (2018), the current study used a combined theoretical approach of ecological systems and resilience theories with an objective to understand the interdependence of a person's experiences on human development (Masten, 2016). These theories were used to expand upon the existing literature by exploring the experiences of individuals with high

ACE exposure and resilience scores. The two theories complement each other, as they reinforce the idea that human development is shaped by individual and environmental factors.

Literature Review

Adverse Childhood Experiences

Original ACEs Study

ACEs include forms of abuse, neglect, or household dysfunction that may cause trauma and can have long-term, negative effects on a person's health and well-being (Felitti et al., 1998b; Sacks et al., 2014). Felitti et al. (1998b) conducted the first study that examined quality of life, utilization of health care, and mortality based on the long-term impact of abuse and household dysfunction in childhood. The specific types of ACE exposures studied included physical abuse and neglect, emotional abuse and neglect, sexual abuse, domestic violence, substance abuse in the home, mental illness of a parent, separation or divorce of parents, and incarceration of a parent (Felitti et al., 1998b). Participants responded to questions that determined their ACE count to be between zero and ten. The ACEs survey counts each type of adversity or trauma reported as one, no matter how many times it occurred for the participant.

Findings from the Felitti et al. study (1998b) indicate that 52% of participants had experienced one or more ACEs, while 6.2% reported an ACE score of four or more (Felitti et al., 1998b). Moreover, participants who experienced four or more ACEs prior to the age of 18 also had an increased risk for substance use or abuse, depression, self-report of poor health, high number of sexual partners, sexually transmitted disease, and

suicide attempt (Felitti et al., 1998b). Among participants, the most prevalent ACE exposure was substance abuse in the home (Felitti et al., 1998b). Poor health related behaviors were also noted in participants who scored four or more, such as being twice as likely to smoke and seven times more likely to be an alcoholic (Felitti et al., 1998b). Additionally, a significant association was found between abuse exposure or household dysfunction during childhood and multiple risk factors for certain leading causes of death (Felitti et al., 1998b). For example, having an ACE count of four or more was determined to increase the risk of emphysema, chronic bronchitis, cancer, and heart disease (Felitti et al., 1998b). Furthermore, individuals with high ACE counts are more likely to be violent, have more marriages, more drug prescriptions, depression, and suffer from autoimmune disease (Felitti et al., 1998b). The data suggested that ACEs were correlated with anxiety, depression, and anger, as well as the likelihood of maladaptive internal and/or external behaviors, resulting in long-term negative health outcomes through the lifespan. In addition, those with an ACE count of six or greater were determined to be at risk for reduced life expectancy up to 20 years (Felitti et al., 1998b). Hence, supporting the notion that ACEs are a public health crisis (Bethell et al., 2017).

Expanded Adverse Childhood Experiences

The original ACE questionnaire created and researched by Felitti et al. (1998b) included 10 adverse exposures within the categories of abuse, neglect, and household dysfunction. As research surrounding ACEs has evolved, there is inconsistency on what is considered an adverse experience when assessing ACEs (Finkelhor et al., 2013). In response, recent studies have included additional adverse experiences to create a more

exhaustive ACE questionnaire (Finkelhor et al., 2013). This section will discuss research on expanded ACE variables.

To identify additional ACEs that may not be included in the conventional questionnaire, an ACE inventory was administered to include peer victimization, peer isolation, community violence exposure, and low socioeconomic status (Finkelhor et al., 2015). Researchers ascertain that exposure to violence can lead to mental and behavioral health problems, bullying and peer victimization, and long-term psychological impact (Finkelhor et al., 2015). Based on the scoring with additional ACEs, 11.8% of respondents reported an ACE count of greater than five (Finkelhor et al., 2015). Data analysis revealed the new ACE items had a greater effect than that of the original ACE items among this population. Specifically, peer isolation was the greatest predictor of health problems or distress (Finkelhor et al., 2015). Finkelhor et al. (2015) found that youth with low SES are at-risk for almost 2 times the number of negative health indicators when compared to non-low SES youth. This research supports the addition of ACE items to the original ACE scale to further assess their relationship with developmental and behavioral risk factors.

Wade et al. (2016) investigated the association between community violence, property victimization, bullying, peer victimization, neighborhood violence, urban crowding and noise, and perceived racism and child health. Expanded ACE counts were found to be associated with risky health behaviors and mental health, but not current physical health conditions (Wade et al., 2016). A positive SES effect was found for ACEs and adult health conditions, and may be explained by environmental stressors and

economic distress (Wade et al., 2016). Researchers concluded that negative experiences contribute to negative adult health outcomes and stated a possible linkage between impoverished neighborhoods and limited health behavior options, as well as increased access to substances (Wade et al., 2016).

To identify various ACEs for low-income urban youth residing in areas of Philadelphia, Wade et al. (2014) conducted a structured qualitative inquiry. Seventeen focus groups were conducted with a total of 105 participants between the ages of 18 and 26 (Wade et al., 2014). Ten ACE domains were identified by participants in the focus groups, including the following: family relationships, community stressors, personal victimization, economic hardship, peer relationships, discrimination, school, health, child welfare/juvenile justice, and media/technology (Wade et al., 2014). Of the 10 ACE domains, the two that were identified to be the most stressful were family relationships and community stressors (Wade et al., 2014), which are not conventional ACEs.

Due to concerns of suicidal ideation often being related to recurrent and cumulative risks, Cluver et al. (2015) explored individual behaviors in the month prior to study interviews. The focus of the interviews were suicide attempts, planning, and ideation; mental health disorders; drug and alcohol use; and ACEs. Trained interviewers with experience working with vulnerable youth interviewed one randomly selected adolescent per household in the participant's preferred language (Cluver et al., 2015). A total of 3,515 children ages 10-18 participated with parental consent (Cluver et al., 2015). Conventional and expanded ACEs were used including AIDS orphanhood, parental AIDS illness, parental death by homicide, community violence exposure, and food

insecurity (Cluver et al., 2015). Of the total number of participants reporting no ACEs, 1.9% reported a suicide attempt, while 6.3% of those reporting five or more ACEs indicated they had attempted suicide (Cluver et al., 2015). Thirty-four percent of teens who reported suicidal ideation and 43% of teens reporting suicide planning, attempted suicide in the month prior to the survey (Cluver et al., 2015). Additional findings suggest a strong relationship between cumulative ACEs and suicidal behaviors after one year (Cluver et al., 2015).

Expanded ACE questionnaires and screenings provide a more comprehensive assessment of ACEs (Wade et al., 2014). In recent years, research on expanded ACEs has added to the scholarly knowledge. Still, no ACEs screening tools identify all childhood adversities and there remains an undetermined consensus about what ACE variables should be included in research.

Social and Health Implications

Social determinants of health as defined by the World Health Organization are the "conditions in which people are born, grow, live, work, and age" based on the "distribution of money, power, and resources at global, national, and local levels" (Bruner, 2017, p. s123). As such, results from the Felitti et al. (1998b) study suggested that ACEs may be responsible for workplace absenteeism, increase costs of healthcare, emergency response demand, along with a rise in mental health and criminal justice related issues (Felitti et al., 1998b). Research conducted by Salinas-Miranda et al. (2015) revealed an association between ACE and health-related quality of life (HRQoL) along with certain symptoms expressed later in life among victims of ACEs, concluding that

ACEs affect mental and behavioral health in adulthood. The number of unhealthy days reported by participants was associated with ACE counts, perceived stress, and sleep disturbance (Salinas-Miranda et al., 2015). An increasing impact of ACEs as a social determinant of health is evident in the literature (Bellis, Hughes et al., 2017; Bethell et al., 2017; Felitti et al., 1998b).

Furthermore, Bellis, Hughes et al. (2017) discovered a high demand for health services among those with a higher number of ACEs and indicated that healthcare utilization was more dependent on the number of ACEs rather than socioeconomics or demographics, especially among respondents ages 18 to 29 years. The same study found that medical visits tend to increase with age, while emergency department visits were higher for younger adults. Researchers concluded that the elevated use of the emergency department could be associated with ACEs, as a result of unintentional injury, violence, mental health conditions, substance use, or somatic symptoms (Bellis, Hughes et al., 2017). Alternatively, the literature on social determinants of health suggests improved living conditions over time contribute to increased life expectancy and better health outcomes (Braveman & Gottlieb, 2014).

In addition to effecting attitudes and behaviors toward health, ACEs have been shown to have positive and negative outcomes (Herrod, 2007) on brain development and function (Dong et al., 2003; Felitti et al., 1998b). For example, Herrod (2007) found that children who lived in orphanages with inadequate stimuli and lack of nurturing, prior to being adopted into loving homes, experienced long-term behavioral and developmental challenges. Early childhood is a critical time to establish healthy intellectual, social,

emotional, and moral development (Harper-Browne, 2014) that are fundamental to a person's internal and external protective factors and beneficial across the life span (Howard et al., 1999; Johnson & Wiechelt, 2004; Masten, 2016). Perry and Hambrick (2008) stated,

> Children exposed to consistent, predictable, nurturing, and enriched experiences develop neurobiological capabilities that increase their chances for health, happiness, productivity, and creativity, while children exposed to neglectful, chaotic, and terrorizing environments have an increased risk of significant problems in all domains of functioning (p. 40).

Moreover, the effects of childhood experiences are not always recognized until adulthood and may be explained by the concepts of nature, the internal factors, and nurture, the external factors (Herrod, 2007).

Not only has research found that ACEs are associated with long-term negative health outcomes (Bethell et al., 2017), there is a noticeable cumulative impact with each additional ACE (Bellis, Hughes et al., 2017; Cluver et al., 2015; Finkelhor et al., 2011). Research indicates that ACEs rarely occur alone (Bethell et al., 2017; Dong et al., 2003; Felitti et al., 1998b; Finkelhor et al., 2011) and if an individual has experienced one ACE, they are 87 % more likely to have experienced two or more ACEs (Felitti et al., 1998b). Ultimately, ACEs are compounding, complex, and predictive of long-term health outcomes (Dong et al., 2003).

Toxic Stress

Life Course Health Development theory suggests there are critical periods in which adverse events, such as trauma and stress, may interrupt an individual's development (Halfon et al., 2017) and their ability to cope (Logan-Greene et al., 2014). The National Scientific Council on the Developing Child (2014) differentiated three types of stress which influence human development: positive stress, tolerable stress, and toxic stress. Positive stress is when a child encounters a change or challenge that is brief and causes increased heart rate or changes in hormone level but returns to homeostasis (Harper-Browne, 2014). This type of stress can motivate and prepare a child for handling future stressors (Harper-Browne, 2014). When a child has safe, stable, nurturing relationships (SSNRs), the stress experienced from adversities is buffered and damaging effects mitigated (Halfon et al., 2014; Jaffee et al., 2013; Schofield, Lee, Merrick, 2013). Next, tolerable stress is when severe challenges occur, having potentially lasting effects; however, the individual has a support system that buffers the negative effects of the stressor (Harper-Browne, 2014). Lastly, toxic stress occurs when frequent and intense challenges cause stress to the brain and body, such as abuse, and there is a lack of support resulting in an overactive stress response system (Harper-Browne, 2014). Toxic stress leads to impaired brain function; disruption of the stress response system; decreased activity in the areas of the brain responsible for reasoning skills and behavior control; increased activity in the areas of the brain related to fear, anxiety, and impulsivity; and increased levels of stress hormones that can damage the learning and memory areas of the brain (Harper-Browne, 2014).

As with any biopsychosocial process, its impact on health is complex. When the body's systems endure toxic stress, they are altered (Braveman & Gottlieb, 2014) via the process of allostasis (Braveman & Gottlieb, 2014). Allostasis is a physiological protective response that occurs when there is a need to cope with adverse events (Larkin et al., 2014). However, chronically elevated stress can reduce the effect of allostasis (Larkin et al., 2014). Larkin et al. (2014) stated that "as the number of categories of adverse childhood experiences increases, each new type of risk to the body's allostatic system can potentially lead to excessive allostatic load and associated physiological and behavioral symptoms" (p. 3). Therefore, chronic exposure to social and environmental stressors may create biological "wear and tear" (Braveman & Gottlieb, 2014, p. 23). Repeated exposures to ACEs can create diminishing returns on the allostatic system resulting in its inability to protect against physiological and behavioral challenges (Larkin et al., 2014).

Diverse Populations Researched

When assessing ACEs and its impact on health, it is imperative that individuals from various sociodemographic backgrounds are considered. To gain a holistic understanding of sociodemographic factors associated with ACEs, a literature review was conducted. In this section, the focus will be on sociodemographic characteristics among populations where ACEs have been studied.

Dong et al. (2003) studied the relationship between exposure to childhood sexual abuse (CSA) and other ACEs. Of the respondents, 21% reported being a victim of CSA. Those who reported multiple occurrences of CSA were also likely to report multiple

ACEs. In a more recent research study, Iniguez and Stankowski (2016) reported sexual abuse was indicated by 21.1% of females and 10.9% of males. Moreover, Dong et al. (2003) assessed CSA along with nine other ACE categories and discovered a strong association between CSA and physical abuse, physical neglect, and physical abuse during childhood, with the highest association being for emotional abuse. Researchers concluded that CSA rarely occurs independent of other forms of adversity.

Based on findings from Dong et al. (2003), it was concluded that narrowly studying one or two childhood exposures limits the understanding of the cumulative or compounding impact adversity has on development and health. Therefore, Dong et al. (2004) investigated the interrelationship of multiple ACEs in a sample size of 8,629 adults. Results indicated that approximately two-thirds of the sample reported having experienced one or more ACEs (Dong et al., 2004). In this study population, more than 80% of participants reported exposure to more than one ACE (Dong et al., 2004). The data analysis demonstrated a varied distribution, showing cumulative rather than isolated ACE occurrence (Dong et al., 2004). For example, 80.5% of participants who reported emotional abuse also reported physical abuse and 64.5% of participants reporting domestic violence in the home also reported substance abuse (Dong et al., 2004). This research exemplifies the relationship between ACEs and social factors related to health and wellbeing.

Furthermore, a population-based study on the relationships between ACEs and adult physical and mental health examined patterns across adulthood for four birth cohorts grouped according to age, spanning from ages 18 to 79, and assessed

demographics, socioeconomics, ACEs, and protective factors (Logan-Greene et al., 2014). The study sample consisted of 19,333 participants using the Behavior Risk Factor Surveillance System (BRFSS) survey in partnership with Washington State and the Centers for Disease Control and Prevention. Findings showed a higher rate of reported ACEs among younger cohorts (Logan-Greene et al., 2014). More often younger study participants reported family mental illness, imprisonment, and parental divorce when compared with older cohorts (Logan-Greene et al., 2014). However, older cohorts reported less significant levels of witnessed family violence, physical, and emotional abuse (Logan-Greene et al., 2014). Yet, there was a correlation between ACEs and poor health in each cohort as well as patterns between protective factors moderating ACEs (Logan-Greene et al., 2014). Protective factors examined included sleep quality, social and emotional support, and life satisfaction (Logan-Greene et al., 2014). The research demonstrated that the protective factors examined moderate the effects of ACEs (Logan-Greene et al., 2014); however, additional protective factors were not included such as self-efficacy and spiritual or religious practices. A benefit of this study design is that semi-structured, qualitative interviews with use of open-ended questions will allow respondents to describe their own perceptions of the protective factors that contributed to their resilience.

Additionally, a study conducted by Mersky et al. (2013) investigated ACEs in urban, minority young adults by using data from the Chicago Longitudinal Study. This study monitors a cohort of 1,142 minority children who were born into low-socioeconomic, urban households in 1979 or 1980 (Mersky et al., 2013). Researchers

discovered that 79.5% of the sample experienced at least one ACE and 48.9% experienced multiple ACEs (Mersky et al., 2013). These findings are noted to be higher than previous studies (Burke et al., 2011; Felitti et al., 1998b). Also, findings suggested rates of ACE exposure are higher for males than females (Mersky et al., 2013). Remarkably, McCall-Hosenfeld et al. (2014) reported a higher prevalence for females to have a lifetime history of post-traumatic stress disorder compared to males; and males were reported to be more likely to be diagnosed with substance related disorder and impulsive control disorders. Mersky et al. (2013) explained that 25.2% of females and 14.8% of males reported no ACEs; while 5% of females and 12.3% of males reported experiencing five or more ACEs. Multivariate analysis demonstrated associations between the number of ACEs and poor health, therefore the dose-response relationship was supported (Mersky et al., 2013). Stratified analysis found that sex did not moderate the relationship between ACEs and poor health outcomes (Mersky et al., 2013).

Strong associations were discovered between cumulative adversity and cumulative negative health outcomes, supporting previous research on the comorbidity of physical and mental health (Mersky et al., 2013). This research data suggests long-term negative health outcomes and poor life satisfaction are evident in early adulthood, as opposed to emerging in middle to late adulthood (Mersky et al., 2013). Of note, high prevalence of depression, anxiety, and substance use was reported by young adults in this sample (Mersky et al., 2013).

Burke et al. (2011) examined the relationship between ACEs and learning and/or behavior problems and obesity among low income, urban youth. Research was conducted

through chart review of 701 children and youth who received services at the Bayview Child Health Center located in San Francisco, California. In this study, 67.2% of the sample population had an ACE score of one or higher, and 12% had a reported ACE score of four or more (Burke et al., 2011). Of those reporting an ACE score of four or more, 51% were reported to have learning and/or behavioral problems and 45.2% met criteria as overweight or obese, based on physician documentation (Burke et al., 2011). Overall, most of the sample had an ACE score of one or higher, with an ACE score of four or higher indicating an increased risk for learning and/or behavior problems and obesity (Burke et al., 2011).

Researchers Garcia et al. (2017) conducted a longitudinal study which included a nationally representative sample of children and youth in the child welfare system (Garcia et al., 2017). The study sample consisted of children who were reportedly maltreated between the ages of 0-14 years (Garcia et al., 2017). Results revealed the most prevalent ACE exposures were hospitalization for a medical condition (33.5%), neglect (30.3%), community violence exposure (26.9%), and exposure to domestic violence (26.7%) (Garcia et al., 2017). Of those exposed to ACEs, one-third were diagnosed with clinically pervasive behavioral and emotional symptoms (Garcia et al., 2017). There were also differences in ACE exposure and resulting behavioral and health challenges by race, ethnicity, and sex. For instance, Whites were more likely to experience sex abuse compared to African American or Latino participants (Garcia et al., 2017) whereas Latino youth were found to be at a higher risk for exposure to community violence compared to African American or White participants (Garcia et al., 2017). Whites were also more

likely to be diagnosed with externalizing problems and more likely to receive mental health services compared to other groups (Garcia et al., 2017). Lastly, men had a greater likelihood of being diagnosed with externalizing behavior problems than women (Garcia et al., 2017).

Furthermore, Garcia et al. (2017) reported no relationship was found between mental health services and changes in social, emotional, or behavioral outcomes. However, a limitation is that the nature, extent, timing, type, and quality of mental health services received are unknown. Results suggest "current standard of practice may not be addressing the needs for our most vulnerable youth who experience ACEs in a timely manner" (p. 301).

Handley et al. (2015) studied lifetime trauma exposure, lifetime suicidal ideation, post-traumatic stress disorder (PTSD), and other psychiatric disorders of rural community residents to determine long-term outcomes. Researchers used the World Mental Health Composite International Diagnostic Interview to assess 623 respondents. Authors noted previous research reporting higher rates of PTSD in rural regions (Handley et al., 2015). It was discovered that traumatic events can result in a variety of psychological and social consequences, including compounding effects of multiple trauma exposure (Handley et al., 2015). Also, findings indicate considerable risk of poor health outcomes may occur for rural residents where service availability is low (Handley et al., 2015). Adequate and timely support may reduce the impact of traumatic events (Handley et al., 2015).

Iniguez and Stankowski (2016) conducted a community-based ACE study to examine the relationship between self-reported ACE counts and health related outcomes

using electronic medical records (EMR). Of the 800 people who participated in the survey, 62% reported having one or more ACE and 15% reported four or more ACEs (Iniguez & Stankowski, 2016). The most frequently reported ACE was emotional abuse (38.8%) followed by substance abuse (27.4%) (Iniguez & Stankowski, 2016). Alternatively, in a meta-analysis study by Fuller-Thomson & Sawyer (2012), physical abuse was reported more frequently among the two groups researched with 41% of respondents from the National Population Health Survey (NPHS) and 36% of respondents from the Canadian Community Health Survey (CCHS) having reported physical abuse during childhood or adolescence (Fuller-Thompson & Sawyer, 2012). These percentages are higher than the results from Felitti et al. (1998b), suggesting that research with diverse populations present a more comprehensive understanding of risks, as well as resources that may contribute to resilience.

Radcliff et al. (2018) surveyed 18,176 adults using data from the 2014-2015 BRFSS survey to determine ACE exposure in South Carolina. Comparisons were made between those residing in rural and urban areas. Findings indicate similarities of the three most prevalent ACEs: parental separation or divorce, emotional abuse, and household substance use. Although a higher number of ACE scores were reported by urban residents, the scores for rural residents were comparable. ACE scores from 1 to 3 were reported in 44.1% of urban adults and 43.6% of rural adults, whereas 17.6% of urban adults and 15% of rural adults reported ACE scores of at least four or more. As a result, Radcliff et al. (2018) advocated for statewide public health action.

In another study that closely examined the urban-rural continuum concerning trauma exposure, McCall-Hosenfeld et al. (2014) found that experiences of trauma and lifetime mental illness are common regardless of geographic residence. Therefore, rural residents are just as likely as urban residents to experience mental illness (McCall-Hosenfeld et al., 2014). It has been estimated that 20% of non-urban counties lack mental health services, therefore research findings suggest the need for increased mental healthcare access for rural communities, based on the indicated shortage (Barnett et al., 2014; McCall-Hosenfeld et al., 2014). Also, McCall-Hosenfeld et al. (2014) stated residents of rural communities reported lower incomes and education status and were more likely to be uninsured. Interestingly, researchers reported that previous studies on rural mental healthcare indicated that rural primary care physicians did not perceive trauma exposure to be a common experience for their patients, meaning potential for a greater number of mental health concerns to go unnoticed and unaddressed by physicians in rural settings (McCall-Hosenfeld et al., 2014).

Halfon et al. (2017) utilized data from the National Survey of Children's Health (NSCH), a nationally representative sample population, to evaluate ACEs and health outcomes in children. This study used NSCH data from 2011 to 2012 consisting of 95,677 parents with children between ages 0-17 years old (Halfon et al., 2017). Findings from this study show that children residing in households where the income is below the federal poverty line are three times as likely to have two or more ACEs and five times more likely to experience four or more ACEs than children living in households where the income is at or above 400% of the federal poverty line (Halfon et al., 2017). While

there are higher rates of ACEs among poorer children, it is important to note that findings reveal risk for ACEs at every income level (Halfon et al., 2017).

Research on ACEs has been conducted among various populations and has identified several specific types of adversity that individuals may experience. While some ACE studies have found high rates of physical abuse among participants (Fuller-Thompson & Sawyer, 2012), other studies have found high rates of emotional abuse (Iniguez & Stankowski, 2016; Merrick et al., 2018) and family and community stressors (Wade et al., 2014). Through continuous scholarly endeavors, researchers have discovered that there is a cumulative impact of ACEs and that those exposed to ACEs have a greater probability of experiencing additional ACEs (Burke et al., 2011; Dong et al., 2003; Felitti et al., 1998b; Finkelhor et al., 2011; Fuller-Thompson & Sawyer, 2012; Mersky et al., 2013).

State Specific Data

The Sycamore Institute is an independent, nonpartisan public policy research center for Tennessee that researched the negative health effects of ACEs in the state. Analysis of the 2014-2017 BRFSS data provided to The Sycamore Institute by the Tennessee Department of Health stated that over half (60%) of the adult Tennesseans participating in the research reported at least one ACE and 17% had experienced four or more (Melton, 2019). In 2017, ACEs among Tennessee adults contributed to an estimated $5.2 billion in direct medical costs and lost productivity from employees missing work (Melton, 2019). Additionally, adults in the state with more ACEs were found to be more

likely to smoke tobacco and experience depression (Melton, 2019). Therefore, the negative health effects of ACEs carry a significant cost for the state of Tennessee.

Daugherty and Poudel (2017) researched the level of public awareness about ACEs in Tennessee, sources of adversity, potential impact of ACEs, and level of support for efforts to mitigate ACEs. Findings demonstrated that a majority of survey participants agreed that abuse, violence in the home, and substance use are to be considered ACEs (Daugherty & Poudel, 2017). In addition, the majority of respondents agreed that malnourishment, separation from parents, and racial and cultural discrimination should also be considered ACEs (Daugherty & Poudel, 2017). A higher percentage of respondents reported that malnourishment, bullying, and discrimination should be considered ACEs, compared to the percentage that reported consideration of poverty as an ACE (Daugherty & Poudel, 2017). This is interesting due to recent research on expanded ACEs that consider experiences in the community, as opposed to conventional ACEs that are limited to abuse, neglect, and household dysfunction.

A collaborative research effort was conducted in Shelby County, Tennessee whereby data on ACEs for residents of the county were similar to the trends found in other studies (The Research and Evaluation Group at PHMC, 2014). In Shelby County, 52% of surveyed adults reported having at least one ACE, 20% indicated they had experienced two or three ACEs, and 12% reported having four or more ACEs (The Research and Evaluation Group at PHMC, 2014). The proportion of individuals who report use of illicit drugs, diagnosis of depression, and attempt of suicide are higher among those reporting ACEs, as opposed to those who do not report ACEs (The

Research and Evaluation Group at PHMC, 2014). Overall, consistent research on ACEs has helped to understand patterns and expand the knowledge on what are considered to be ACEs in diverse populations. However, less is known about the phenomenon of resilience when a person has experienced an elevated number of ACEs.

Resilience

Despite adversities that can create negative outcomes, it is possible for an individual, family, or community to experience resilience (Vickers & Wells, 2017). Surprisingly, resilience may be more common than expected (Southwick et al., 2014). Therefore, understanding how the protective factors of resilience counteract adversities is critical (Vickers & Wells, 2017). The following section will discuss literature on resilience and its relationship with adversity.

Researchers, such as Masten (2016), assert caregiver behavior may either jeopardize or buffer children's development. Protective factors made available during sensitive periods of plasticity in human development, such as high-quality parenting and self-regulation skills, influence a person's ability to adapt (Masten, 2016). Hence, resilience can be culturally influenced by the family, social supports, and religious practices (Masten, 2016) as external protective factors within a person's mesosystem, exosystem, macrosystem, or chronosystem. While much has been discovered about what adverse experiences do to the developing mind and body, less is known about the adaptive experiences that buffer adversity and trauma (Masten, 2016).

Cortina et al. (2016) studied the relationship between cognitive interpretation of children and resilience; examining how cognition, an internal factor within the

microsystem, relates to resilience. The researchers defined resilience as “absence of psychological problems as well as the presence of positive social skills despite exposure to chronic adversity including high rates of HIV within the community” (Cortina et al., 2016, p. 40). With parental consent, researchers surveyed 1,025 school aged children in 4th grade through 6th grade in a socioeconomically disadvantaged area in South Africa. Several instruments were used including the Cognitive Triad Inventory for Children (CTI-C) and other child behavior and trauma checklists to examine cognitive interpretations related to psychological functioning and perceptions of the school environment.

Findings revealed consistency with other studies, as the respondents with more positive cognitive interpretations had better psychological functioning. This research suggests children’s cognitive interpretation of events and the world around them may influence their self-image, perception of the school environment, future aspirations, and social interactions (Cortina et al., 2016). The better a person’s cognitive interpretation, the better psychological functioning related to mood, somatization, and traumatic events (Cortina et al., 2016). Thus, cognitive interpretation is a key factor influencing resilience.

Heard-Garris et al. (2018) demonstrated resilience is associated with child, family, and community system level factors. Using data from the National Survey of Children’s Health 2011-2012, Heard-Garris et al. (2018) discovered a relationship between ACEs and parent-perceived resilience in children and examined the child, family, and community level factors associated with child resilience. The researchers defined resilience as staying calm and in control when faced with a challenge, or the

ability to withstand difficulties or rebound from significant difficulties (Heard-Garris et al., 2018). Findings indicated 32.6% of parents perceived their child was not demonstrating resilience, while 67.4% perceived their child was demonstrating resilience (Heard-Garris et al., 2018). As the ACE count increased, the probability of parent-perceived resilience decreased (Heard-Garris et al., 2018). Certain family factors were found to contribute to resilience such as shared family meals, religious attendance, and communication of ideas with the child (Heard-Garris et al., 2018). Similarly, community level factors were found to contribute toward resilience such as neighborhood cohesion, neighborhood safety, and neighborhood amenities (Heard-Garris et al., 2018). Findings support that individuals exposed to ACEs may also experience resilience.

Borge et al. (2016) reviewed resilience research on the adaptive process recognizing that despite exposure to adversity some individuals have the ability to function well or flourish. These researchers adopted Masten's (2016) definition of resilience as the "capacity of a system for successful adaptation to disturbances that threaten system function, viability, or development" (Borge et al., 2016, p. 294). The following studies were discussed: the Fragile Families and Child Wellbeing longitudinal study; a qualitative inquiry using a standardized classroom quality scale known as CLASS, child self-regulation, and child temperament among high and low risk groups in preschool children in Portugal; school engagement and life satisfaction of Roma youth living in Bulgaria; a cross-sectional study comparing academic achievement of immigrant youth in Greece; and a longitudinal study on preschool-aged children's mental health and prosocial behavior when exposed to an isolated, acute traumatic event. Different patterns

of protective factors were detected in the studies including the effect of family functioning, self-regulation skills, social connectedness, and personal and familial resources (Borge et al., 2016).

Edwards et al. (2016) conducted research with 161 students between the ages of 16 and 21 to identify whether specific variables such as exposure to ACEs, locus of control, academic delay of gratification, and age would predict resilience. Edwards et al. (2016) found that higher levels of adversity with an individual's parent or guardian was related to lower levels of resilience and determined that a lack of adversity with a parent or guardian and an internal locus of control would predict higher levels of resilience.

Narayan et al. (2018) conducted a pilot study to validate the Benevolent Childhood Experiences (BCEs) scale in a cohort of expectant mothers (N=101) with a history of childhood adversity. The BCE is a culturally sensitive questionnaire that examines ten positive childhood experiences, such as perceived safety, healthy attachment, effective parenting behaviors, and community resources. Additional instruments were used to inquire about ACEs, depression, stress, and post-traumatic stress disorder (PTSD). It is noted, the BCE survey is independent of the ACE survey and items are not to be considered in direct relation to the ACE survey items. Findings indicated that though the sample reported high levels of low SES, BCEs were prevalent and, perhaps, counteracts negative outcomes associated with ACEs (Narayan et al., 2018). In this study population, 28% reported having experienced all ten BCEs and 94% reported at least one or more ACEs (Narayan et al., 2018). Those who indicated a high number of BCEs were less likely to report prenatal stressful life events (SLE),

depression, and post-traumatic stress symptoms were reported (Narayan et al., 2018). Contrarily, ACEs were found to be a predictor of prenatal SLEs (Narayan et al., 2018). Researchers suggest that five or fewer BCEs may indicate risk for future impairment and that increased vulnerability may occur when a person's ACEs outnumber their BCEs (Narayan et al., 2018).

Countries that have experienced a high level of adversity due to war exposure have endured historical crises, yet communities within such countries have relied on their local community support and have been found resilient (Gelkopf et al., 2012). Gelkopf et al. (2012) studied factors associated with vulnerability to chronic stress for Israeli individuals exposed and unexposed to war-related attacks in rural and urban communities. The study population consisted of 740 individuals living in four selected communities (Gelkopf et al., 2012). Findings revealed that despite greater resources, the community with the highest level of reported posttraumatic stress, distress, functional impairment, and health care utilization was the highly exposed urban area (Gelkopf et al., 2012). Among the highly exposed rural area, participants reported great community solidarity, sense of belonging, and trust of authorities which encompass the protective factors mitigating the extent of their stress response (Gelkopf et al., 2012). Therefore, lower levels of adversity may be attributed to protective factors within a person's community, such as social cohesion, shared values, networks, and institutional and cultural resources that promote resilience (Gelkopf et al., 2012). Respondents from the rural areas reported a greater sense of belonging and connection with social networks, which offer emotional support (Gelkopf et al., 2012). These findings contribute to an

understanding of individual and community protective factors that decrease traumatic stress.

Beutel et al. (2017) studied the role of resilience among 2,508 German individuals with and without reported ACEs. Participants who reported childhood adversities also reported lower perceptions of social support, lower social status, less education, lower income, and more experiences of unemployment. Those who reported greater resilient coping also reported less depression, anxiety, and somatic symptoms compared to other participants. Research findings confirmed the hypotheses that childhood adversity is associated with unfavorable adjustment, distress, decreased social support, somatic symptoms, and lower resilience across the lifespan (Beutel et al., 2017). Beutel et al. (2017) confirmed that resilience buffered the effects of childhood adversity and distress for the researched population.

Research Informed Prevention and Intervention

Some discovery has been made regarding prevention and intervention measures that promote resilience. Moeller-Saxone et al. (2014) conducted a narrative review of 20 studies that promoted resilience for those who had experienced intimate partner violence (IPV) or child maltreatment (CM). Findings revealed that only few studies use specific resilience measures to identify factors contributing to resilience and inform practices that advance resilience (Moeller-Saxone et al., 2014). However, several qualitative studies produced strong evidence supporting prevention strategies that promote resilience, such as home visitation for at-risk mothers, a methadone program for women, and substance abuse programs (Moeller-Saxone et al., 2014). Also, cognitive restructuring was found to

be effective at reducing stress and symptoms among IPV survivors (Moeller-Saxone et al., 2014). In low- and middle-income countries and indigenous settings, becoming a village health worker improved women's perception of personal control, increased civic and social engagement, and reduced discrimination (Moeller-Saxone et al., 2014).

Practice and policy changes, including family support programs, culturally relevant parenting, quality education, and evidenced-based clinical interventions are commonly discussed as interventions to reduce the effect of ACEs (Larkin, et al., 2014). Masten (2016) advocated that an integrated, multi-systems framework, such as the developmental systems framework, addresses the various threats and risks experienced by an individual. Research findings suggest using an integrated, multidisciplinary (Radcliff et al., 2018), and multi-generational approach (Radcliff et al., 2018; Masten, 2016) to address the ACEs health crisis. Moreover, the literature suggests that interventions which activate personal and community support systems need to improve the overall health and wellbeing of those experiencing adversity (Moeller-Saxone et al., 2014; Handley et al., 2012; Handley et al., 2015). Yet, Gelkopf et al. (2012) and Cortina et al. (2016) recommend interventions that are tailored at the appropriate education-level and are culturally sensitive for children. Lastly, Iniguez and Stankowski (2016) highlight the importance of disseminating information about resources to promote resilience and well-timed interventions to mitigate the negative effects of ACEs.

Summary

In conclusion, ACEs are common, cumulative, complex, and predictive of long-term health and well-being (Felitti et al., 1998b; Dong et al., 2003). Researchers indicate

that high exposure to ACEs result in greater risk for physical, mental, and behavioral health disparities (Bethell et al., 2017; Felitti et al., 1998b). Due to the overwhelming health implications of ACEs, it is imperative that mechanisms are developed to prevent ACEs while increasing the capacity for healthy adaptation or resilience.

The definition of resilience may vary based on the context or specific meaning for an individual, family, organization, or culture (Southwick et al., 2014). However, researchers have identified specific internal factors or microsystem variables that tend to promote resilience, such as the ability to problem solve, self-efficacy, optimism, autonomy, close and supportive relationships, self-regulation (Heard-Garris et al., 2018), self-esteem (Braveman & Gottlieb, 2014), personality, emotional regulation skills, goal-orientation or the capacity to visualize the future, and intrinsic motivation based on mastery system (Southwick et al., 2014). There are also external factors associated with resilience, including healthy relationships and environments (Heard-Garris et al., 2018; Southwick et al., 2014), economic resources, and social support (Southwick et al., 2014). These are considered to be what Bronfenbrenner (1979) would refer to as a person's mesosystem. Resilience may be generalized across systems (Masten, 2016), just as adversities occur at various levels within a person's ecosystem. In the state of Tennessee, programs such as Building Strong Brains Tennessee and the ACE Awareness Foundation have utilized ACE and resilience research to take measures toward educating the public, mitigating ACEs, and building resilience.

Although the researchers discuss variables that contribute to resilience, there is a lack of research on the lived experiences of the co-occurring ACEs and resilience. To fill

this gap in knowledge, the current qualitative study using purposive sampling explored the lived experiences among individuals residing in Tennessee with elevated ACE and resilience scores. Interviews with participants who met study criteria brought insight on perceptions about what has led or contributed to their resilience, including internalizing and externalizing protective factors, personal characteristics, coping and stress response, resources utilized when addressing their own ACEs, and relationships. Research on resilience is important for understanding the roles of contributing factors and for informing interventions that can mitigate ACEs.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore the lived experiences among individuals in Tennessee with elevated ACEs and resilience. I used qualitative inquiry to discover insight on the phenomenon of resilience despite experiences of adversity during childhood. This chapter provides detailed information about the methods including approach, design, role of the researcher, sample, data collection, data analysis, and methodological strengths and limitations as well as issues related to human subject protection.

Research Design and Rationale

Research Tradition and Question

As discussed previously, quantitative research studies on ACEs have revealed that ACEs are common, contribute to poor health and social outcomes later in life (Bethell et al., 2017; Dong et al., 2003; Felitti et al., 1998b; Finkelhor et al., 2011), and are considered a public health crisis (Bethell et al., 2017). Similarly, quantitative research using resilience scales indicate that resilience or adaptability in the midst of difficult circumstances (Masten, 2016) can be common (Southwick et al., 2014) and influence personal growth (Joseph & Linley, 2005) and well-being (Southwick et al., 2014). At present, literature that evaluates the lived experiences of both ACEs and resilience is lacking. Qualitative research offers an in-depth understanding of a phenomenon for which quantitative research is limited. Therefore, I applied basic, qualitative research

design to explore the lived experiences among individuals with elevated ACE and resilience scores.

Qualitative Research Rationale

Qualitative inquiry was appropriate for this study as it contributes to knowledge on lived experiences. The basis of qualitative research is exploration (Prasad, 2015) and relies heavily upon human experiences in their natural environments and interpretation of their experiences in the world as a means for discovery, understanding, and meaning making, with special attention to process and relationships (Padgett, 2016; Patton, 2015; Ravitch & Carl, 2016). Padgett (2016) described the qualitative research method as a person-centered, contextual means to obtain insider perspectives on complex social processes and topics that may be described as sensitive or emotional. Qualitative research is valued in social science professions due to the contribution of knowledge on social phenomena that otherwise may remain undiscovered (Padgett, 2016). I facilitated a qualitative study to explore participants' experiences with consideration of how human beings "order, classify, structure, and interpret" the world and how those interpretations are acted upon (see Prasad, 2015, p. 13). In this case, the social phenomena of interest was resilience despite childhood adversities. The qualitative research tradition allowed for semi-structured interviews using open-ended questions to inquire about protective factors, personal characteristics, stress response, resources utilized, relationships that contributed to resilience, and other insights from participants. Qualitative research produced data that is representative of participant experiences and the meaning that has been attached to those experiences (Denzin & Lincoln, 2018).

Role of the Researcher

My role as the primary research instrument involved designing the interview questions, asking participants the questions, and analyzing the data. Based on subject literature and theoretical framework, I developed open-ended questions to be asked during interviews to gain deep insight into participants' experiences. I conducted interviews either through online video conferencing or by telephone, and I audio-recorded to collect data about participant experiences. I used active listening during interviews to carefully give attention to participants' verbal responses and non-verbal cues when possible, such as noticing when a participant paused, and more time was needed for their response, or when strong emotions were expressed along with the spoken words as evidenced by a change in voice volume or crying. Additionally, I managed all transcript data by entering it into the MaxQDA software program and compared the transcripts with the audio-recordings to ensure accuracy. Finally, I used MaxQDA software coding tools to code and categorize the data to determine meaningful themes from the participants' experiences.

At the time this research was conducted I held professional positions in the community including work as a licensed clinical social worker at a pediatric hospital and an adjunct professor at a local university. Also, I was involved in ACE related activities and affiliations as a Building Strong Brains Tennessee trainer and a member of the regional ACEs Knowledge Mobilization Team, which is a team of professionals who meet quarterly to work toward advancing knowledge and training about ACEs and resilience in communities throughout the region. The connections with other

professionals through these ACE related activities were beneficial to my research because this is how I was introduced to the staff at TCCY and other ACEs Knowledge Mobilization Team members who played an integral role in emailing my study invitation to contacts. I maintained careful consideration of ethical standards and did not recruit or include participants with whom I had a direct power hierarchy, such as clients, current students, or supervised persons. I discuss additional information on participant selection and protocol later in this chapter.

Participants contributed by sharing their experiences. Semi-structured, open-ended questions do not have predetermined answers, allowing the participants opportunity to express their unique ideas and experiences (Merriam & Tisdale, 2016). As the researcher for this study, I learned from participants' knowledge and wisdom, rather than speak for the target population.

There is some element of bias in all research despite efforts to avoid it (Patton, 2015; Ravitch & Carl, 2016). To reduce bias, a qualitative researcher strives to maintain objectivity (Denzin & Lincoln, 2018), reflexivity (Padgett, 2016) and neutrality (Patton, 2015; Rubin & Rubin, 2012). Further, Patton (2015) explained that the researcher should not be detached from engaging with participants but to instead be empathic, arguing that a qualitative researcher may not be able to fully understand a person's thoughts, actions, or feelings without "empathy and sympathetic introspection" (p. 57). I have experienced resilience personally following several adversities in my home and school environments as a child. Also, I am acquainted with individuals, both professionally through my work as a social worker and personally through other activities and relationships, who have

experienced resilience. Throughout the research process, I was intentional in being self-aware of what has shaped my personal understanding of resilience to enhance reflexivity and reduce the risk of being misled by personal experiences or interpretations. Reflective journaling, described in detail below, helped to ease the influence of personal interpretation on research outcomes.

The qualitative researcher engages in intellectual labor and immersion in the data as the instrument researcher (Padgett, 2016). To produce credible research, researchers must remain cautious and open as to not form their own interpretations and maintain accurate documentation (Patton, 2015) through rechecking and comparing the documentation and data (Rubin & Rubin, 2012). For this study, I employed reflective journaling, audit trail, and member checking.

A process of reflective journaling through use of memos or note taking on personal experiences and perspectives can help build awareness of the researcher and differentiate their own interpretations from the researched population (Ravitch & Carl, 2016). Transparent reporting of bias contributes to achieving validity (Ravitch & Carl, 2016). Using data analysis software, I designated space to document all memos, notes taken during and following interviews, and other personal insights to distinguish my responses from that of the participant. In addition, I wrote about my personal thoughts and feelings following each interview to gain personal awareness of my views to distinguish from those of the participants. I created an audit trail by documenting each step of the research process, as this aids the fidelity of the research (Rudestam & Newton, 2015). Additionally, I used member checking by asking the interviewees to review the

conclusions to ensure their responses accurately communicated what was intended (see Cope, 2014; Ravitch & Carl, 2016; Rubin & Rubin, 2012). Once the analysis of each interview was completed, I contacted interviewed participants by their indicated preferred method, and I provided them with information on the interpreted themes from their interview in order to give each participant an opportunity to confirm or deny accuracy. I documented each participant's response during member checking, including confirmation of accuracy or errors indicated by the participant. When there were errors or additional information was provided by a participant, I documented the email responses from participants and added the corrected information to the corresponding interview transcript in MaxQDA for analysis. Also, I asked follow-up questions through member checking as needed for clarification when errors were indicated. I applied the aforementioned steps described to reduce bias and produce credible research.

Methodology

The purpose of this study was to understand the lived experiences of individuals in Tennessee with elevated ACEs and resilience. I used basic qualitative design to explore the lived experiences with a purposive sample among individuals 18 years of age and older living in Tennessee. Foundational to the qualitative approach is the belief that human beings have unique experiences and unique interpretations of their experiences, yet a shared essence or core meaning(s) can be derived from a phenomenon commonly experienced by a specific group of people (Patton, 2015). Applying this philosophy, I interviewed willing participants who met the detailed study criteria explained in this section. I received approval (06-24-20-0509696) from Walden University's Institutional

Review Board (IRB) and conducted in-depth, semi-structured interviews to allow respondents the opportunity to share first-hand knowledge about their ACEs and experience of resilience. I discuss the interview sample, instrumentation, data collection, and data analysis in this section.

Participant Selection and Protocol

I followed a multistep process to recruit participants. Prior to conducting my research, I received permission from the TCCY and Walden University's Institutional Review Board (IRB) for TCCY Regional Coordinators to distribute my invitation letter and link for the screening profile via email to professional contacts of the TCCY, an organization comprising adults working in health care, education, social services, and other disciplines. The contacted individuals who received the email invitation and screening profile link could choose to participate themselves or send the email to others they know who may be willing to participate. My invitation email included information about the study criteria and nature of the study to be considered when deciding whether to participate. There were several rounds of emails sent with the study invitation and details. I sent the first round of email invitations to rural health professionals in western Tennessee with whom I am acquainted through my job at Methodist Le Bonheur Healthcare Community Outreach and sent a second round of email invitations to my personal and professional contacts. Then, TCCY Regional Coordinators emailed the invitation to two groups of professional contacts; first, the Rural West Tennessee ACEs Knowledge Mobilization Team and lastly, TCCY council members. The screening profile

was closed once I was able to determine that the interview data resulted in no new themes.

To facilitate the process, I developed a screening profile in an online format via SurveyMonkey.com, which included informed consent and confidentiality information, respondent demographic information, the original Adverse Childhood Experiences Study Questionnaire (ACESQ) (Felitti et al., 1998a) and the Five-by-Five Resilience Scale (5x5RS) (DeSimone et al., 2017). The screening profile began with consent information in order that participants were made aware of the criteria for the study, nature of questions asked, and associated risks. I provided a link on the screening profile for participants to access and save a copy of the consent information and study details. Demographic information gathered in the screening profile included age, sex, race/ethnicity, education level, occupation, zip code, and preferred method of contact with contact information. I designed the screening profile in order that demographic information and less intrusive questions were asked first. Participants were required to be age 18 years of age or older, speak English, have a score of four or greater on the ACESQ, have a score within the top two quartiles on the 5x5RS, and have lived in the state of Tennessee for more than 10 years. It was important that participants lived within the state for a period of 10 or more years to be familiar with common resources in the state, since aspects of this research are related to the availability and access to resources that contributed to a person's resilience and utilized during childhood or adulthood. If a person did not meet demographic criteria, such as younger than 18 years of age and not a resident in the state of Tennessee for ten or more years, then the online screening process

ended immediately by automatically generating the final, thank you page of the screening profile. The purpose of this was to avoid asking invasive questions unnecessarily if a person did not qualify.

The ACESQ is a 10-item self-reporting measure comprised of yes or no questions and covering categories of abuse, neglect, and household dysfunction. Although there are expanded and revised questionnaires used in research studies on ACEs, they have not yet been determined to be valid and reliable. For instance, Finkelhor et al. (2015) stated that further testing would be necessary to ensure that additional items on the Adverse Childhood Experiences Inventory—Revised fit the context of the original ACE scale. Therefore, the ACESQ is the questionnaire of choice due to reliability and validity from previous research (Burke et al., 2011; Dong et al., 2003; Dong et al., 2004; Merrick et al., 2018; Mersky et al., 2013; Radcliff et al., 2018; Sacks et al., 2014).

The 5x5RS is administered in a self-report format and consists of 25 Likert scale questions on adaptability, emotion regulation, optimism, self-efficacy, and social support. Responses range from very inaccurate to very accurate. DeSimone et al. (2017) assessed the factor structure, reliability, convergent validity, and criterion-related validity of the 5x5RS using two samples (n = 475 and n = 613). Researchers concluded that the 5x5RS demonstrates high levels of internal consistency, correlates with the Connor-Davidson Resilience Scale (CD-RISC) commonly used to measure resilience, and indicated the 5x5RS demonstrated ability to assess individuals within at least one standard deviation of the mean on relevant resilience traits. Additionally, when compared to other resilience scales, the 5x5RS includes both internal and external protective factors shown to

determine a person's level of resilience (DeSimone et al., 2017). It is important to note that based on their research, Desimone et al. (2017) reported findings consistent with the notion that individuals who score high on a resilience measure do not necessarily experience fewer life stressors, but simply react differently than other individuals.

When notified by SurveyMonkey.com about completed screening profiles, I reviewed results to determine who met the designated study criteria. If a person who completed the screening profile did not meet the study criteria, I contacted them by their preferred contact method to thank them and state that no further information was needed at this time. All individuals who met the study criteria were contacted via their preferred contact method and asked to voluntarily participate in a 60-90 minute audio-recorded, online video conference or telephone interview with the researcher during the participant's personal time.

Sample

I applied a nonprobability, purposive sampling approach based on the purpose, participant criteria, and scope of this research study. Experts have differences of opinion about the range sample size for a credible study (Mason, 2012), and the exact number of participants for a qualitative study depends on the theoretical framework, methodology, design, data collection method, time, and funding (Baker & Edwards, 2012). Participant recruitment and sample size for a qualitative study are determined by saturation of concept and adequacy of data (Guest et al., 2006; Rudestam & Newton, 2015). Therefore, the sample size should be large enough to reveal most or all the perceptions while not being redundant (Mason, 2010). It was projected that this research would include a

sample size of approximately 5-15 participants. This range was based on the specified participant criteria for narrowing the sample and yielding rich data. In qualitative research using thematic analysis, data saturation is indicated when obtaining more data will not produce new themes or enhance information pertaining to the research question, and when there is sufficient data to justify conclusions (Lowe et al. 2018). I compared themes derived from each interview. When no new themes emerged from new interview data, but only supported previously discovered themes, I considered this the point of saturation. Additional information on data saturation is discussed in Chapter 4.

Instrumentation

Open-ended interview questions were developed by the researcher for semi-structured interviews to explore participants' perceptions about what has led or contributed to their resilience, including protective factors, personal characteristics, stress response and coping, resources utilized, relationships that contributed to resilience, and other insights. Similar to adversities occurring at various levels within a person's ecosystem, resilience may also be developed across system levels (Masten, 2016). Therefore, interview questions were prepared using key concepts from literature on ACEs and resilience, Bronfenbrenner's ecological systems theory, and resilience theory. For example, participants were asked questions about internal and external factors, including resources and social supports, that contributed to their resilience, along with questions about how they cope with stress and reasons for not giving up that lend to understanding an individual's thought processes when experiencing adversity. Based on the applied theories, a person engages at various levels with interrelated systems (Bronfenbrenner,

1979) and interaction between systems become personal influencers (Masten, 2016). Also, based on the research findings that ACEs continue to effect a person's behavior into adulthood and across the life span (Bellis, Hughes et al., 2017; Felitti et al., 1998b; Iniguez & Stankowski, 2016; Larkin et al., 2014; Salinas-Miranda et al., 2015), participants were asked about ways the ACEs they have experienced may still affect them to some degree (in relationships, emotionally, mentally, physically/health, sexually, etc.). Concepts from the literature and theory provide a foundation for the interview questions. A list of all interview questions is located in the Appendix.

Data Collection

I consistently followed the same steps with each participant in the study during the data collection phase. First, each participant received an email invitation and online link to complete the screening profile. As previously discussed, if the individual met the study criteria based on the screening profile scoring, I contacted the individual according to their indicated preference of email or phone, to invite them to participate in a voluntary interview. Once a person replied with agreement to participate, an interview was scheduled based on the participant's preference for an online video conference using Zoom (in a protected meeting for privacy) or an audio-only phone interview. I developed semi-structured interviews that encompassed primary questions in the interview script with follow up probes as needed to further explore participant responses. Interviews lasted approximately 60 to 90 minutes. Each interview was audio-recorded to ensure verbatim responses of participants were captured.

I facilitated online video conferences or telephone interviews to explore the lived experiences of participants with elevated ACEs and resilience. The Centers for Disease Control and Prevention (2020) recommended that individuals avoid close contact by practicing social distancing as a means to prevent the spread of the Coronavirus Disease 19 (COVID-19). Therefore, face-to-face interviews were not recommended at the time this research was conducted. Less traditional qualitative interview methods, such as online video conferencing or telephone interviews, perhaps improves the participant's comfort level (James & Busher, 2007). Due to the increase of internet use and familiarity, online technology is a helpful resource for conducting qualitative research, with the additional benefits of real time conversation and culturally safe space without the limitations of geographical distance (Neville et al., 2016). With the use of online interviews, it was critical for me to store all data in password protected areas and adhere to the NASW ethical code of conduct to maintain research integrity (James & Busher, 2007). See the section on ethical procedures for additional details on safeguarding confidentiality.

I followed interview protocol, such as stating the purpose for the research, explaining the use of audio-recording, explaining of the opportunity for member checking, and stating how participant responses would be used to form research conclusions. When all questions had been answered, I stated that the interview had concluded and stopped the audio-recording. Due to the sensitive nature of the topic, I debriefed with each participant by asking how the person felt after answering the interview questions and if there was any information mentioned which brought

discomfort or safety concern in order to assess the need for a referral. Specific debriefing questions are located in the Appendix. The debriefing was not recorded and there were no referrals needed to be made or documented. All participants were offered contact information for therapeutic services in the local area through verbal or email communication in case they wish to contact additional support after sharing their experiences. There was no indication that any participant was experiencing physical or psychological discomfort during or following the interview, but the researcher was prepared to make an immediate referral for appropriate medical or mental health attention if needed. I provided my contact information so that any post-interview questions or comments may be discussed. Also, I explained the data analysis process and informed the participants that they would be contacted to confirm that the themes from their interview have been accurately interpreted. Lastly, I emailed a gift card in the amount of $20 following the interview as appreciation for participation.

Data Analysis

Qualitative data analysis is a systematic process in which the researcher becomes immersed in the data (Rubin & Rubin, 2012; Saldana, 2016). Glaser and Laudel (2013) defined data analysis as the process to systematically reduce the amount of information generated from data collection. Following each interview, I used Temi.com to transcribe the audio-recordings. I reviewed the transcriptions while listening to the audio-recordings to ensure accuracy, made corrections as necessary, and became familiar with the data. Benefits of transcription review include reliability through cross-checking, closeness to the data as a researcher, and listening for tone of voice (Halcomb & Davidson, 2006).

Next, I uploaded transcripts for viewing in MAXQDA qualitative data software and organized the raw data from interviews using deductive coding. I coded the data line-by-line by identifying words or phrases that gave meaning to the raw data. Then, I assigned codes to categories that I had predetermined based on the literature, as well as theoretical concepts from ecological systems theory and resilience theory. For example, I applied literary and theoretical concepts to classify codes into categories including the effects of ACEs, internal protective factors related to a person's microsystem, and external protective factors related to the mesosystem, exosystem, macrosystem, or chronosystem.

For this qualitative research, I aimed to discover meaningful themes related to the resilience phenomenon and become familiar with the experiences of each participant. Therefore, thorough analysis of verbatim content allowed me to identify themes based on participant experiences. I determined the relevance of data based on the relation to the research question (see Glaser & Laudel, 2013; Saldana, 2016). Saldana (2016) suggested that qualitative researchers should form conclusions based on what is fundamental to the topic. Therefore, I focused on identifying patterns and themes related to participant experiences of ACEs and resilience that answered the research question.

Once the thematic analysis of each interview was complete, I summarized the themes shared by the individual participant for member checking. I organized themes using interview questions as headings to help participants recall and review the main themes of their responses. I individually emailed participants the themes discovered from their interview and asked them to respond by email to state whether the conclusions were

accurate or that the themes were inaccurate with clarification, as discussed in the online consent and at the time of the interview with interview protocol. As interviews continued, I compared subsequent data with themes previously discovered, bringing forth either new themes or recurring patterns from experiences. Then, I used themes to interpret the data and answer the research question.

During analysis, a researcher may find there are discrepant cases when a portion of the data complicates or challenges the understanding and interpretation of the data as a whole (Ravitch & Carl, 2016). Ravitch and Carl (2016) suggested that in the case of discrepancies, the researcher may look for alternative explanations. There are several discrepancies to report from my research and these are discussed in detail in Chapter 4.

I implemented the systematic analysis process described to discover themes within the data with the use of qualitative data software. Use of data software helped with the organization of the narrative responses, coding data, categorizing, documenting themes that emerge, reflective comparison of interviews, and reflective journaling of the researcher's own biases. The themes discovered from my research are (a) giving back, (b) faith and spirituality, (c) influence of strangers, (d) buffer within household, (e) system resources as barriers, (f) limited resource access for participants of color, and (g) generational factors. Finally, I wrote conclusions about the themes discovered to answer the research question, with examples from data to support the interpretation. Dissemination of study results to participants and stakeholders will occur at the conclusion of dissertation writing and final approval. I will share an audience-appropriate

summary of the study results, approximately three to five pages, with participants and TCCY staff via email or postal mailing, if preferred.

Issues of Trustworthiness and Credibility

Qualitative research has been questioned by critics for not having the same approach of ensuring validity and reliability as in quantitative research; therefore, establishing trustworthiness and credibility are of utmost importance (Cope, 2014; Rubin & Rubin, 2012). As previously mentioned, use of reflective journaling, audit trail, and member checking were practices applied to assist in bias reduction and accurate interpretation of data. I used data analysis software to ensure credibility of the research, to carefully document codes, categories, and themes that describe the resilience phenomenon in detail, and to demonstrate reflection of the raw data. For dependability, I constructed an audit trail by documenting all steps in the processes of data collection and analysis in order that another researcher may audit the steps I took to reach conclusions and confirm accuracy or replicate the study. If a researcher is not transparent in documenting how the data is obtained, recorded, and reported, readers may question the validity of the study (Ravitch & Carl, 2016; Rubin & Rubin, 2012). Transferability is possible when clear context is provided on the phenomenon occurrence so that research conclusions can be used to make sense of other contexts or situations (Constantinou et al., 2017). I clearly defined the sample population and criteria as it relates to the resilience phenomenon, giving context for the research. Also, I applied key concepts from literature on the topic and theories that ground the study to develop open-ended questions for participant responses. However, there are limitations of transferability based on the study

sample and the uniqueness of the participant responses that may not represent a larger population. To demonstrate confirmability, I performed member checking to ensure the conclusions reflect the participants' experiences and not what the researcher thinks or values. Additional steps to aid trustworthiness and credibility included purposive sampling as well as special attention to the wording of questions, so they were objective and not leading. Despite efforts taken to reduce bias, the use of deductive coding with predetermined categories, even when based on the literature and theoretical framework, may have influenced my research outcomes. Although a risk of bias was present, I produced credible research and followed ethical procedures.

Ethical Procedures

To ensure the privacy of participants, I considered certain ethical aspects when planning research and informing participants. I addressed confidentiality in the voluntary consent information at the start of the screening survey to assure participants of the steps taken to protect personal information, while also informing them of limitations to confidentiality based on legal mandates. No information was disclosed during interviews that could not remain confidential, such as a threat of harm toward self, others, or information pertaining to abuse or neglect of a minor child. In addition, I explained to participants that the interviews were for scholarly research and the purpose of the research was stated (see Patton, 2015). I took steps to protect confidential data by storing data in password protected areas and using initials or pseudonyms only known by the researcher for any written notes. Names were not used to identify any participant, including when using quotations from data transcripts. Only myself, my dissertation

committee, and peer reviewers have access to the data, but no identifying information will be revealed. I will continue to store data in a secure location upon conclusion of the research for up to five years in order that it may be retrieved for future research endeavors.

Because participants shared their experiences of resilience in the aftermath of adversity and trauma, the ethical standard to do no harm was upheld. I actively weighed participants' responses with the potential risk of distress (see NASW Code of Ethics, 2017; Patton, 2015). I informed participants of their right to refuse questions or stop the interview at any time. Again, as a courtesy, I provided contact information of mental health providers to participants for assistance, if desired. If there was any indication that the participant experienced physical or psychological discomfort during or following the interview, I was prepared to make an immediate referral for appropriate medical or mental health attention, however this did not occur. In appreciation for the participant's time, I emailed a gift card in the amount of $20 to each participant following the interview.

Dignity and worth of humans and research subjects are of value in the social work profession (NASW, 2017). Therefore, in no way did I intrude or place pressure on participants during facilitated interviews. I allowed participants to respond freely, sharing their own perspectives without projecting my own attitudes upon participants. If an ethical dilemma had arisen, I would have consulted with the research committee, IRB, or a professional organization such as the National Association of Social Workers (NASW),

and report the issue within the research (see Patton, 2015); however, there were no ethical dilemmas to note.

Summary

I used a qualitative research design to answer the question, what are the lived experiences among individuals in Tennessee with elevated ACEs and resilience? Data from qualitative interviews was used to discover knowledge on the complex phenomenon of resilience in the aftermath of adversity occurring during childhood. I collected data through conducting semi-structured interviews with individuals who meet specific sample criteria based on responses on a screening survey comprised of demographic information, the ACESQ, and the 5x5RS. Then, I invited participants who met designated criteria on the screening tool for an online video conference or telephone interview. To better understand the experiences of resilience in light of ACEs, I asked open-ended questions during interviews. Also, I took steps to uphold ethical standards and ensure human subject protection. Lastly, I transcribed and analyzed interview data for themes with careful interpretation of interviewee responses to draw thematic conclusions.

Chapter 4: Results

Introduction

The purpose of this study was to explore the lived experiences of individuals in Tennessee with elevated ACEs and resilience. Individuals of interest were those who indicated multiple ACEs and demonstrated high levels of resilience. To understand the relationship between ACEs and resilience among these individuals, I conducted qualitative interviews. The interviews explored the ecological system-level resources mentioned by participants as assets or barriers for addressing ACEs and harnessing resilience. The overarching research question answered by this study was:

RQ: What are the lived experiences among individuals in Tennessee with elevated ACEs and resilience?

Setting

I conducted this research using Zoom and phone interviews during a unique time due to the COVID-19 pandemic and heightened political tensions related to civil rights and racial injustice issues. Therefore, it is important to note that at the time of data collection, participants were experiencing many life changes in their roles as parents, employees, and community leaders. During interviews, it was not uncommon for participants to comment on their stress level due to the pandemic, being on furlough from their job, and limitations in social gatherings that had been a source of personal encouragement (e.g., church attendance). However, characteristic of resilience, study participants expressed positive statements, found time to reflect, recognized resources that they had not fully used prior to the pandemic (e.g., telehealth), and formed a new

appreciation for positive relationships that uplift during difficult times. When reflecting on the pandemic, one of the participants pondered, “What can I do to redeem the time to make the best of it?” Of note, some participants shared their thoughts and feelings regarding race-related issues and hopes for a greater sense of unity. Taken together, the effects of COVID-19, racial tension, and political turmoil may have played a role in participant responses and influenced interpretation of the data. These factors will be discussed in detail later in this chapter as they relate to the ecological systems theory.

Demographics and Overview of the Sample

All participants in this study were adults who have lived in the state of Tennessee for more than 10 years. My research was not designed to only include individuals who resided in the Western region of the state; however, this naturally became the sample population because recruitment began in the western region of the state and data saturation occurred prior to recruitment efforts in other areas of the state. The Western Tennessee region is predominantly rural, with areas like Chester County where two participants resided, which has a population of 17,297 people, and Gibson County, where two participants resided and which had a population of 49,133 in 2019 (U.S. Census Bureau, 2019). Four of the 12 participants resided in Madison County where the population was reported to be 97,984 in 2019 (U.S. Census Bureau, 2019). It is important to highlight that individuals living in rural areas often have fewer resources for help, as opposed to those in urban areas (Barnett et al., 2014; Handley et al., 2015; McCall-Hosenfeld et al., 2014), which is significant when interpreting the data collected and for the implications of the study findings.

In total, there were 21 responses to the online screening survey, and of these, 17 were female and four were male. Twelve of the 17 females met eligibility criteria and were sent an invitation to participate in an interview, to which 11 responded with interest. Three of the four males qualified and were sent an invitation to participate in an interview, to which only one responded with interest, which brought a total sample of 12 when recruitment of participants ceased due to reaching the point of data saturation. I determined that saturation was met by comparing themes derived from each interview and no new themes emerged from subsequent interviews but only supported previously discovered themes. Based on my thematic analysis and the process described, I resolved that I had met the point of saturation after interviewing 11 participants. However, I had already scheduled the twelfth interview and decided to proceed. The final interview further confirmed data saturation as it also supported previously discovered themes and no new themes arose. All participants spoke English, experienced a high number of challenges during childhood, and had a high resilience score.

One participant identified as being in the age range of 20-29, three participants were between the ages of 30-39, one participant identified as being in the age range of 40-49, and seven participants were age 50 and up. Three of those participating were non-White and shared about their experiences being persons of color in relation to interactions and resource access.

Participant responses on the ACESQ ranged from 5 to 10 (maximum). The average number of ACEs reported by the group of participants was 7.33. The majority (*n* = 11) of the participants answered yes to the ACESQ items about emotional abuse and

substance abuse in the home. The 5x5RS scale, used to determine resilience, examined areas of adaptability, emotional regulation, optimism, self-efficacy, and social support. Nine out of the 12 participants self-scored the lowest in the area of emotional regulation and eight out of the 12 participants self-scored the highest in the area of self-efficacy on the resilience scale. It is interesting to note that all participants reported "accurate" or "very accurate" to the item, "Am good at analyzing problems."

All participants were professionals, completed high school, and had completed at least some college. My research was not designed to only include professional individuals; however, this naturally occurred with the manner of recruitment. Five participants held graduate degrees. One was currently working toward completing a master's degree and two were working toward completing doctorate degrees. This demonstrated that some participants had used education as a resource toward personal development and resilience. Over half of the participants reported beginning and completing an associate's or bachelor's degree later in life, as opposed to following high school or as a young adult. Other participants had some college education (n = 2), an associate's degree (n = 2) or a bachelor's degree (n = 3). Among the participants, there were a variety of occupational backgrounds including art/design (n = 1), education (n = 2), healthcare (n = 2), caregiving (n = 1), sales (n = 1), legal (n = 1), juvenile justice (n = 1), and social services (n = 3). The majority (10) of the participants had been provided with information or training about ACEs prior to participating in this research project.

Data Collection

Prior to the study, I decided that recruitment would begin by only sending the invitation email to one cohort of 200-300 potential participants at a time for reasonable management of the response. The first round of email invitations was sent by my colleague at Methodist Le Bonheur Healthcare Community Outreach to over 200 work-related contacts on July 15, 2020. I sent another round of email invitations on August 4, 2020 to approximately 30 personal and professional contacts. On August 8, 2020, TCCY staff who agreed to partner with me sent the email invitation to approximately 230 individuals who were a part of the Rural West Tennessee ACEs Knowledge Mobilization Team, a large group of professionals who are interested in helping strengthen communities through ACEs awareness and community resilience building. Then, TCCY regional coordinators sent a final round of email invitations on August 31, 2020, to a group of regional TCCY council members. All emails sent to potential participants stated that responding to the email and participation in the study was voluntary.

There was a total of 21 online screening tool responses via SurveyMonkey.com for this study. Of the 21 responses, 15 individuals met the criteria for the study and were invited to participate in interviews via Zoom or by phone. Twelve of the respondents agreed to participate and were interviewed. Although I was acquainted with some participants, none of the participants were clients, students, supervised persons, or other relationships with a conflict of interest. Six of the participants chose to complete the interview online via Zoom and the other six completed the interview by phone.

Conducting telephone interviews did not appear to hinder the depth and richness of communication in comparison to Zoom interviews with camera. Evidence of this was found in the extensive sharing of information by individuals over the phone. Perhaps some felt more comfortable conversing over the phone and maintaining a greater sense of privacy. However, with the increase use of Zoom and technology for video chat during COVID-19, participants appeared to use this method with ease and comfort.

The interviews occurred between the dates of August 10 and September 8, 2020. I audio-recorded all interviews using the Zoom recording feature (if a Zoom interview) and a voice recording application on my personal device for data transcription and content accuracy. I used active listening and took notes during each interview. The length of time for interviews varied somewhat, with the shortest interview being 24 minutes in length and the longest interview was 140 minutes in length. Three of the interviews went over the 90-minute time designation; however, this was a result of the interviewees' willingness to share deep insights and personal experiences.

I followed interview protocol as indicated in the methodology. Questions during the interview remained open-ended unless a follow up question was needed for clarification. During the occasional moments of silence or hesitation for the interviewee, I reminded the participant that they may only share what they were comfortable sharing or to take as much time as needed to collect their thoughts. Other times I may have paused to write notes and disclosed this to the participant before asking the following question. As stated in the methodology, I created an audit trail to document the data collection process.

There was enough data to justify conclusions after the 11th interview, in which no new themes or information emerged. As mentioned previously, I had already scheduled an interview with the 12th participant and decided to proceed. The final interview further confirmed data saturation as it also supported previously discovered themes and no new themes arose. Because saturation was met with a small sample of participants in the rural region of Western Tennessee, this limits the transferability of the study findings. No unusual circumstances occurred during interviews.

I audio-recorded all interviews for accuracy of data analysis. A technological issue encountered was a brief interruption of internet connection during one Zoom interview, but I asked the participant to repeat what was said after what was last heard. I used Temi.com to transcribe the recordings, which provided mostly accurate transcriptions. I listened to each interview recording while reading the transcription to make corrections to any errors. The revisions needed were primarily due to accent, pronunciation, or volume. The only other technological issue was that two of the audio-recordings during phone interviews did not have strong enough sound quality to be transcribed by Temi.com. For the interviews that were unable to be transcribed by Temi.com, I transcribed the data by hand through listening to the recordings and typing the verbatim data within the MaxQDA software. I took measures to ensure accurate interpretation of the data through member checking. Additional information on data analysis and member checking is discussed in the following section.

Data Analysis

I performed a thorough review of the data, including examination of interview data a minimum of five times. During the initial review, I checked the accuracy of the transcription by listening to each recording and reviewing the corresponding transcript by hand. Then, I studied the data to review and compare with notes taken during each interview. Next, I coded the data and organized it by placing codes into color-coded categories. As previously discussed, some categories were predetermined based on the literature and theoretical concepts, and included categories such as ACEs, effects of ACEs in childhood and adulthood, personal attributes, protective factors and ecological systems. Other categories naturally formed as a result of interview questions and responses, such as what resilience means to the individual, what resources the participant wished for access to, coming to terms with personal ACEs, traumatic experiences, words of wisdom, and future goals. There were also unanticipated categories that emerged during the coding process and included COVID-19, race matters, depression and hopelessness, and system barriers. A complete list of categories can be found in Table 1. While coding and categorizing data, I also created memos as appropriate. Then, I summarized each participant's responses and listed the themes from the responses in a manner that could easily be reviewed by participants for member checking. Finally, I reviewed the collective data to note trends and patterns. I printed the coded data by category for easy viewing and to further examine trends and patterns within the categories. I also printed the interview summaries that were provided to participants during member checking to search for themes. The sample themes emerged based on the

patterns and resemblances of the participants' lived experiences. Many reviews of the materials occurred for me to organize, analyze, and be immersed in the data. Data from one interview lacked depth due to limited information provided by the participant. Still, there were important insights to glean from what information was shared and it did not contradict other data. As stated in the methodology, I documented an audit trail throughout the data collection and analysis processes.

To organize all data and then to move inductively from coded units to larger representations of patterns and themes, I used MAXQDA data software. I identified codes within the data including words and phrases such as unpredictability, protective, desire to leave, avoidance, abuse, neglect, distrust, feeling less than, boundaries, strength, determined, relate to others, work ethic, empathy, love for learning, positive personality, caring, compassionate, emotional, resourceful, finding the good, therapeutic resources, belonging, extended family, created family, employer, teacher, coach, friend, therapist/counselor, stranger, learning/education, church, and faith. I organized codes from each interview into categories, then the data within the categories was analyzed to find overarching patterns and themes. There was a total of 1,179 coded segments of data organized within 16 categories and a total of 7 themes. The themes are discussed in detail with quotations from participants to further support the findings in the results section. The relevance of data was based on my interpretation of the relationship to answering the research question. Experiences and opinions of participants varied, however, there were no contradictions found during data analysis and member checking.

Table 1

Data Analysis Categories

Category	Number of coded segments in the data
COVID-19 related	10
ACEs and traumatic memory	91
Effects of ACEs as a minor	32
Effects of ACEs as an adult	51
Depression or hopelessness	43
Meaning of resilience and examples	126
Personal attributes	189
Coping strategies (adaptive and maladaptive)	97
Future goals (personal and professional)	74
Protective factors based on ecological systems theory	290
Reasons for not giving up	16
Resources wished for	25
System barriers	11
Race matters	32
Making sense of or coming to terms with ACEs	70
Words of wisdom	22
Total	1,179

Note. Categories are listed in the order they appear within the text, but not all categories are discussed at length.

After interviews were conducted, I sent a follow-up email message to each participant with attached interview summaries including themes from the interview for the purpose of member checking. Eight of the 12 participants responded to the member checking email. Seven of the participants who responded to the member checking confirmed accuracy. Only one participant reported that after reviewing the member checking information, there seemed to be a misunderstanding and the participant clarified what she intended to say with further explanation. I copied and pasted the verbatim email response into the appropriate interview portion in MaxQDA and analyzed the data. I

responded back to the participant in appreciation of her time and effort taken to make certain that the information was accurately understood. Two of the individuals who confirmed accuracy added further comments to expand upon what was already stated during their interview. I also analyzed the additional information.

Evidence of Trustworthiness

I maintained confidentiality of information and carried out other ethical provisions, such as keeping documents and recorded information stored in password protected locations and not using identifiable information. In addition, I thoroughly checked and re-checked the data, documents, and notes. To establish credibility, I followed interview protocol as outlined and used data analysis software to document and organize the raw data. Interviews consisted of open-ended questions to remain objective and reduce bias. Also, I used reflective journaling and memos to distinguish my personal thoughts and responses from those of the participant. In regard to transferability, I constructed an audit trail for all steps of data collection and data analysis by recording steps taken to reach conclusions in order that the study could be replicated. I demonstrated dependability by clearly defining the sample population and all participants having met the specified criteria. To ground the study, I applied key concepts from the literature and theories. I used member checking to confirm accurate interpretation of the information and to reduce the influence of bias.

To help establish trustworthiness, there are several discrepancies in the data to report prior to discussing the results of my study. I noticed the first discrepancy while conducting interviews as most participants were open to discussing their ACEs, while a

couple stated they tend to avoid personal discussions about ACEs. None of the interview questions directly asked participants to disclose information about their ACEs, however participants often chose to discuss details of their experiences to explain their answers or provide examples. In addition, some individuals described that they were confrontational toward their abuser(s), attempted to avoid the abuser at all costs, or had experiences of both, stating that their response depended on the person and situation. Nine of the participants reported having received professional counseling either during childhood, adulthood, or both. Others have not received any form of professional counseling. This difference may be due to the access and availability of resources, belief they did not need counseling, or preference not to discuss their past. Another discrepancy that emerged during case analysis was that nine out of the 12 participants reported having difficulty developing trusting relationships and healthy attachments because of their ACEs, whereas the other three participants did not mention this as an effect of their experiences. This difference may be due to each person's unique experiences with trust in relationships or possibly not recalling this to be one of the effects of their ACEs at the time of the interview. Two additional discrepancies came from the same participant whose lived experience did not align with the reoccurring themes from other interviews. Specifically, the participant described herself as being an atheist and denied having any faith or spiritual beliefs that contributed to her experience of resilience, as opposed to all other participants who reported faith or turning to God to be a contributing factor toward their resilience. A possible explanation for this may simply be due to her different lived experience in relation to spiritual beliefs. While others described how they have made

sense of their ACEs or come to terms with them, this same participant stated that she has not yet been able to, stating, “I haven’t come to terms…I’m still trying to do that.” An explanation for this may be that she reported having only received brief therapy and stated it was unhelpful and wished that she had access to trauma therapy. Therapy was indicated by other participants to have positively contributed to their resilience. Also, it is important to report that one interview was brief and resulted in limited information and lack of richness. I considered alternative explanations and decided to keep the data as part of the research since it was not contradictory to other data and did provide support for themes and patterns from other interviews.

Results

Adverse Childhood Experiences and Their Effects

To set the stage for understanding resilience, it is important to first learn that participant experiences of resilience were influenced by their experiences of trauma and its effects. Unlike quantitative statistics that demonstrate the impacts of ACEs, this research allowed participants to articulate their experiences, including growing up in “hostile” and violent environments, along with “hellacious disfunction at home” due to significant emotional, mental, physical, and sexual abuse and/or neglect by an adult caregiver. Some participants described traumatic situations where they were beaten, molested, threatened to be killed, and stolen from. Even some endured physical and sexual abuse both at home and at school.

Other experiences mentioned during interviews include being left alone with strangers who offered illegal drugs; witnessing domestic altercations, sexual abuse, and

gun violence of which family members were victims; being told by those whom they should be loved and protected by that they were not good enough; measures taken and attempts to protect themselves at night in bed; constant verbal abuse and fear; estrangement from family; and having parents choosing substances or romantic relationships over them. These experiences led to various effects during childhood, such as a lack of nurture, daydreaming about someone who would care, deep resentment, emotional instability, externalizing behaviors of anger, and believing the lie that they were the source of the problem. For example, a White woman of senior age stated, “My mother would always tell me I wasn’t wanted.” Internalizing behaviors to cope with pain were described by a Black woman when stating, “I held it all inside.” Other participants expressed the effects of ACEs brought about a strong desire to run away or leave home, truancy issues, development of Post-Traumatic Stress Disorder (PTSD), eating disorders, mood disorders, and suicide attempts. A middle-aged White woman articulated, “I developed OCD, Separation Anxiety, and a controlling personality from being in that environment.”

No matter the age in childhood or adulthood, the majority of participants (n=9) noted difficulty with trust and attachment, including the need to designate boundaries to protect self from being hurt in relationships. One individual described this when stating, “I don't trust anyone and I don't believe in anyone. I don't trust anyone to be good to me or to take care of me or to truly help me.” Ten of the participants stated in the interview that they had little to no relationship with their father during childhood. Other common effects mentioned to be experienced during adulthood by participants, include lack of

self-worth where they experience a deflated self-value with increased insecurities; overly self-critical at times, feeling unloved, experience sexual confusion, can be reclusive and distant from others, or have people pleasing behaviors. Recognizing the various effects of ACEs, one participant shared, I have to "filter what I feel and what I know."

Not all the mentioned consequences of ACEs were negative. The positive effects reported include their ability to empathize and connect with others well; a strengthened bond with their own children, with whom they strive to protect and provide for; enhancement of their work related duties to connect with others who may be struggling; utilizing positive personality traits, such as strength and not giving up when life is difficult; and a strong desire to help others. For example, a young White woman reflected on the effects of her experiences stating, "They [ACEs] equipped me to be able to do the job that I do now to the best of my ability and better than a lot of people… I can empathize on a level that other people cannot." ACEs are a "platform to teach my students and kids," reports a middle-aged, White woman. Then, a middle-aged White man stated,

> I deal with kids on a daily basis mentoring … working with these kids. It [personal ACEs history] definitely helps. It helps me communicate with them a lot better. They realize, he kinda gets where we're coming from and so they're able to connect.

It is evident that those involved in this study experienced significant adversity; yet, are cognizant of their ability to bring positivity and help others. The effects of adversity and trauma influenced participants' experiences of resilience.

Resilience

Participants described what resilience means to them personally stating, “getting up again,” “to rise above by the grace of God,” “to bob and weave,” “adjusting to life’s challenges,” “starting over again,” “to redirect my future,” and the “ability to overcome trauma or negative experiences in your life and not let them change you permanently or cause you harm permanently.” A Black woman participant even described resilience as “The sheer will to breathe. Sheer will to live. Desire to live. I was afraid of dying in the state I was in. I didn’t want to stay in, so I scraped, digging out.” During interviews participants shared aspects of their personality or their self that have contributed the most to their experience of resilience. Responses revealed first-hand that participants view themselves as having unique determination and inner strength. While witnessing and experiencing abuse, neglect, and resilience simultaneously during childhood, one White female described that seeing resilience examples time and time again among those she lived with taught her that she could also bounce back and not give up.

Additional resilience examples include the following statements:

- Therapy sometimes brings up things that are hard to deal with…. I had to cope and work through a lot of those issues if I ever wanted to really, really move forward.
- I had very little hope … I am now a person with a lot of hope and a lot of peace and a lot of joy in spite of bad things. God is my hope.
- I graduated magna cum laude … and was told as a kid, I wasn’t smart enough to do that. I wasn’t smart enough to get a degree. And I did that even after

> brain surgery. My ceiling has now become my floor. So, whatever I am facing, God's going to show me how to make it my floor.

Other reoccurring character traits mentioned by participants included strong work ethic, care and compassion for others, having a love for learning, positive personality, experiencing strong emotions, resourcefulness, ability to forgive, and able to find the good in themselves and others. Each of the participants made difficult decisions to move forward through the darkest times in their life.

Key Findings: Protective Factors Contributing to Resilience

Four of the seven themes that emerged in this research study are related to protective factors contributing to resilience. The first theme discovered from my research is that every participant identified as being a helper and giving back to others in some meaningful way through their daily work in their career or in volunteer service. During the 12 interviews, statements about giving back and helping others were mentioned on 23 occasions. An example of this is when a middle-aged, Black woman stated, "I did overcome a lot of trauma as a kid, as a teenager, and even…in my early adulthood, so I see myself giving back to people." A White woman stated that she believes her experiences are a "guiding factor to help other people overcome their trials and struggles." A Black woman reported, "I'm here to help someone else…. My assignment is not about me, but to help someone else." Many participants were caregivers and at times providers for their siblings and even adult(s) living in the home. Seven of the participants reported that they found work at an early age, either as a child or teen in order to help meet their needs or the needs of others. They have all established

themselves in their careers as adults, many in helping professions, and one participant even began a grass-roots partnership among community agencies. Another participant shared her reason for political involvement in her community is to encourage others toward seeing the good in humanity from a multi-cultural perspective during the current social and political climate that is heavy with racial tension. Others described a strong conviction to work toward the prevention of ACEs rather than just responding, to fight for the disadvantaged in a variety of settings, and to give hope to others who are in a dark place as they once were. The lived experiences of elevated ACEs and resilience have influenced this research sample to extend help to others.

Next, the second theme and significant discovery of this study is the contribution of an individual's personal faith in God and involvement in spiritual practices to the experience of resilience. Spirituality and faith were named a total of 38 times during the 12 interviews. However, participants spoke more about a personal faith in God than church involvement. For example, when asked about the aspects outside of self that have contributed the most to experiencing resilience, one participant emotionally expressed, "God. Simply God. He helped me." Another participant described God as being,

> A friend that absolutely is present every minute ... The creator of everything is right there helping me to get through it and to know what to do and to solve those situations or get away from those situations, whatever wisdom I need. I have access to that.

The majority (n=11) of the participants described some spiritual aspect being a protective factor or source of coping. Ten participants identify with Christian beliefs, one identified

as having agnostic beliefs, and one identified as being atheist. The lived experiences of faith and spirituality have contributed to the resilience of this research sample.

A third theme related to protective factors not mentioned in the literature are life changing, helpful encounters with strangers. For example, one participant shared,

> I was walking in the snow to get to school and the lady took me in…. I didn't know this lady, but I guess she saw my willingness to go to school at such an early age. I would walk myself to school. And so, she just let me stay at her house right across the street from school. So, I kept going to school.... I was so young. But she took me in, and she bathed me, and she combed my hair until the teacher realized…and after a month or so I had to go back home.

Another example shared was when a participant encountered a stranger and began a conversation.

> She said, “Honey, I'm a woman.” And she said, “You out here with this little girl” and she gave me the keys to the apartment. I had no job. I had no money…. She also gave me a job to help clean the apartments for my rent.

The lived experiences of encounters with strangers made a tremendous influence on the resilience of this sample population.

Additionally, the fourth theme discovered from research participants, was that despite horrific dysfunction in the household, it was actually within the household that there was also a positive individual they could identify as a buffer and source of aid. This commonly took the form of a family member who worked hard and provide for their needs. One participant stated,

> She always tried to do things with me or give me the attention that I needed…and she worked so hard. I saw her every day just working so hard to make sure that I had food on the table and clean clothes and lights, which didn't always happen.

Another participant described, "he took me places" to get away from the house "and I adored my time with him." Other participants reported that they were the caregiver or positive buffer for siblings or others in the home. A positive support person in a dysfunctional home environment may be the foundation for an individual to cultivate resilience.

Other System-Level Protective Factors

Participants offered a plethora of information about the protective factors that existed for them at the micro-, meso-, exo-, and macrosystem levels. At the microsystem level, participants have learned to adapt and manage difficult circumstances by using a variety of coping strategies. Among those most commonly listed are time with child(ren) or family time, exercise and sports, meditation or prayer, reaching out to a friend or someone to talk to, establishing healthy boundaries in work and personal relationships, creating something or artistic expression, reading something positive like scripture or self-help books, attending church services and events, serving others, participating in therapy or a support group, laughter, and crying. One participant shared a meaningful coping strategy that she learned in therapy of wearing a necklace every day, stating, "Wearing a necklace can help me remember where I'm at and stay in the moment; to harness and keep me in the now." Additional supports mentioned on the microsystem level include physical activity such as going to a gym, playing a sport, and other

extracurricular activities. However, not all participants had access to these types of opportunities.

Similar to other resilience studies, this sample reports being directly engaged with positive supports on the microsystem level by extended family members of origin, employers and co-workers, friends, professional mental health counselors, support groups like Adult Children of Alcoholics (ACOA), created family, and other learning resources such as advising and tutoring. This was described best by a participant who stated, “You need pillars on sides to hold you up. You can’t do it alone.” Other roles named by this sample to have helped make a difference for them include pastors who were available to listen and pray with, neighbors as close support, grandparent(s) who taught life skills and values, mentors who gave of their time and attention, therapists/counselors to confide in, medical providers to share advice, teachers who encouraged and leveled the socio-economic differences in the classroom, coaches who motivated, and even a banker who went above and beyond to help in a time of need. One participant recalled the impact of a teacher stating,

> I remember changing schools and going from a poor performance academically to making the honor roll with a new teacher in 4th grade. I remember she would say to me, “You’ve got this.” I needed that positive recognition. This same teacher took me to Pizza Hut and she ordered enough to have leftovers for me to take home to my siblings. Then she took me to Walmart and bought me a new outfit. No one had ever done anything like that for me.

This type of interaction demonstrates positive relational impact. In addition to personal relationships, several participants attribute their personal growth and processing their life experiences at the microsystem level to attainment of education and job-related training.

The mesosystem also influences resilience with the interaction of two or more settings such as home, school, peer group, work, or neighborhood. Several participants shared that there was little crossover in communication or involvement between home and other environments (e.g., school). An example of this limited involvement across systems was described by one participant when she stated that she believed her teachers suspected harm occurring at her home, but that "it was not discussed back then." In contrast, another participant shared that a teacher connected her with a school counselor who met with her once and recommended help for the family. Following the action taken, the family received short-term family counseling, but the service did not result in long-term change. Other mesosystem level supports mentioned were playing or talking with friends in the neighborhood as positive influences on their experience of resilience.

Although less often than direct contact, the exosystem level of indirect contact was still identified by some participants as being a positive support. For example, receiving hand-me-down clothing from a parent's employer. Due to reports of there being very few, if any, resources or programs to help address the ACEs participants endured, there was little opportunity for assistance that would indirectly support the well-being of the child or family system. Current regional programs that participants mentioned would have benefited them if available and known about during their childhood include Women/Men's Rape and Assault Prevention (WRAP), Carl Perkins Center for the

Protection of Child Abuse, and Agape Ministries. A national resource mentioned that would have been helpful was the National Alliance on Mental Illness (NAMI), as several participants remarked that they wished their parents were better educated about mental health as well as their neglectful and abusive behaviors and experiences to break the cycle of harm.

Participants also discussed the larger context of the macrosystem where culture and belief systems influence a person. The protective factors on the macrosystem level that were mentioned include religion, prayer, and a belief system. A middle-aged Black woman stated, “I believe God allows certain things into my life.” With the technology age having emerged over the past several decades, some participants reported that online resources have been a source of support by being able to search for specific websites or information when assistance was needed. Also, the increase in discount food and clothing stores in certain communities were mentioned as a helpful resource during childhood and adulthood to supply basic needs. Lastly, the momentous impact of the civil rights movement was discussed by another Black woman who stated, “A whole lot of people fought for me,” referring to all that was done so she could be treated as a citizen. These protective factors contributed to participants’ experiences of resilience.

Key Findings: Barriers to Resilience

In addition to protective factors, there were an additional three themes related to barriers and unfortunate circumstances identified by participants. These barriers pertained to receiving help at various system levels and the information shared about these barriers offer insights for practice implications.

A fifth theme discovered from participant responses was that system resources intended to help can also be barriers. On the microsystem level, participants mentioned relationships being impacted due to not being able to trust; not knowing who to confide in; not having access to therapy; feelings of anxiety toward therapy; and treatment received in therapy not being what was needed, such as a judgmental response or more like talk-and-listen sessions rather than offering beneficial feedback and suggestions. Seven of the participants indicated that access to quality counseling in childhood would have benefitted them. Although most participants received some form of counseling either in childhood or adulthood, several reported that the help was not received soon enough or did not address their traumatic experiences. A White woman between the ages of 20-29 explained her experience and perspective in detail stating,

> I was receiving services from community mental health agencies when I was younger. As I got older, [I] branched out to other branches of therapy because I realized that the quality of mental healthcare that some therapists through community mental health were able to provide wasn't what I necessarily needed. A lot of community mental health agencies seem to have a medication first perspective…and therapy is just almost an afterthought. The therapist would forget who I was between sessions, ask if I was taking my medication, and I would have to remind him that I wasn't taking medication. I felt bad for other people who've really struggled with their mental health having to receive such low par services. So, the quality of mental healthcare is extremely important in

> building resiliency and I'm really sad to say that I don't think a lot of people are able to get that anymore.

This information leads to a conclusion that even when individuals are able to access therapy, it may not address the needs of the individual. In some cases, negative experiences with a therapist or counselor may steer the person away from receiving therapeutic help. This information sheds light on the gap between the research and service delivery, particularly for those living in rural areas where the need for mental health counseling is just as prevalent than in other areas, but services are scarce.

Since access to resources varies, it was important to learn from participants their perspectives about what they wished they had access to for help. The most common response to asking participants to name what they wished they had access to for help was therapy or a specific counseling service, such as trauma therapy, a specific support group, and Eye Movement Desensitization and Reprocessing. More general answers were given by participants to this same question, saying they would have liked to have had more options for help or knowledge about available resources, such as family centers, mental health treatment, parental guidance, and financial education. Other responses included wishing to have "an adult that would have stepped up and tried to help;" to have been heard, trusted, loved, and believed; a safe home; the ability to enjoy being a kid; and to have had a sense of belonging. Although participants shared about many positive supports during these interviews, access to specific resources for help was found lacking.

Some participants recalled unfortunate experiences on school premises and in the education system that have remained in their memory for decades. School was described

by one participant as being “horrible” due to the treatment including being belittled by a principal and others in authority, along with physical and sexual abuse by peers. Another participant described that her behavior choices at school were often due to simply being hungry and recalls “acting like I’m not starving in the lunch line. Humming aloud in line to mask [my] stomach growling and the teacher saying, ‘Shh! Be quiet.”

Lack of knowledge about adequate and appropriate resources available for help can prolong a person’s adversity. After sharing about being a victim of domestic violence, a professional counselor suggested to one of the participants to go and speak with an attorney. She did and according to the individual, the attorney advised,

> “Let me tell you what’s going to happen.” He said, “Your kids are gonna lose their home. You’re going to be given $1,500 a month to live on. You’re going to live in God knows what kind of place and your kids are gonna hate you. So, I think you need to just go back home and suck it up.”

This individual remained in an abusive living situation with her children until additional resources for help were made available, demonstrating her ability to adapt and persevere in the midst of major life challenges.

Although spiritual and religious practices, such as a personal relationship with God, prayer, meditation, and church involvement, were named as protective factors accessed for support, church involvement specifically was mentioned by a few individuals as a source of pain. This was explained to be due to interactions with others at or associated with a religious institution. People often seek help from a faith-based community during a vulnerable time in life. When their experience makes them feel

judged or they feel imposed upon, such as not wanting to be hugged or like they have to fit a certain mold without freedom to come as they are, then there is potential for harm.

Barriers identified on the mesosystem level include community agencies, like law enforcement and the Department of Children's Services (DCS), that were involved in the child's environments but were reported to not have done what was within their means to change the problems that brought about the service. Stark realities of system barriers were shared during interviews, such as one participant stating that the police were no help because they knew her abuser. Another participant reported the harsh truth of her experience when stating,

> DCS was on a first name basis with my mom … and should've stepped in and taken us. They knew the history and didn't check on us enough. Each time a relative stepped forward, DCS would back off. My relatives didn't need to take care of us either. I had an uncle who was a sex offender, this wasn't known by the authorities, and said he'd take care of us only to satisfy DCS. My mother had a long history with the law and making poor decisions, but the truth is that DCS doesn't really want to be stuck with your kids. Yes, their primary goal is to keep families together and I think they try to do that, but they need to understand that they can't do that to a fault. People need second chances, but not when a child's life is at stake. Maybe there needs to be a probationary period of trust to be re-established and not just a temporary change. From the age of five to 17, I was subjected to abuse.

A different individual described that when DCS did remove a sibling in the home, there was no real help for what happened. The sibling was simply moved to live with someone else, but no additional assistance like counseling was provided and the abuser and the other children in the home remained. This same participant passionately discussed her thoughts during the interview stating,

> I've heard social workers say that they aren't there to take your children. And we pride ourselves on keeping the child with the family even if the family is the cruelest of all. This is twisted. Social workers should put a brick in their back and say, 'If it is necessary, we will take your children at the first sign of abuse, not after an investigation.' And they should be proud to say this.

Such a perspective brings forth concerns about whether the system can handle the burden of need to provide safe, stable, nurturing environments for the number of children who are placed in custody of the state.

On the macrosystem level, there were more barriers than sources of aid mentioned by participants. An additional barrier identified was a lack of reliable transportation resources at both the meso and macrosystem levels as this was reported to impact the ability to get basic living necessities as well as attend school and work, especially pertaining to rural areas where public transportation is not available. Other macrosystem level barriers mentioned were numerous and also include poverty, limited educational options, lack of accessible quality mental healthcare or limited number of sessions based on what was approved by insurance, and little to no public knowledge about community resources that may help with basic or complex needs. One participant described that even

when she went to family centers or to the health department for assistance and services, there was not any navigation to community resources or additional options for help provided. Another participant explained her experience stating,

> I have to take kids to court a lot and … juvenile [court authority] says, there's nothing we can do with them until they're 13. We don't have resources. And, I'm like, by the time they're 13, we're almost too far past the point of making a difference.

Frustration can result from a community's limited resources available to address needs before harm occurs. Despite these barriers being identified as hinderances, they did not prevent this research sample from experiencing resilience, further demonstrating that overcoming barriers builds resilience. Practice implications related to these barriers are discussed in Chapter 5.

A sixth theme discovered in my research was that, unfortunately, all participants of color reported experiencing or observing negative treatment and limited access to resources based on race or skin-tone. One Black participant described her experience of discrimination, stating she was the darkest in her family and was picked on by family and others because of this. She recalled as a very young child, "My mother would put me in a brown box outside to play in the sun and in the heat. And left me there. Just me." Then at school she reported sitting in the back of the class and was considered "stupid, a waste of time…I was picked on regularly. Told I wasn't clean enough. Light skinned meant that you get a job, people can trust you, and a dark child had a hard time. Darker meant harder." Also, she reports not having been taught Black History when growing up,

stating, “They didn’t teach us. I’m just now learning about Betsy Ross and other people. I didn’t know.” A different participant of color stated she “passed the paper bag test,” explaining that if your skin was the color of a paper bag or lighter, then you were favored over darker-skinned individuals. She remembered the moment when a friend of hers, who was darker, explained to her about this difference of treatment and she recalled the hurt on her friend’s face. Then she stated, “Because I passed the paper bag test, my journey hasn’t been as hard…. They [darker-skinned individuals] had to work harder.” A White woman participant who has a bi-racial son described her fear as a parent of a brown-skinned male. Not just the typical concern that a parent has for their child, but that “somebody might do something bad to him … because of the way he looks. It’s a different kind of fear.” Discrimination is one of several new items added to the list of expanded ACEs due to experiences of maltreatment solely due to a person’s skin color. These insights from participants indicate that what is formally and informally taught will determine how people perceive others who are different from their own skin color as well as how people are treated.

It is unjust for a person to be treated poorly because of their skin color. One participant stated that she believes people of color are suffering from depression and anxiety due to the treatment of others based on their skin-tone. She further stated, “It needs to be talked about, but people are uncomfortable with it.… It’s generation after generation of taught hate.” This could include hate among those of a different race and hate among those of the same race. Another participant described,

> It's such a rare thing that you notice when a Black mother is nurturing with her children versus being like really aggressive and sometimes even brutal…. And honestly, I think it goes back to slavery because if you think about [it], the majority of Black people in this country were brought here as slaves for generations, enslaved and brutalized. Violence…is so ingrained in our culture.

Overall concern for the state of our nation was expressed by a Black participant when she mentioned the Coronavirus pandemic, racial tensions and protests, and social determinants of health that raise heightened concerns for people of color in America. The lived experiences of discrimination among participants of color reveal barriers to resilience that can be prevented. Opportunities to address injustices and build resilience at various system levels will be further discussed in Chapter 5.

Making Sense of Adverse Childhood Experiences

Coming to terms with life circumstances and adversity is challenging. This was evident based on participant vulnerability, as they still struggle to make sense of their experiences. A White, senior adult female reported, "I think maybe people 100 percent can't get over that foundation, but I think sometimes it's still in there and…you just have to battle it again." The foundation mentioned here refers to the formative years of a person's life, during which she experienced heightened adversity.

A seventh and final theme discovered is related to how participants explained the conclusions they have reached about their ACEs. Participants reported that generational factors played a role in the occurrence and continuation of their ACEs. Generational factors were mentioned seven times by participants during the 12 interviews. The most

frequently occurring response when participants were asked how they now make sense of their ACEs, was related to their parents' circumstances (e.g., being raised in environments with high poverty, abuse, violence, mental illness, alcoholism, emotional and physical absence from family, and being young or lacking support when they became parents). As a result, their parents conducted family life based on what they knew from their experience. One participant explained that her father was a member of a gang, which was his way of meeting the needs for belonging and survival. Other participants shared explanations including that it just seemed normal for their ACEs to occur or what happens at home stays at home, the experiences were not talked about outside the home in a manner to get help, and eventually having to remove themselves from the circumstances that were perpetuated in the environment and out of their control.

Additional common responses when asked about making sense of their ACEs, was not deserving the treatment received, and acknowledging it is not their fault, but due to the choices of others. For example, a Black woman stated, "It's not about me. It was about them." Statements were also made by participants about how their faith and belief system helps them to reconcile what has happened to them. For instance, one participant described her beliefs about good and evil and how her faith gives her guidance to understand the differences between the two. A general conclusion shared by participants was the belief that bad things happen to good people. Although most participants stated that they have come to terms with their ACEs and offered explanations, generational factors that contributed to ACEs were a reoccurring theme discussed by participants.

Words of Wisdom

Participants were asked to share words of wisdom that they would give to their young self or young person facing adversity. The reason I decided to ask this question was to create a reflective opportunity for participants and to gain insight from their perspective about what would be encouraging for a young person to hear when experiencing similar adversities. Participants responded with uplifting statements about their significance as a person, how they are deserving of love, to embrace and use their gifts confidently, and to not give up. Quotes were shared about withstanding adversity and striving for success, along with scriptures offering hope, and a poem about persevering. Advice was given by participants including, “give yourself permission to be better” and “choose not to be what statistics say you should be.” One participant simplistically stated, “You don’t have to hate those who hurt you. You can be better and still love them.” Another participant added that it is good to recognize mistakes and when decisions cost us something, but not to beat themselves up, as “God can restore.” Other advice shared included, “Come to know God,” “be honest about how you feel,” “trust yourself,” “get to the right person to talk to…a counselor,” “get help,” and “find your purpose.” Considering the unimaginable hardships that these participants endured early in life, these words of wisdom offer hope to others and are reflective of their experiences of resilience.

Summary

To better understand the lived experiences of individuals with high ACEs and resilience, participants in the research study candidly shared deep insights during

qualitative interviews. My research reinforces the notion that resilient individuals have unique attributes and do not give up easily when facing challenges. These individuals openly shared about the supportive relationships and protective factors at various system levels that contribute to their resilience and identified ecological system-level barriers they recognize could be a hinderance to a person's resilience. Overarching themes from my research include (a) giving back, (b) faith and spirituality, (c) influence of strangers, (d) buffer within household, (e) system resources as barriers, (f) limited resource access for participants of color, and (g) generational factors.

This sample population demonstrates courageous mental, emotional, physical, and spiritual fortitude to withstand and overcome childhood adversity and survive life-threatening and traumatic experiences. Participants expressed internal and external reasons they continued to push forward through life's most challenging circumstances to include the value and love for their own child(ren), hope from God and others, and internal determination that something better lies ahead. Despite difficulty trusting others and the tendency to turn inward to protect oneself, these unique individuals continue to find the good in life, rely on their strong values, and aspire to help others along the way.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

In this qualitative research study, I explored the lived experiences of individuals in Tennessee with elevated ACEs and resilience. Strategic measures have been and continue to be taken to educate public and private sectors about ACEs and resilience in the state of Tennessee. My research provides those interested in addressing ACEs and resilience building with data directly from resilient individuals. Rich insight was learned from study participants about the protective factors that contributed to their resilience, as well as the adversities and system barriers experienced. The study findings revealed themes learned from the sample population including (a) giving back, (b) faith and spirituality, (c) influence of strangers, (d) buffer within household, (e) system resources as barriers, (f) limited resource access for participants of color, and (g) generational factors. I discuss information about how these themes relate to the literature, recommendations for future research, and implications for practice in this chapter.

Interpretation of Findings

The results of this study support the ecological systems theory (Bronfenbrenner, 1979) and resilience theory (Masten, 2016) as fundamental for understanding human development and human potential. Consistent with resilience theory, the data from this study demonstrated that resilience is a compilation of various personal traits and resources (Masten, 2016). Similar to research by Fang et al. (2012), my research further confirmed ACEs and their lasting effects contribute to physical, behavioral, mental, financial, legal, and social problems. Findings of this research confirm what Borge et al.

(2016) and Johnson and Wiechelt (2004) posited in that some individuals can overcome adversity and function well in life despite their traumatic experiences. In addition, my research echoes existing literature on the topic of resilience in demonstrating that an individual's capacity for resilience depends on many systems, not just a single character trait (Masten, 2016).

Internal and external protective factors associated with resilience were reported by participants. The sample population identified protective factors that became four of the seven themes discovered from this research. These include helping others in a meaningful way, personal faith and spiritual practices, encounters with strangers, and a positive support person living in the childhood household.

Helping others or giving back in a meaningful way may provide a form of coping with ACEs or a sense of purpose. Lietz (2011) discovered two primary reasons why resilient people may aspire to help others and these reasons include (a) altruistic behaviors to benefit others, to honor the memory of someone, to find meaning or purpose in their struggle, or for their own survival; and (b) empathy for others due to their own experiences. While researching an indigenous population, Moeller-Saxone et al. (2014) found that taking on a helping role as a village health worker had several positive outcomes, including improving individuals' sense of personal control and autonomy. My research demonstrated that study participants not only had strong qualities of adaptability, self-efficacy, optimism, and social support, but they were intrinsically motivated to help others and desired to make a positive difference.

Another theme found in my research was the extensive data about the importance of spirituality and personal faith beliefs as means to develop resilience, cope with adversity, and gain a sense of purpose and meaning. Shahina and Parveen (2020) found spirituality, different from participation in organized religion, to be a good predictor of resilience and mental health. Other researchers discovered that religious attendance contributed to resilient outcomes (Heard-Garris et al., 2018). Participants in my research described independent spiritual practices as well as organized group events to have contributed to their resilience. Therefore, faith-based resources are needed to encourage a person's spirituality and connectedness to God and others.

A protective factor that was not discussed in the recent literature on resilience, but that participants in this research study mentioned were encounters with strangers that contributed to their resilience. The work of Reeder (1998) was the only related literature found on the topic of stranger benevolence, and he argued that the concern of a stranger is typically generated from a moral and religious experience, viewing others as a creation of God, or from fairness and justice beliefs, viewing the stranger as a person deserving love to an equal extent as others. Perhaps strangers respond in generous ways for similar reasons that this population expressed they are motivated to help others and want to make a difference because they know what suffering is like from personal experience. Based on the data from my research, the kindness and empathy participants received from others was reported to be tangible assistance and influenced their experience of resilience.

While it is widely accepted that positive relationships and social supports can be protective factors that buffer trauma (Heard-Garris et al., 2018; Southwick et al., 2014),

several participants in this research study brought new information from their experiences of having a positive support person within the same household where ACEs occurred. Bellis, Hardcastle et al. (2017) explored whether a continuous trusted adult support in childhood imparted life-course resilience against ACEs and the findings indicated that support from an always available adult was found to improve mental well-being of the child. In my research, the supportive person identified was sometimes an adult or sibling in the home who acted as a buffer and influenced the resilience of others in the home. This further demonstrates that protective factors vary for every individual and can often occur where they are least expected.

Participants were not only impacted by protective factors, but also by barriers to receiving help. The remaining three themes discovered in my research are related to the barriers identified by participants from their lived experiences.

Professionals in the field of social science have known ACEs are a predictor of poor health outcomes related to both physical and mental health (Bellis, Hughes et al., 2017; Felitti, 2002). Experiences recorded in this study further support this claim, as multiple participants discussed diagnoses of cancer, obesity, anxiety, and depression. One of the system barriers identified by participants in this research was the lack of quality mental health services. Researchers Garcia et al. (2017) proposed that the current standard of care in mental health practices may not be adequately addressing the needs of those with ACEs. This was echoed during interviews with some participants who shared that the counseling they received was limited, unhelpful, or lacked trauma-informed approaches. Additionally, the sample population in my research study resided in rural

communities, where researchers Barnett et al. (2014) and McCall-Hosenfeld et al. (2014) suggested the need for increased mental healthcare access, based on an indicated shortage. Further, Bellis, Hughes et al. (2017) concluded that there is a correlation between the high demand for health services and high healthcare use among individuals with a high number of ACEs. Perhaps there may be improvement in physical health outcomes if mental health needs, particularly those related to trauma and ACEs, are adequately addressed in a timely fashion and with quality.

My research with individuals with high ACEs and resilience further supported the notion that experiences of discrimination and poverty should be considered ACEs and traditional ACE surveys and research instruments should be expanded to include these topics. Discrimination was discussed by each participant of color and poverty was frequently mentioned by all ages and ethnic backgrounds. Anderson et al. (2020) discovered that children who experienced racial discrimination were more likely to suffer with anxiety and depression as well as to report poorer overall health. It is important to note that negative health associations vary among racial, ethnic, or socioeconomic groups (Anderson et al., 2020); however, Whites are more likely to receive mental health services compared to other groups (Garcia et al., 2017). Positive social change is necessary to address discrimination, poverty, and culturally competent mental health services.

Lastly, this research study reinforced the fact that ACEs can be perpetuated from one generation to the next and child maltreatment is a public health problem that must be addressed (Fang et al., 2012). More importantly, interventions should take an

intergenerational approach because behaviors and norms of functioning can be passed along, resulting in facilitative or obstructive child development (Masten, 2016). In my research, participants explained that their ACEs were directly influenced by their parents' and other family members' experiences of adversity or behaviors that were either considered acceptable or not something to be talked about if they did occur. This research aligns with the resolution of researchers Masten (2016) and Radcliff et al. (2018) that multi-generational approaches are necessary to address the ACEs crisis.

Strengths and Limitations of the Study

I carried out this basic qualitative study, as designed, with a purposive sample, and captured the unique experiences of those who participated. The screening questionnaire proved helpful toward defining and narrowing the scope of the study, which was to understand the lived experiences of individuals with elevated ACEs and resilience. However, generalizability was not achievable due to the purposive sample and specifications of the study. This study was conducted with individuals residing in a primarily rural region of the state of Tennessee who were not necessarily representative of the larger population of TN individuals with high ACEs and resilience. Therefore, caution should be taken not to overgeneralize the findings.

The use of Zoom and phone interviews made interviewing participants convenient, and participants had the choice to contribute in a format and location familiar to them, thus improving the level of safety and comfort. A benefit afforded by Zoom interviews was the ability for me to observe non-verbal communication. There was no way to make these types of observations when conducting phone interviews, during

which I solely relied on verbal communication and emotion conveyed through tone of voice, volume, and emphasis.

Although I took measures to try and address bias, aspects like participant perception of the researcher, emotions, and the researcher's personal experiences can influence the data collection, analysis, and interpretation. Because participants were asked to recount past experiences, some may have experienced feelings of discomfort or simply forgotten details related to ACEs and resilience that limited the data.

Recommendations

One of the strengths of my research is the specific population due to the purposive sample criteria. Replicating my study in other geographical areas would be interesting to explore how the lived experiences may be similar or different for another population. Future research with a more narrow sample population, such as a specific county or community, could provide helpful feedback on the existing services available within the community, reveal gaps in services requiring further development, and identify strengths and weaknesses of ACEs prevention and resilience building efforts within the community. The system barriers discovered in my research could be further examined through program evaluation at child protective service agencies, mental health facilities, schools, police departments, and faith-based organizations. Additional research could closely examine interactive patterns between the service provider and recipient, as well as any specific measures taken to prevent re-traumatization or increase support. Research comparing agencies that have specific trauma-informed guidelines and practices in place with those that do not strategically implement such practices could add knowledge about

the quality of service. Daugherty and Poudel (2017) researched the level of public awareness on ACEs in Tennessee and follow up research could be conducted to learn whether the awareness has grown in recent years. Since data from my study indicates that adversities such as discrimination and poverty are the lived experiences of some individuals, a more comprehensive assessment of ACEs and resilience could incorporate the expanded ACEs questionnaire to include community violence, perceived racism, poverty, homelessness, bullying, and other environmental stressors could bring valuable insight.

Implications

Large-scale initiatives on ACEs and resilience, like Building Strong Brains Tennessee, use common terminology that helps to change interactions. An example of changing the language in response to people facing life challenges and adversities is to ask the questions "How can I help?" or "What's happened to you?" rather than, "What's wrong with you?" (Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration, 2019). Positive changes in everyday language and interactions with others can create a cultural shift of societal and generational norms surrounding ACEs. Abuse, neglect, and other forms of preventable adversity should no longer be acceptable or excused in ways participants in my study reported to be common beliefs when they were growing up, such as "It's just the way it is", "What goes on at home, stays at home", or "Don't talk about it." I propose that a new framework shift include statements like, "Generational abuse can stop with you and me", "Every person needs safe, stable, and nurturing environments," and "It is okay to seek help." For such a

change to occur, trauma-informed training and education efforts must begin or continue at various system levels, including among professionals in institutions like schools, churches, law enforcement agencies, child protective service agencies, and mental health facilities, where participants in this research study report to have encountered barriers to receiving appropriate help.

ACEs deserve prevention and intervention efforts by professionals, organizations, and community leaders. One option for ACEs prevention and intervention is through high caliber mentoring programs in which volunteers are properly screened and given oversight to be a positive support person for children and adolescents who may not have this type of role within their household or other environments. To prevent and address ACEs that may be inter-generational, educational information on the prevention of ACEs and resource options could be presented to parents, grandparents, and other caregivers at critical time periods and settings according to stages of child development, such as during pre-natal, pediatric, and other medical visits; school orientations or special events; faith-based services; and organized sports. Furthermore, increasing access to resources in minority communities along with implementation of policies and practices that prohibit forms of discrimination, including racial discrimination and injustices, demonstrate the importance of fair and just treatment of all people. To improve Also, funding sources should be explored, perhaps through grants, for advertising through various media formats so there is wide-spread knowledge of local resource agencies and hotlines for services to benefit those whom they are intended to help. If executed well, strategic

measures like these could maximize protective factors for individuals, families, and the community.

Another way to mitigate ACEs and foster resilience supported by findings in my research is to implement a holistic and integrative approach to healthcare, in which aspects of physical, mental or behavioral, and spiritual wellness are addressed during routine medical check-ups by a multi-disciplinary team of professionals. Integration of services will provide the type of comprehensive care Larkin et al. (2014) proposed, where medical ACEs research and social science research inform policies that support individuals and families. With an integrative approach, adversities and risk factors can be appropriately identified and addressed with the resources of a multi-disciplinary team. This type of healthcare service could promote healthy coping and protective factors like those mentioned by participants in my study, as well as connect individuals and families to supportive resources like high quality, trauma informed therapy which was identified in my research as a need.

While many factors contribute to childhood adversity, ACEs also occur beyond the household and family unit, revealing the need to continue research and the application of knowledge on expanded ACEs, evidence-based and trauma-informed programs, and multi-system level awareness of ACEs and resilience. As these types of efforts are applied and successful, resilience can grow at the micro, meso, exo, macro, and chrono-system levels and ultimately bring about positive social change.

Conclusion

I explored the lived experiences among individuals living in Tennessee with elevated ACEs and resilience. My research aimed to reduce the gap in the literature on the phenomenon of resilience in relation to ACEs. Participants offered valuable insights about what contributed to their experiences of adversity and resilience. Also, my study provides unique insights not seen in previous literature. Based on qualitative thematic analysis, key findings were discovered related to the protective factors that contributed to participant resilience and barriers to receiving help to address ACEs. Consequently, there is a need for trauma-informed services across systems including education, mental health, faith-based, law enforcement, and social services. The results from my study support other literature conclusions that timely interventions to prevent and intervene with ACEs, as well as efforts to cultivate resilience through protective factors are necessary.

References

Anda, R. F., Brown, D. W., Felitti, V. J., Bremner, J. D., Dube, S. R., & Giles, W. H. (2007). Early Adverse Experiences Questionnaire [Database record]. PsycTESTS. https://doi.org/10.1037/t09620-000

Anderson, A. T., Luartz, L., Heard-Garris, N., Widaman, K., & Chung, P. J. (2020). The detrimental influence of racial discrimination on child health in the United States, *Journal of the National Medical Association, 112*(4), 411-422. https://doi.org/10.1016/j.jnma.2020.04.012

Baker, S., & Edwards, R. (2012). *How many qualitative interviews is enough?: Expert voices and early career reflections on sampling and cases in qualitative research.* National Centre for Research Methods website: http://eprints.ncrm.ac.uk/2273/4/how_many_interviews.pdf

Barnett, E. R., Rosenberg, H. J., Rosenberg, S. D., Osofsky, J. D., & Wolford, G. L. (2014). Innovations in practice: Dissemination and implementation of child-parent psychotherapy in rural public health agencies. *Child and Adolescent Mental Health, 19*(3), 215-218. https://doi.org/10.1111camh.12041

Barth, R. P., Scarborough, A., Lloyd, J., Casanueva, C., & Mann, T. (2008). *Developmental status and early intervention service needs of maltreated children.* U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

Bellis, M. A., Hardcastle, K., Ford, K., Hughes, K., Ashton, K., Quigg, Z., & Butler, N. (2017). Does continuous trusted adult support in childhood impart life-course

resilience against adverse childhood experiences - a retrospective study on adult health-harming behaviours and mental well-being. *BMC Psychiatry 17*(1), 110. https://doi.org/10.1186/s12888-017-1260-z

Bellis, M., Hughes, K., Hardcastle, K., Ashton, K., Ford, K., Quigg, Z., & Davies, A. (2017). The impact of adverse childhood experiences on health service use across the life course using a retrospective cohort study. *Journal of Health Services Research & Policy, 22*(3), 168-177. https://doi.org/10.1177/1355819617706720

Bethell, C. D., Carle, A., Hudziak, J., Gombojav, N., Powers, K., Wade, R., & Braveman, P. (2017). Methods to assess adverse childhood experiences of children and families: Toward approaches to promote child well-being in policy and practice. *Academic Pediatrics, 17*(7S), S51-S69. https://doi.org/10.1016/j.acap.2017.04.161

Beutel, M. E., Tibubos, A. N., Klein, E. M., Schmutzer, G., Reiner, I., Kocalevent, R., & Brahler, E. (2017). Childhood adversities and distress: The role of resilience in a representative sample. *PLoS ONE, 12*(3), 1-14. https://doi.org/10.1371/journal.pone.0173826

Borge, A. I. H., Motti-Stefanidi, F., & Masten, A. S. (2016). Resilience in developing systems: The promise of integrated approaches for understanding and facilitating positive adaptation to adversity in individuals and their families. *European Journal of Developmental Psychology, 13*(3), 293-296. https://doi.org/10.1080/17405629.2016.1188496

Braveman, P., & Gottlieb, L. (2014). The social determinants of health: It's time to

consider the causes of the causes. *Public Health Reports, 129*(1), 19-31. https://doi.org/10.1177/00333549141291s206

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.

Bruner, C. (2017). ACE, place, race, and poverty: Building hope for children. *Academic Pediatrics, 17*(7s), s123-129. https://doi.org/10.1016/j.acap.2017.05.009

Burke, N. J., Hellman, J. L., Scott, B. G., Weems, C. F., & Carrion, V. G. (2011). The impact of adverse childhood experiences on an urban pediatric population. *Child Abuse & Neglect, 35*(6), 408-413. https://doi.org/10.1016/j.chiabu.2011.02.006

Campbell-Sills, L., & Stein, M. B. (2007). Psychometric analysis and refinement of the Connor-Davidson Resilience Scale (CD-RISC): Validation of a 10-item measure of resilience. *Journal of Traumatic Stress, 20*(6), 1019-1028. https://doi.org/10.1002/jts.20271

Centers for Disease Control and Prevention. (2016). *The ACE study survey data.* https://www.cdc.gov/violenceprevention/acestudy/about.html

Centers for Disease Control and Prevention (2020). *Coronavirus disease 2019 (COVID-19).* https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html

Cheng, T. L., & Solomon, B. S. (2014). Translating life course theory to clinical practice to address health disparities. *Maternal Child Health Journal, 18*(2), 389-395. https://doi.org/10.1007/s10995-013-1279-9

Cluver, L., Orkin, M., Boyes, M. E., & Sherr, L. (2015). Child and adolescent suicide

attempts, suicidal behavior, and adverse childhood experiences in South Africa: A prospective study. *Journal of Adolescent Health, 57*(1), 52-59. https://doi.org/10.1016/j.jadohealth.2015.03.001

Constantinou, C. S., Georgiou, M., & Perdikogianni, M. (2017). A comparative method for themes saturation (CoMeTS) in qualitative interviews. *Qualitative Research, 17*(5), 571-588.

Cope, D. G. (2014). Methods and meanings: Credibility and trustworthiness of qualitative research. *Oncology Nursing Forum, 41*(1), 89-91. https://doi.org/10.1188/14.onf.89-91

Cortina, M. A., Stein, A., Kahn, K., Hlungwani, T. M., Holmes, E. A., & Fazel, M. (2016). Cognitive styles and psychological functioning in rural South African school students: Understanding influences for risk and resilience in the face of chronic adversity. *Journal of Adolescence, 49*, 38-46. https://doi.org/10.1016/j.adolescence.2016.01.010

Cross, W. E. (2017). Ecological factors in human development. *Child Development, 88*(3), 767-769. https://doi.org/10.1111/cdev.12784

Daugherty, L. M., & Poudel, P. G. (2017). *Public opinion in Tennessee about adverse childhood experiences (ACEs).* University of Tennessee-Knoxville, Social Work Office of Research & Public Service. https://www.tn.gov/content/dam/tn/dcs/documents/health/aces/Public-Opinion-Report-ACES.pdf

Davis, T. S., Guada, J., Reno, R., Peck, A., Evans, S., Moskow-Sigal, L., & Swenson, S.

(2015). Integrated and culturally relevant care: A model to prepare social workers for primary care behavioral health practice. *Social Work in Health Care, 54*(10), 909-938. https://doi.org/10.1080/00981389.2015.1062456

Denzin, N. K., & Lincoln, Y. S. (2018). *The Sage handbook of qualitative research* (5th ed.). Sage.

DeSimone, J. A., Harms, P. D., Vanhove, A. J., & Herian, M. N. (2017). Five-by-five resilience scale [Database record]. PsycTESTS. https://doi.org/10.1177/1073191115625803

Dong, M., Anda, R. F., Dube, S. R., Giles, W. H., & Felitti, V. J. (2003). The relationship of exposure to childhood sexual abuse to other forms of abuse, neglect, and household dysfunction during childhood. *Child Abuse & Neglect, 27*(6), 625-639. https://doi.org/10.1016/s0145-2134(03)00105-4

Dong, M., Anda, R. F., Felitti, V. J., Dube, S. R., Williamson, D. F., Thompson, T. J., Loo, C. M., & Giles, W. H. (2004). The interrelatedness of multiple forms of childhood abuse, neglect, and household dysfunction. *Child Abuse & Neglect, 28*(7), 771-784. https://doi.org/10.1016/j.chiabu.2004.01.008

Edwards, T., Catling, J. C., & Parry, E. (2016). Identifying predictors of resilience in students. *Psychology Teaching Review*, *22*(1), 26-34.

Fang, X., Brown, D. S., Florence, C. S., & Mercy, J. A. (2012). The economic burden of child maltreatment in the United States and implications for prevention. *Child Abuse & Neglect, 36*(2), 156-165. https://doi.org/10.1016/j.chiabu.2011.10.006

Felitti, V. J. (2002). The relation between adverse childhood experiences and adult

health: Turning gold into lead. *Permanente Journal, 6*(1), 44-47. https://doi.org/10.13109/zptm.2002.48.4.359

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998a). Adverse childhood experiences study questionnaire [Database record]. PsycTESTS. https://doi.org/10.1037/t26957-000

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998b). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245-258. https://doi.org/10.1016/s0749-3797(98)00017-8

Finkelhor, D., Shattuck, A., Turner, H., & Hamby, S. (2013). Improving the adverse childhood experiences study scale. *Journal of American Medical Association Pediatrics, 167*(1), 70-75. https://doi.org/10.1001/jamapediatrics.2013.420

Finkelhor, D., Shattuck, A., Turner, H., & Hamby, S. (2015). A revised inventory of adverse childhood experiences. *Child Abuse & Neglect, 48*, 13-21. https://doi.org/10.1016/j.chiabu.2015.07.011

Finkelhor, D., Turner, H., Hamby, S., & Ormrod, R. (2011). Polyvictimization: Children's exposure to multiple types of violence, crime, and abuse. *Juvenile Justice Bulletin*, 1-11.

Fuller-Thomson, E., & Sawyer, J. L. (2012). Is the cluster risk model of parental adversities better than the cumulative risk model as an indicator of childhood physical abuse?: Findings from two representative community surveys. *Child:*

Care, Health, and Development, 40(1), 124-133. https://doi.org/10.1111/cch.12024

Fusarelli, L. D. (2015). Child welfare, education, inequality, and social policy in comparative perspective. *Peabody Journal of Education, 90*(5), 677-690. https://doi.org/10.1080/1061956x.2015.1087779

Garcia, A. R., Gupta, M., Greeson, K. P., Thompson, A., & DeNard, C. (2017). Adverse childhood experiences among youth reported to child welfare: Results from the national survey of child & adolescent wellbeing. *Child Abuse & Neglect, 70*, 292-302. https://doi.org/10.1016/j.chiabu.2017.06.019

Gelkopf, M., Berger, R., Bleich, A., & Silver, R. C. (2012). Protective factors and predictors of vulnerability to chronic stress: A comparative study of 4 communities after 7 years of continuous rocket fire. *Social Science & Medicine, 74*(5), 757-766. https://doi.org/10.1016/j.socscimed.2011.10.022

Glaser, J., & Laudel, G. (2013). Life with and without coding: Two methods for early-stage data analysis in qualitative research aiming at causal explanations. *Forum: Qualitative Social Research, 14*(2), 1-37.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18*(1), 59-82. https://doi.org/10.1177/1525822x05279903

Halcomb, E. J., & Davidson, P. M. (2006). Is verbatim transcription of interview data always necessary? *Applied Nursing Research, 19*(1), 38-42.

Halfon, N., Larson, K., Lu, M., Tullis, E., & Russ, S. (2014). Lifecourse health

development: Past, present, and future. *Maternal Child Health Journal, 18*(2), 344-365. https://doi.org/10.1007/s10995-013-1346-2

Handley, T. E., Kelly, B. J., Lewin, T. J., Colman, C., Stain, H. J., Weaver, N., & Inder, K. J. (2015). Long-term effects of lifetime trauma exposure in a rural community sample. *BMC Public Health, 15*(1), 1176-1183. https://doi.org/10.1186/s12889-015-2490-y

Harper-Browne, C. (2014). *The strengthening families approach and protective factors framework: Branching out and reaching deeper*. Center for the Study of Social Policy.

Heard-Garris, N., Davis, M. M., Szilagyi, M., & Kan, K. (2018). Childhood adversity and parent perceptions of child resilience. *BMC Pediatrics, 18*(1), 204-213. https://doi.org/10.1186/s12887-018-1170-3

Herrod, H. G. (2007). Do first years really last a lifetime? *Clinical Pediatrics, 46*(3), 199-205. https://doi.org/10.1177/0009922806297303

Howard, S., Dryden, J., & Johnson, B. (1999). Childhood resilience: Review and critique of literature. *Oxford Review of Education, 25*(3), 307-323. https://doi.org/10.1080/030549899104008

Iniguez, K. C., & Stankowski, R. V. (2016). Adverse childhood experiences and health in adulthood in a rural population-based sample. *Clinical Medicine & Research, 14*(3-4), 126-137. https://doi.org/10.10.3121/cmr.2016.1306

Jaffee, S. R., Bowes, L., Ouellet-Morin, I., Fisher, H. L., Moffitt, T. E., Merrick, M. T., & Arseneault, L. (2013). Safe, stable nurturing relationships break the

intergenerational cycle of abuse: A prospective nationally representative cohort of children in the United Kingdom. *Journal of Adolescent Health, 53*, s4-s10. https://doi.org/10.1016./j.jadohealth.2013.04.007

James, N., & Busher, H. (2007). Ethical issues in online educational research: Protecting privacy, establishing authenticity in email interviewing. *International Journal of Research & Method in Education, 30*(1), 101-113. https://doi.org/10.1080/17437270701207868

Johnson, J. L., & Wiechelt, S. A. (2004). Introduction to the special issue on resilience. *Substance Use & Misuse, 39*(5), 657-670.

Joseph, S., & Linley, P. A. (2005). Positive adjustment to threatening events: An organismic valuing theory of growth through adversity. *Review of General Psychology, 9*(3), 262-280. https://doi.org/10.1037/1089-2680.9.3.262

Joseph, S., & Linley, P. A. (2006). Growth following adversity: Theoretical perspectives and implications for clinical practice. *Clinical Psychology Review, 26*, 1041-1053. https://doi.org/10.1016/j.cpr.2005.12.006

Larkin, H., Felitti, V. J., & Anda, R. F. (2014). Social work and adverse childhood experiences research: Implications for practice and health policy. *Social Work in Public Health, 29*(1), 1-16. https://doi.org/10.1080/19371918.2011.619433

Lietz, C. A. (2011). Empathic action and family resilience: A narrative examination of the benefits of helping others, *Journal of Social Service Research, 37*(3), 254-265. https://doi.org/10.1080/01488376.2011.564035

Logan-Greene, P., Green, S., Nurius, P. S., & Longhi, D. (2014). Distinct contributions of

adverse childhood experiences and resilience resources: A cohort analysis of adult physical and mental health. *Social Work in Health Care, 53*, 776-797. https://doi.org/10.1080/00981389.2014.944251

Lowe, A., Norris, A. C., Farris, A. J., & Babbage, D. R. (2018). Quantifying thematic saturation in qualitative data analysis. *Field Methods, 30*(3), 191-207. https://doi.org/10.1177/1525822x17749386

Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Forum: Qualitative Social Research, 11*(3), article 8.

Masten, A. S. (1994). Resilience in individual development. Successful adaptation despite risk and adversity. In Wang, M. C., Gordon, E. W., (Eds.), *Educational resilience in inner-city America: Challenges and prospects* (pp. 3-25). Erlbaum.

Masten, A. S. (2016). Resilience in developing systems: The promise of integrated approaches. *European Journal of Developmental Psychology, 13*(3), 297-312. https://doi.org/10.1080/17405629.2016.1147344

McCall-Hosenfeld, J. S., Mukherjee, S., & Lehman, E. B. (2014). The prevalence and correlates of lifetime psychiatric disorders and trauma exposures in urban and rural settings: Results from the National Comorbidity Survey Replication (NCS-R). *PLOS ONE, 9*(11), 1-11. https://doi.org/10.1371/journal.pone.0112416

Melton, C. (2019). *The economic cost of ACEs in Tennessee*. https://www.sycamoreinstitutetn.org/2019/02/01/economic-cost-adverse-childhood-experiences/

Merriam, S. B., & Tisdale, E. J. (2016). *Qualitative research: A guide to design and*

implementation. John Wiley & Sons.

Merrick, M. T., Ford, D. C., & Ports, K. A. (2018). Prevalence of adverse childhood experiences from the 2011-2014 Behavioral Risk Factor Surveillance System in 23 states. *JAMA Pediatrics, 172*(11), 1038-1044. https://doi.org/10.1001/jamapediatrics.2018.2537

Mersky, J. P., Topitzes, J., & Reynolds, A. J. (2013). Impacts of adverse childhood experiences on health, mental health, and substance use in early adulthood: A cohort study of an urban, minority sample in the U. S. *Child Abuse & Neglect, 37*(11), 917-925. https://doi.org/10.1016/j.chiabu.2013.07.011

Moeller-Saxone, K., Davis, E., Stewart, D. E., Diaz-Granados, N., & Herrman, H. (2014). Promoting resilience in adults with experience of intimate partner violence or child maltreatment: A narrative synthesis of evidence across settings. *Journal of Public Health, 37*(1), 125-137. https://doi.org/10.1093/pubmed/fdu030

Narayan, A. J., Rivera, L. M., Bernstein, R. E., Harris, W. W., & Lieberman, A. F. (2018). Positive childhood experiences predict less psychopathology and stress in pregnant women with childhood adversity: A pilot study of the benevolent childhood experiences (BCEs) scale. *Child Abuse & Neglect, 78*, 19-30. https://doi.org/10.1016/j.chiabu.2017.09.022

National Association of Social Workers. (2017). NASW code of ethics. https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

National Scientific Council on the Developing Child. (2005/2014). *Excessive stress*

disrupts the architecture of the developing brain [Working paper No. 3, Updated Edition, Center on the Developing Child at Harvard University]. https://developingchild.harvard.edu/resources/wp3/

Neville, S., Adams, J., & Cook, C. (2016). Using internet-based approaches to collect qualitative data from vulnerable groups: Reflections from the field. *Contemporary Nurse*, *52*(6), 657-668. https://doi.org/10.1080/10376178.2015.1095056

Padgett, D. K. (2016). *Qualitative methods in social work research* (3rd ed.). Sage.

Patton, M. Q. (2015). *Qualitative research and evaluation methods: Integrating theory and practice* (4th ed.). Sage.

Peek-Asa, C., Wallis, A., Harland, K., Beyer, K., Dickey, P., & Saftlas, A. (2011). Rural disparity in domestic violence prevalence and access to resources. *Journal of Women's Health, 20*(11), 1743-1749. https://doi.org/10.1089/jwh.2011.2891

Perry, B. D., & Hambrick, E. P. (2008). *The neurosequential model of therapeutics*. www.scribd.com/doc/15622954/Introduction-to-the-Neurosequential-Model-of-Therapeutics

Polaschek, D. (2017). Protective factors, correctional treatment and desistance. *Aggression and Violent Behavior*, *32*, 64-70. https://doi.org/10.1016/javb.2016.12.005

Prasad, P. (2015). *Crafting qualitative research: Working in the postpositivist traditions*. Routledge.

Radcliff, E., Crouch, E., & Strompolis, M. (2018). Rural-urban differences in exposure to adverse childhood experiences among South Carolina adults. *Rural and Remote*

Health, 18(1), 1-14. https://doi.org/10.22605/RRH4434

Ramiro, L. S., Madrid, B. J., & Brown, D. W. (2010). Adverse childhood experiences (ACE) and health-risk behaviors among adults in a developing country setting. *Child Abuse & Neglect, 34*(11), 842-855. https://doi.org/10.1016/j.chiabu.2010.02.012

Ravitch, S. M., & Carl, N. M. (2016). *Qualitative research: Bridging the conceptual, theoretical, and methodological*. Sage.

Reeder, J. P. (1998). Extensive benevolence. *Journal of Religious Ethics, 26*(1), 47-70.

Research and Evaluation Group at PHMC. (2014). *Adverse childhood experiences in Shelby County, Tennessee*. www.aceawareness.org/wp-content/uploads/2016/03/ShelbyCountyACEReport_12=22-14.pdf

Rubin, H. J., & Rubin, I. S. (2012). *Qualitative interviewing: The art of hearing data* (3rd ed.). Sage.

Rudestam, K. E., & Newton, R. R. (2015). *Surviving your dissertation: A comprehensive guide to content and process* (4th ed.). Sage.

Sabina, C., & Banyard, V. (2015). Moving toward well-being: The role of protective factors in violence research. *Psychology of Violence, 5*(4), 337-342. https://doi.org/10.1037/a0039686

Sacks, V., Murphey, D., & Moore, K. (2014). Child Trends. *Adverse childhood experiences: National and state-level prevalence.* http://www.childtrends.org

Saldana, J. (2016). The *coding manual for qualitative researchers* (3rd ed.). Sage.

Salinas-Miranda, A. A., Salem, J. L., King, L. M., Baldwin, J. A., Berry, E. L., Austin, D.

A., Scarborough, K., Spooner, K. K., Zoorob, R. J., & Salihu, H. M. (2015). Adverse childhood experiences and health-related quality of life in adulthood: Revelations from a community needs assessment. *Health and Quality of Life Outcomes*, *13*(1), 1-12. https://doi.org/10.1186/s12955-015-0323-4

Schofield, T. J., Lee, R. D., & Merrick, M. T. (2013). Safe, stable, nurturing relationships as a moderator of intergenerational continuity of child maltreatment: A meta-analysis. *Journal of Adolescent Health*, *53*, s32-s38. https://doi.org/10.1016/j.jadohealth.2013.05.004" https://doi.org/10.1016/j.jadohealth.2013.05.004

Shahina, G. & Parveen, A. (2020). Role of spirituality in building up resilience and mental health among adolescents. *Indian Journal of Positive Psychology*, *11*(4). 392-397.

Skinner, M. L., Haggerty, K. P., Fleming, C. B., & Catalano, R. F. (2009). Predicting functional resilience among young-adult children of opiate-dependent parents. *Journal of Adolescent Health, 44*(3), 283-290. https://doi.org/10.1016/j.jadohealth.2008.07.020

Smith, B. W. Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The brief resilience scale: Assessing the ability to bounce back. *International Journal of Behavioral Medicine, 15*(3), 194-200. https://doi.org/10.1080/10705500802222972

Smith, L. H., & Holloman, C. (2011). Comparing child health, access to care, and utilization of health services between Ohio Appalachia's river and non-river

bordering counties. *Journal of Community Health, 36* (5), 819-830. https://doi.org/10.1007/s10900-011-9380-8

Southwick, S. M., Bonanno, G. A., Masten, A. S., Panter-Brick, C., & Yehuda, R. (2014). Resilience definitions, theory, and challenges: Interdisciplinary perspectives. *European Journal of Psychotraumatology, 5*(1), 1-14. https://doi.org/10.3402/ejpt.v5.25338

Sprang, G., Staton-Tindall, M., Gustman, B., Reer, B., Clark, J. J., Dye, H., & Sprang, K. (2013). The impact of trauma exposure on parenting stress in rural America. *Journal of Child & Adolescent Trauma, 6*(4), 287-300. https://doi.org/10.1080/19361521.2013.836585

Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration Center for Integrated Health Solutions. (2019). *Trauma*. https://www.integration.samhsa.gov/clinical-practice/trauma-informed

Tennessee Department of Children's Services (2018). *Tennessee-ACEs*. https://www.tn.gov/dcs/program-areas/child-health/aces.html

Tennessee Commission on Children and Youth. (2020). *Building Strong Brains Tennessee Quarterly Report Data* [PowerPoint Slides]. https://www.tn.gov/tccy/programs0/tccy-aces/tccy-ace-building-strong-brains.html

U. S. Census Bureau. (2017). *Quick facts*. https://www.census.gov/quickfacts/fact

U. S. Census Bureau. (2019). *Quick facts*. https://www.census.gov/quickfacts/fact

Vickers, M. C. & Wells, N. (2017). Nothing about us without us. *Academic Pediatrics,*

17, S20-S21.

Wade, R., Cronholm, P. F., Fein, J. A., Forke, C. M., Davis, M. B., Harkins-Schwarz, M., Pachter, L. M., & Bair-Merritt, M. H. (2016). Household and community level adverse childhood experiences and adult health outcomes in a diverse urban population. *Child Abuse & Neglect, 52*, 135-145. https://doi.org/10.1016/j.chiabu.2015.11.021

Wade, R., Shea, J. A., Rubin, D., & Wood, J. (2014). Adverse childhood experiences of low-income urban youth. *Pediatrics, 134*(1), e13-e20. https://doi.org/10.1542/peds.2013.2475

Watling-Neal, J., & Neal, Z. P. (2013). Nested or networked? Future directions for ecological systems theory. *Social Development, 22*(4), 722-737. https://doi.org/10.1111/sode.12018

Werner, E. E. (1989). High-risk children in young adulthood: A longitudinal study from birth to 32 Years. *American Journal of Orthopsychiatry, 59*(1), 72-81. https://doi.org/10.1111/j.1939-0025.1989.tb01636.x

Werner, E. E., & Smith, R. S. (2001). *Journeys from childhood to midlife: Risk, resilience, and recovery*. Cornell University Press.

World Health Organization. (n.d.). Adverse childhood experiences international questionnaire (ACE-IQ). www.who.int/violence_injury_prevention/violence/activities/adverse_childhood_experiences/questionnaire.pdf?ua=1

WTCE. (2018). Adverse childhood experiences: A public health issue - Building Strong

Brains Tennessee [Video series]. https://video.wcte.tv/show/adverse-childhood-experiences-public-health-issue-building-strong-brains-tennessee/

Appendix: Interview Protocol

About this Research

"Hello. Thank you for volunteering to participate in this research study. I would like to review and share some information with you before we begin the interview portion. The purpose of this study is to explore the lived experiences of resilience among individuals with elevated ACE and resilience scores. You were selected as a participant because you completed a screening tool and meet the criteria for the study.

For privacy and safety reasons, as well as in the case of an emergency, may you please share information on your current physical location? Thank you. I want to let you know that I will be taking some notes during the interview about what is shared to help me recall the information and focus on certain aspects that I learn from you. After my analysis process, I will provide you with information on the themes discovered from your shared information to make sure my conclusions are accurate. I will be using a script to guide the interview so that I don't leave out any important information or questions. Do you have any questions so far?

Okay, now I would like to share a little bit about myself and my research. I am a Licensed Clinical Social Worker from Jackson, Tennessee and have had the privilege of working with others through counseling in schools and mental health agencies for over 15 years. My research focus is on the topic of resilience. The topic of resilience interests me because of what I have experienced in my own life and have witnessed in others with whom I work and know personally. Resilience has been defined as "successful adaptation to disturbances" (Masten, 2016, p. 298), the ability to bounce back or rebound from

significant difficulties (Heard-Garris et al., 2018), or “a process to harness resources to sustain well-being” (Southwick et al., 2014, p. 4).

The broad goal of my research study is to better understand others’ experiences of resilience and the resources that influence a person’s resilience. Your responses in this interview about your experiences will provide a deeper understanding about resilience from your perspective, having endured several adversities in your life. As you respond to the following questions, I would like for you to consider both the adversities and strengths of your experiences. Are you ready to begin?

The first set of questions are related to resilience, or the ability to adapt, maintain healthy functioning after a highly adverse event or events, or harness resources to sustain well-being.

1. What does resilience mean to you?
2. What aspects of your personality or individual-self have contributed the most to your experience of resilience?
3. What aspects outside of yourself have contributed the most to your experience of resilience?
4. How do you cope when feeling stressed?
5. When you had every reason to give up, why didn’t you?
6. What are the goals you have for your future?
7. Please share 1-3 words or phrases that come to mind when you think of your resilience story.

The next set of questions have to do with resources during childhood and adulthood that you may or may not have had.

8. What resources did you utilize in childhood to cope with or address the adversities you experienced? What made these resources easily available and accessible, or not?
9. What resources have you used in adulthood to cope with or address the adversities you experienced? What made these resources easily available and accessible, or not?
10. What do you wish you had access to for help?

The final set of questions are related to what are called adverse childhood experiences or ACEs. You may recall that you previously answered some questions about ACEs in the screening tool. I am not going to ask you about your specific ACEs. However, I do want to read the list of ACEs aloud to you simply to inform you of what types of experiences are being referred to. Adverse childhood experiences have been researched in recent decades and include physical abuse and neglect, emotional abuse and neglect, sexual abuse, domestic violence, substance abuse in the home, mental illness of a parent, separation or divorce of parents, incarceration of a parent, discrimination, poverty, and community violence.

11. How do you make sense of your adverse childhood experiences?
12. How might the ACEs you experienced still effect you to some degree? (in your relationships, emotionally, mentally, physically/health, sexually, etc.)

13. What words of wisdom would you say to your young self or a young person facing adversity?
14. Is there any additional information you would like to share?

This will conclude the interview. I will now stop the recording. Next, I'd like to take some time to debrief. How do you feel after answering the interview questions? Was there any information discussed that brought discomfort or a safety concern? Are you seeing anyone for help about the information shared? If so, I would like to encourage you to reach out to this person for any needed assistance. Do you wish to receive a referral for additional support at this time?

Since we have discussed sensitive information, I would like to offer you contact information for services that may be of interest in case you find yourself experiencing any concerning thoughts in the days and weeks to come. This is simply a step toward self-care and I encourage all participants to utilize appropriate services if such a need were to occur. May I provide this contact information to you verbally, by email, or by text message at the end of the interview?

Also, I want to share with you my contact information so that you may contact me in the future with any questions or comments. I will be transcribing and analyzing what you have shared within the next week or so and then I will contact you again to review the concluded themes from your responses to verify that your information was interpreted accurately.

Lastly, I'd like to send you a gift card in appreciation for your time and participation." Researcher will confirm the email address and phone number on file. "It

has been an honor to hear your perspectives. Thank you for your contribution to my research.”