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# Resilience and Healthy Adult Relationships Post-Childhood Maltreatment

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Walden University
2019

# Abstract

Resilience and Healthy Adult Relationships Post-Childhood Maltreatment

by

Nicole Sharie Jackson

Master of Science Forensic Psychology, Walden University

Bachelor of Science Business Management Organization Innovation, Phoenix University

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

June 2019

**Abstract**

The purpose of this study was to understand the role of resilience and protective factors (PFs) in the life of women who have experienced childhood maltreatment (CHM). A further purpose was to understand how women who faced CHM develop resilience, and how the proper use or misuse of PFs later affected their adult relationships, whether intimate, social, or familial. Resiliency theory was the theoretical foundation that informed the study. A qualitative methodology with an interpretative phenomenological analysis design was used in this study. Participants included 7 women who were recruited through social media support groups for adult survivors of child abuse. Participants were interviewed via telephone and Skype. Data from these interviews were analyzed and coded according to the interpretative, phenomenological method. Five main themes emerged, providing awareness as to the development of resilience and PFs as well as the role of resilience and the impact PFs have on relationships survivors entered as adults. The themes included: trauma results in resilience and healing through helping others; time and interventions heal perception of abuse; guarding trust to avoid hurt as the effects of CHM lasts a lifetime; support is key then and now; and the effects of CHM and protective factors affect healthy adolescent and adult relationships. The findings were compared with existing literature to recommend ways therapeutic practitioners and social service workers can provide early interventions for those exposed to CHM and help them move past the starting point of unpacking the trauma to the ending of point of sustaining healthy adult relationships.

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Chapter 1: Introduction to the Study

**Introduction**

Childhood maltreatment (CHM) occurs when children are physically abused or neglected and includes those who have been exposed to domestic violence (Kidsdata, 2017). Children who are exposed to CHM experience physical and psychological trauma and are more likely than others to carry that trauma with them through adolescence and adulthood (Kidsdata, 2017). In 2014, there were an estimated 702,000 cases of CHM in the United States (Kidsdata, 2017).

Women who have experienced childhood abuse or maltreatment not only endure emotional suffering but experience discomfort on a psychological level, that acts as a roadblock to experiencing healthy and appropriate adulthood relationship (Riggs, Cusimano, & Benson, 2011). Additionally, those exposed to CHM have been known to have their emotional development stunted, causing their emotional development to remain at the age the adversity occurred (Orbke & Smith, 2013). Emotional stunting occurs when an individual fails to develop resilience, that in turn affects their ability to function in relationships (Orbke & Smith, 2013). However, women who have experienced CHM and develop a solid foundation of support tend to be more resilient and able to build healthy relationships as adults (Howell & Miller-Graff, 2014; Meyers, 2016). The women's foundation of support could consist of an association to a therapist, being in tune with spirituality, or have a support system outside of the family (Glenn, 2014; Howell & Miller-Graff, 2014; Meyers, 2016).

However, there are even more women who have yet to heal from their exposure to CHM and who struggle with sustaining healthy relationship connections. Information regarding the role of resilience in women's ability to sustain healthy relationship post-CHM is minimal. Researchers have examined the development of resilience as well as what life is like for those who have or have not been able to overcome life adversities such as CHM (Maneta, Cohen, Schulz, & Waldinger, 2015; Meyers, 2016). However, information remains absent regarding what role resilience plays in women's ability to manage the traumas of childhood and keep them from compromising later life relationships, whether intimate, social, or familial. I conducted this study to fill in the gaps in understanding the role of resilience by focusing on how resilience assists women in the healing process and with the ability to successfully move forward into adulthood.

**Background**

The ability of women to develop resilience is underestimated. There is a notion that most people facing adversities in childhood never develop resilience and tend to lead a life of relived traumas as they move from relationship to relationship, never building strong bonds and healthy sustainable life habits (Burt & Paysnick, 2012; Shastri, 2013). However, other studies have shown that women who were exposed to CHM and failed to develop resilience still have an opportunity of becoming resilient in adulthood with the help of therapeutic interventions (Orbke & Smith, 2013). Furthermore, not everyone who has experienced CHM fails to become resilient or will they handle like situations in the same manner (Helitzer, Graeber, LaNoue, & Newbill, 2015). A survivor's perception of the intensity of the adverse environment tends to dictate how they respond to adult

relationships post-CHM (Helitzer et al., 2015; Zimmerman, 2013). Some survivors perceive the impact of the adversity as high and respond in a tense manner to situations triggering the emersion of suppressed emotions; whereas, others perceive the impact as low and, therefore, respond in a more controlled manner to situations, that may trigger the emersion of suppressed emotions (Helitzer et al., 2015).

The perception seems to influence how they emotionally cope in later relationships. Women who experience excess internal emotions, that many times are left unchecked and buried deep within, are faced with the fact that these emotions lie dormant until there is a triggering event that requires them to emerge (Traue, Kessler, & Deighton, 2016). Triggering events could simply consist of the individual's partner unknowingly completing an action or making a statement that is a reminder of past the abuses (Riggs et al., 2011), such as do as I say. Unfortunately, the emersion of the suppressed turmoils, such as fear of closeness, fear of betrayal, and negative views of self and others, tends to happen at inopportune times (Dalton et al., 2013; Riggs et al., 2011). The emersion may cause women who have survived a chaotic childhood to jeopardize opportunities to operate successfully in adult relationships (Riggs et al. 2011). The behaviors that accompany the emersions of suppressed emotions appear to be the reason past researchers of resilience believe that many people fail to become resilient in the face of adversity (Burt & Paysnick, 2012).

Resilience is a process, that appears in a "fragile space between healing and devastation," enabling an individual to evade undesirable life situations and develop an ability to adapt to stressful situations in a positive manner (Glenn, 2014, p. 37; Ogińska-

Bulik & Kobylarczyk, 2015). Resilience also plays a role in preventing the survivor from experiencing the negative consequences of their adverse environment (Glenn, 2014). Studies have shown the need to examine the mechanisms that link early maltreatment, such as childhood emotional abuse (CEA) or siblings abuse, to women's ability to develop resiliency and sustain healthy relationships (Maneta et al., 2015; Meyers, 2016). The need for further examination of the linkage between maltreatment that occurred in early developmental stages and an individual's ability to sustain healthy relationships post-CHM is the effects of CHM have been found to leave the survivors with interpersonal turmoils, such as attachment anxiety, low self-confidence, and fears of abandonment, that interfere with their ability to sustain a healthy intimate relationship (Riggs et al., 2011; Savla, Roberto, Jaramillo-Sierra, & Gambrek, 2013).

Women who desire to establish healthy adult relationships can overcome the adversity of their abusive environment with the implementation of resources outside of the adverse environment (Dalton et al. 2013, Howell & Miller-Graff, 2014; Meyers, 2016). These resources could consist of therapy to address interpersonal turmoil post-CHM exposure (Dalton et al. 2013, Howell & Miller-Graff, 2014; Meyers, 2016). Some survivors fight to become resilient and break away from the abuser, while others will rely on their outside resources to rebuild a relationship with the abuser because the survivor wants the relationship to remain viable (Meyers, 2016).

Furthermore, in search of relief from the adversities of life, those who used social and community resources were able to develop resilience and were able to transition into healthy adult relationships and life habits (Howell & Miller-Graff, 2014). Multiple

researchers have reported the importance of social support in the forms of spirituality and emotional intelligence because these aspects support the building of resilience in young adults who were exposed to CHM (Chandler, Roberts, & Chiodo, 2015; Howell & Miller-Graff, 2014; Waldorn, Scarpa, & Kim-Spoon, 2018). I conducted this study in an attempt to provide a better understanding of how the connection to resources outside of the adverse environment aids in the development of resilience and what role resilience plays in the ability to sustain healthy adult relationships post-CHM.

**Problem Statement**

Resilience is defined as a person's ability to progress in life despite being exposed to adversities in their environment (Brinkerhoff, 2017; Chandler et al., 2015; Hamby, Grych, & Banyard, 2018; Werner, 1989). In this study, adversity was defined as exposure to CHM. Between childhood and adulthood, individuals generally develop the skills needed for the development of resilience (Shastri, 2013). Individuals can be successful in building their foundation of resilience by establishing connections outside of the familial environment (Burt & Paysnick, 2012). The established connections may consist of seeking the help of a therapist or developing an understanding of self-worth (Burrill, 2016; Chandler et al., 2015; Dalton, Greenman, Classen, & Johnson, 2013; Meyers, 2016; Shastri, 2013). Individuals may also fail at developing the skills needed to establish resilience, resulting in complications in later relationships (Burt & Paysnick, 2012). The complications may present as struggles with insecurity, that does not allow women to attach to their partners securely. Furthermore, women could struggle with interpersonal episodes of anxiety and self-doubt (Riggs et al., 2011; Wright & Folger, 2017), resulting

in an inability to connect with and be tuned to the emotions of the partner (Maneta et al., 2015).

Researchers have also indicated that those who have experienced CHM seldom develop resilience (Holmes, Yoon, Voith, Kobulsky, & Steigerwald, 2015; Orbke & Smith, 2013; Shastri, 2013). Meaning, they are not able to rebound from the adverse childhood experience (Chandler et al. 2015).

Another aspect of understanding the connection between women's ability to sustain healthy relationships and CHM is comprehending the effects trauma has on the survivor's interpersonal relationships (Goff et al., 2006; Riggs et al., 2011). Unfortunately, women who have deep-seated CHM histories are more likely to struggle when searching for satisfaction in relationships because they may still suffer from some effects of their childhood experiences (Maneta et al., 2015). For example, those lingering challenges could affect how the women perceive the affection of the partner and jeopardize their relationship (Burt & Paysnick, 2012; Dalton et al., 2013).

The need for further research regarding the role of resilience and the proper use or misuse of protective factors is evident in the findings of current studies. Protective factors are either internal or external and encompass seeking therapeutic services, connecting with peers, emotional well-being, and intrapersonal dysfunction (Folger & Wright, 2013; Hamby et al., 2018; Holmes et al., 2015). I will discuss protective factors in more detail in Chapter 2.

One area not readily covered by current research has been what roles gained resilience and the proper use or misuse of protective factors play in how a survivor

transitions from one relational stage to the next. Meaning, how does gained resilience or the proper use or misuse of developed protective factors affect the survivor's ability to function in relationships from childhood to adolescence to adulthood. This topic is in line with Meyers (2016), who stated there was a need to further understand how protective factors influence or compromise other relationships the individual may later enter as well as the ability for the survivor to trust and progress towards the development of deep and healthy relational connection.

## Purpose of the Study

The purpose of this study was to understand the role of resilience and protective factors in the life of women who have experienced CHM and how resilience and the proper use or misuse of protective factors later affects their adult relationships, whether intimate, social, or familial. With this qualitative study, I aimed to further understand how resilience influences the healing process and women's ability to maintain a healthy relationship in the face of adversities while struggling deeply with emotional issues and adult relationships associated with their exposure to CHM (see Meyers, 2016). Researchers have found that not everyone becomes resilient in the face of adversity, meaning they are not able to adapt positively to their adverse environment (Cleary, 2016; Holmes et al., 2015; Shastri, 2013). Such findings seem to contradict other researchers that concluded that an individual overcoming the adversity of their environment is possible even for adults who were not able to develop resilience in childhood due to the stunting of their emotional development if external resources such as therapy are implemented (Howell & Miller-Graff, 2014; Meyer, 2016; Orbke & Smith,

2013). Therefore, in this study, I examined why some women can implement resilience and protective factors successfully and not impede their adult relationships, while others struggle to become resilient or use their developed protective factors in a manner that does not adversely affect the adult relationships (see Dalton et al., 2013; Meyer, 2016).

## Research Questions

1. What is the role of resilience in women's ability to maintain healthy relationships in adulthood, whether intimate, social or, familial, post-childhood maltreatment?

2. How is resilience developed in women who are exposed to childhood maltreatment?

3. How do protective factors utilized by women exposed to childhood maltreatment later affect other relationships the individual may enter?

## Theoretical Framework

The framework that anchored this study was resiliency theory. Werner (1989) defined resilience as "successful adaptation following exposure to stressful life events" (p. 72). Using resiliency theory, an individual can look to see how positive outcomes are managed after a negative experience, such as CHM, has occurred (see CITE). Resiliency theory also provides an understating of how women manage to cope with adversity in a way that develops characteristics of resilience (Sagone & De Caroli, 2014). Resiliency theory can be used to further examine the development of tools and skill that help those exposed to CHM persevere in the face of adversity (Sagone & De Caroli, 2014).

Werner (1989) introduced resiliency theory when conducting a longitudinal study on children regarding the development of biological progression, that could be affected by prenatal stress factors such as trauma. Werner also viewed environmental difficulties and psychological growth in adverse environments, aiming to understand how a child's environment affected the development of biological and psychological risk factors as well as protective factors in the various stages of life. The stages of life examined in Werner's study included early and middle childhood, late adolescence, and young adulthood. However, since the completion of Werner's study, the resiliency theory been applied to the adult population with an aim to understand how adults function in relationships after CHM (Ogińska-Bulik & Kobylarczyk, 2015; Orbke & Smith, 2013).

Resiliency theory explains how protective factors aid young girls in successfully transitioning into adulthood and establish healthy relationships . Resiliency theory was more appropriate for this study than other theories, such as the attachment theory, because the examination of an individual's resilience not only allows for the examination of why a person struggles with relationships but also allows for a deeper exploration into how individuals deal with and overcome adversities despite the lack of attention or vital connections in their immediate familial environment. Studies have shown that no matter the disadvantages of the environment, some children can display a remarkable degree of resilience, especially when their situation is addressed from a positive stance (Werner, 1989; Zimmerman, 2013). Additionally, helping young girls view their adversity from a positive perspective enables them to establish resilience (Cleary, 2016; Orbke & Smith, 2013; Sagone & De Caroli, 2014; Zimmerman, 2013).

In this study, I focused on the role of resilience and women's ability to sustain healthy relationships post-CHM. Utilizing resiliency theory as the framework and anchor for this study was important and appropriate as the construct of resilience is relevant when individuals are submerged in stressful environments and experiences such as CHM (see Sagone & De Caroli, 2014). Resiliency theory provides a further understanding of an individual's ability to cope with adversity in a way that yields resilient qualities and protective factors (Smith-Osborne, 2007). Furthermore, the theory was suitable for the study because the foundation or perceptions of relationships are developed in childhood, as is resilience, that shapes how individuals function once they have reached adulthood and engage in adult relationships (see Sagone & De Caroli, 2014).

## Nature of the Study

In this study, I employed a qualitative methodology with an interpretative, phenomenological analysis (IPA) design. Qualitative research enables understanding from the perspective of the individual experiencing the phenomenon (Patton, 2015). Specifically, the focus of the study was to understand the role of resilience regarding women experiencing healthy relationships post-CHM. The methodology not only allowed the voice of the participants to be heard, but it also helped me obtain a better understanding of the phenomenon from the perspective of the individuals who had experienced, lived through, and survived the phenomenon.

I implemented the IPA design through semi-structured interviews with participants, that revolved around the participants sharing information about her life

experience with resilience post-CHM from her perspective (see Patton, 2015; Pietkiewicz & Smith, 2014). The purpose of using an IPA was to capture the beginning, middle, and end of the participants' experiences in their purest form. Such an approach aids the researcher in better understanding the person from which the story comes (Patton, 2015; Pietkiewicz & Smith, 2014). Additionally, the IPA approach allows the researcher to gather in-depth and rich data (Pretkiewicz & Smith 2014). As part of the IPA approach, I planned to use in-depth interviewing as well as an interview guide.

## Definitions

*Childhood maltreatment (CHM)*: The term childhood maltreatment was a general term that covered those who have been exposed to emotional abuse, sibling abuse, physical abuse, abandonment, and other forms of abuse in childhood.

*Protective factors*: These factors aid individuals in the development of resilience. PFs define mechanisms that are put in place to survive in an adverse environment and drive the development and implementation of resilience as well as how a person will function in relationships in adulthood (Dalton et al., 2013; Meyers, 2016).

*Relationships*: For the purpose of this study, relationships are operationally defined as familial, social, or intimate relationships in that the survivor has or had not successfully engaged in post-CHM.

*Resilience*: A process that leads to an individual's ability to survive the experience of adversity, specifically exposure to CHM (Smith & Osborn, 2007; Werner, 1989).

*Stages*: The levels of development (i.e., childhood, adolescence, and adulthood; Werner, 1989).

*Survivor*: A person who has overcome the experience of CHM .

## Assumptions

I made several specific assumptions regarding the design of this study. I assumed the reports of experience with CHM provided by the participants would produce data that would truthfully answer the research question. Meaning, an individual would not choose to identify as being a survivor of CHM without having experienced acts of it.

A further assumption was that individuals would be honest about their adverse environment and how they were able or not able to develop resilience as well as whether the protective factors they developed in childhood had been properly used or misused in relationships post-CHM. I also assumed that the participants would be supportive of the purpose of the study and be forthcoming when answering the interview questions regarding CHM, relationships, and PFs. In addition, there was an assumption the study would have sufficient enough participants to allow for the gathering of satisfactory amounts of data to identify all applicable themes.

An additional assumption was that, as the researcher, I would be capable of conducting the interviews in an environment free of interruptions, that could have compromised the privacy and confidentially of the participants. I also assumed my interactions with the participants would be free from biases. It was assumed, I would pose questions in a manner that did not present as judgmental, allowing for the participants to feel supported and free to openly express themselves.

**Scope and Delimitations**

In this study, I examined the role of resilience in a woman's ability to sustain healthy adult relationships post-CHM. Only women were selected as participants for this study due to the need to understand why this population struggles with sustaining healthy, meaningful relationships post-CHM. Purposive sampling was used in the selection of the participants. This type of sampling allowed for greater thematic findings and analysis. For inclusion in the study, the participants had to be a woman who was 25 years of age and older and who self-identified as having experienced CHM. The reason for the minimum age was the older the participant, the more experience she would have with relationships post-CHM. Participant exclusions for the study included college students because the college population saturates the study of resiliency regarding relationships (see Howell, & Miller-Graff, 2014; Meyers, 2016). Further exclusions were individuals who disclosed having a mental health diagnosis whose symptoms could have been aggravated through participation in the study. The reason for this exclusion was those with mental health diagnosis are a sensitive population and the chance of reintroducing trauma was high. Resilience is not specific to age and gender; therefore, the results of this study can be transferred to the male gender and those who fall under the age limitation of the current study. However, findings should only be able to be applied to this population with caution.

The participants were all female because the gaps in current literature called for further examination of resilience from the female perspective. Furthermore, men who experienced CHM were not invited to take part in this study because their experiences

with CHM may differ from the female experiences and may not have provided a clear and concise answer to the posed research questions. Some participants were pulled from a support group and had full awareness of how to discuss the topic and provide rehearsed answers, that could have skewed the data.

Furthermore, IPA may not offer the same findings of past quantitative studies of survivors of CHM and resilience. In the past, quantitative studies have been used to address how and why an individual becomes resilient and specifically categorized what a person needed to develop resilience. The findings of this study were limited to clarification of the role of resilience rather than measurable data.

## Limitations

I identified the following limitations of the study. Participants presented their stories from their perspectives, that required them to recall the timeline of events that could have been vague. The problem with this is some people tend to block out trauma, that may have caused the participant to piece together the information provided during the interview vaguely. I viewed the elimination of those possible participants with a mental health diagnosis due to a higher chance of reintroducing trauma as a necessary limitation because individuals with such a mental health diagnosis may have experienced a higher level of distress due to CHM. However, this population could have supplied rich data and helped answer the research question in depth.

Self-selection bias was noted as a limitation as well. Some potential participants may not have wanted to participate because talking about past trauma may have been an uncomfortable conversation. I viewed the nonparticipation of eligible individuals as a

limitation because there is a possibility the information they would have reported would differ from those who agreed to participate in the study and share their story.

Finally, I also considered the availability of resources a limitation of the study. Although researchers have addressed the development of resilience in the past, the topic of how resilience aids in the sustainability of healthy relationships post-CHM is a relatively new area of study. Due to my examination of a fairly new research topic, the availability of literature published in the past 5 years was minimal. To address this limitation, I utilized literature that addressed hardships in relationships after sibling abuse, childhood adversity, and the use of resources such as therapy to develop resilience.

## Significance of the Study

With this study, I attempted to provide answers to how establishing resilience helps women function in intimate, social, or familial relationships post-CHM. The original contribution of this study to the field is based on the fact there are few qualitative studies that address the subject of women and resilience post-childhood trauma. Furthermore, practitioners who provide therapeutic care for girls and women at various stages of exposure and healing can better aid in the healing process if they first understand which support systems help women functioning in healthy adult relationships post-exposure to CHM. Support systems can consist of therapeutic interactions or connections with friends or groups outside of the familial environment (Meyers, 2016; Werner, 1989). Practitioners could further benefit from the findings of this study because it included women of all socioeconomic backgrounds. The presence of diverse backgrounds will be helpful for treating practitioners as the research questions were

answered from different perspectives of trauma exposure. Furthermore, the findings should help the therapy and counseling community to understand how to address the phenomenon at both the childhood and adulthood stages.

The results of the study further indicated how resiliency is established when the survivor establishes a support system outside of the childhood home (see Dalton et al., 2013; Meyers, 2016; Riggs et al., 2011). Therefore, there are important implications for positive social change. The findings could lead to the development of interventions or community clinics, that would be established to specifically address the needs of those who have disclosed CHM and would aid in the process of developing resiliency. The goal of this study was for therapeutic practitioners to grasp the importance of early interventions, addressing trauma, and the development of social support, that leads to the proper establishment of resiliency and resilient factors that do not come naturally to all women.

**Summary**

CHM comes in many forms, but the one commonality appears to be the resulting trauma, which impacts the child and their ability to function and sustain healthy adult relationships. Researchers have recognized the trauma of CHM has influences on internal discomfort and the development of resilience and resilient factors in many of the women who have experienced CHM. Researchers have further documented that for women to develop resilience, they must connect with resources, such as a therapist, or make a spiritual connection outside of the adverse environment (Chandler et al., 2015; Howell & Miller-Graff, 2014). Although there are biological an and psychological factors that drive

the ability to develop resilience (Werner, 1989), the thought is many children are not able

to overcome the adversity and, therefore, never become resilient (Shastri, 2013)

Past reseearchers have mentioned how resiliency and the factors thereof are

developed; however, what remains unclear is how the use of resilience aids in women's

ability to sustain healthy relationships. In this study, I attempted to understand the

experiences of women who were exposed to CHM and their journey to establishing

healthy relationships to aid treatment providers in understanding how the implantation of

interventions when the abuse is initially reported may aid the development of resilience at

an early age. This chapter will be followed by a review of the relevant literature in

Chapter 2.

Chapter 2: Literature Review

**Introduction**

The number of child abuse incidents reported annually in the United States sits  4 million, with 7.2 million children being affected due to some households having multiple children (National Children's Alliance, 2017). Out of the 4 million reported incidences, approximately 700,000 children receive services due to CHM (National Children's Alliance, 2017). The forms of abuse can include physical, sibling, sexual, and emotional abuse as well as bullying and neglect . Physical abuse and neglect were reported more often than the other forms of abuse (National Children's Alliance, 2017). Furthermore, neglect was reported more often than physical abuse (National Children's Alliance, 2017). Past researchers have found only an estimated one third of the children who were exposed to some form of abuse can demonstrate resilience, develop past the trauma of CHM, and have healthy life habits (Orbke & Smith, 2013).

Although there are many reasons for individuals to develop resilience, the goal of this study was to understand the development of resilience in those exposed to CHM. Evidence has shown understanding the foundation for what triggered a survivor of CHM's need for resiliency begins with following the developmental journey of the individual from childhood to adolescents then into adulthood (Burt & Paysnick, 2012).

In this chapter, I will provide a brief outline of the literature search strategies and the theoretical framework that guided the study. The literature review section will contain a summary of all the current reviewed literature as well as the benefits and limitations of

the findings. Finally, the chapter will conclude with a summary and discussion of how the results of this study contribute and add depth to the current gaps in the literature.

In this study, I took an in-depth look specifically at the need for and development of resilience in women who have endured CHM. All humans have suffered some form of trauma and need to develop resilience. The trauma could be the loss of a loved one, cancer, or career development to name a few instances; however, the purpose of this study was to understand the role of resilience in the life of women who have experienced CHM and how the development of resilience later affects their adult relationships, whether intimate, social, or familial. In this qualitative study, I aimed to further understand how resilience influences the healing process and women's ability to maintain healthy relationships while struggling deeply with emotional issues associated with their exposure to CHM (see Meyers, 2016).

## Literature Search Strategy

Due to the lack of current empirical studies, I needed to draw from earlier studies as far back as 2006. A search of the literature was conducted to locate peer-reviewed journal articles through Walden University databases, including PsycINFO, ProQuest, and SAGE Journals, and websites dedicated to accessing scholarly articles, such as Google Scholar, that are dedicated to accessing scholarly articles. The keyword terms used while completing the literature search included mixtures of *resiliency post-childhood maltreatment\*; healing post-childhood maltreatment\*; women and resiliency; relationship post-childhood maltreatment\*; resilience and relationships; IPA methodology, protective factors, and childhood maltreatment; IPA methodology,*

*resilience, and childhood maltreatment; failure to develop resilience during and after*

*child maltreatment; effect of childhood maltreatment on adult relationships; development*

*of resilience; protective factors\*; risk factors associated with childhood maltreatment;*

*controlling risk factors associated with childhood maltreatment; ;child abuse\*;*

*sustaining relationships\**; *establishing healthy relationships; healing strategies; post-*

*childhood maltreatment\*; spirituality; transitioning to adulthood; accessing resiliency;*

and *resiliency theory*. Additionally, I reviewed academic books on related topics to

discover pertinent periodical articles referenced by the author(s). To ensure the

information provided was current, the search was limited to articles published in the last

5 years. The number of studies available specifically regarding the topic of resilience in

women post-CHM was few.

## Theoretical Framework for the Study

The framework that anchored this study was resiliency theory. Resiliency theory

is a theoretical standpoint that is encompassed within developmental psychopathology

specifically focused on chronological lifespan and an individual's ability to overcome life

adversities (Smith & Osborn, 2007). Stress and coping theories provide the important

bases of resiliency theory (Smith & Osborn, 2007). Resilience is defined as "successful

adaptation following exposure to stressful life events" (Werner, 1989, p. 72). Using

resiliency theory, a researcher looks to see how a person manages positive outcomes after

a negative experience, such as CHM, has occurred. Resiliency theory also provides an

understanding of how women manage to utilize coping mechanisms that aid in the

development of resilient characteristics as well as tools and skill, that help them persevere in the face of adversity (Sagone & De Caroli, 2014).

When attempting to comprehend an individual's capability to overcome the adversity of her environment, there is a necessity to look at risk factors (RFs), such as poverty, maternal disconnection, and other life disadvantages (Werner, 1989). Equally necessary is the need to examine the implementation of PFs, such as external family support to include peers, elders, and extended family members (Rutter, 1987; Werner 1989). Werner (1989) identified the development of support systems outside of the familial unit as PFs because these support systems assist the individual in understanding she is more than her situation and that she has control over her life outcome, which in turn develops resilience. Further, Werner found the more stressful the environment and the more disadvantaged individuals were, implementation of PFs was needed as a counterbalance in pursuance of a positive outcome.

The use of PFs has a more substantial influence on an individual's ability to become resilient than the RFs or the experienced adversity (Chandler et al., 2015; Werner, 1989). RFs were identified by Werner (1989) as the elements of the adverse environment that triggers the need for the development of PF and resilience. RFs present in the form of poverty, the lack of parental love, or any situation or circumstance that would prevent an individual from effectively fulfilling a stable and healthy way of life (Werner, 1989). Moreover, as will be discussed in greater detail later in the chapter, RFs lie opposite to PFs on a scale of emotional stability and resilience; the higher the RFs, the

more the person struggles to develop and even maintain resilience (Rutter, 1987; Werner, 1989).

Upon examination of resiliency theory, survivors of CHM are continuously and delicately balancing their ability to face and conquer negative experiences with the desire to develop successful, healthy, and sustainable relationships post-CHM. Resiliency theory can be further used to develop tools and psychological health, that help those exposed to CHM persevere in the face of adversity. One particular area of examination is an individual's psychological well-being, that encompasses the ability to think positively and successfully problem solve (Mehring, 2014; Sagone & De Caroli, 2014). Having healthy psychological well-being aids an individual on her journey to resilience because the development of resilience is aligned with a person's ability to exercise coping skills, have positive thoughts about herself, and remain hopeful while experiencing adversity (Sagone & De Caroli, 2014).

The stages of life examined in Werner's (1989) study included infancy, early and middle childhood, late adolescence, young adulthood, and adulthood with the early and middle childhood stages of development showing as the most crucial developmental stages because they relate to how individuals will be affected by the fallout of CHM as they reach adulthood and attempt to engage in relationships. In each developmental stage, Werner found characteristics within the individual, their families, and connections the individual had outside of the family home that contributed to the development of resilience. From infancy through childhood, the children were described as being active and of good nature (Werner, 1989). Children in this developmental stage were also

described as easy to rear and having had developed early social skills regarding communication and the ability to help themselves (Werner, 1989). By the time the individual reaches the ending of high school, she was described as having a positive self-image and control over situational outcomes (Werner, 1989). A majority of the adverse life events that would significantly contribute to a lack of resilience will have occurred in the infancy and childhood developmental stages (Werner, 1989).

Since the publication of Werner's (1989) study, resiliency theory has been applied to the adult population in an aim to understand how adults function in relationships after childhood maltreatment (Ogińska-Bulik & Kobylarczyk, 2015; Orbke & Smith, 2013). Past researchers have also applied the concepts to adult life, such as leadership and organization stability, an individual's ability to build and sustain work relationships, and the ability to face adversity in adult life and persevere (Ledesma, 2014; Ogińska-Bulik & Kobylarczyk, 2015; Orbke & Smith, 2013). Orbke and Smith (2013) examined the possibility of nonresilient adults becoming resilient after addressing developmental arrest in childhood due to their adverse environments. Although there is an ongoing debate regarding resilience being a character trait or a phenomenon born of a person's environment (Ledesma, 2014; Orbke & Smith, 2013), what is known is only when individuals are submerged in stressful environments and experiences, such as CHM, does resilience develop (Sagone & De Caroli, 2014). Meaning, if adversity is absent, an individual lacks a need to develop resilience. Resiliency theory provides a further understanding of an individual's ability to cope with adversity in a way that yields resilient qualities and protective factors (Smith-Osborne, 2007).

**Review of Research and Methodological Literature**

My detailed search of literature regarding resilience in women post-CHM and the effect CHM has on a woman's ability to sustain healthy adult relationships revealed an insufficiency in extant studies. Yet, a few researchers were able to provide an understanding on how and why resilience is developed during the exposure to adverse environments, which is important when attempting to understand why some women can sustain healthy adult relationships post-CHM and others cannot. Other researchers were able to further outline in more detail information on how familial and social support, therapeutic options, the development of resilience based upon the type of abuse, and how development factors aid women on their journey towards resilience. However, since only a few of the referenced articles pertain to the role of resilience in women's ability to sustain healthy adult relationships post-CHM, these studies can only be considered preliminary and should be interpreted cautiously.

**Protective and Risk Factors**

Understanding PFs and their connection to the development of resilience was essential to this study. In a longitudinal study, Werner (1989) defined PFs as the existence of personal proficiencies and the foundations of support that help individuals develop and maintain their levels of resilience. Rutter (1987) described PFs as stemming from the notion of resilience. Meaning, when thinking about the resilience of another, the thought of what external resources or internal factors were utilized to develop and sustain resilience despite faced adversities is at the forefront of the thought process.

Brinkerhoff (2017) conducted a qualitative study aimed at examining how the presence of PFs fosters the development of resilience in a person who had experienced childhood adversity. A further purpose was to provide information on how to foster healing in children exposed to CHM and other life adversities (Brinkerhoff, 2017). The study included randomly selected students from a blind classroom roster who completed online questionnaires, and Brinkerhoff found that when a person has established PFs, there is a neutralizing effect on the negative outcomes, that are the result of psychological effect and long-lasting life pressures. Additional findings were resilience is present due to the development of PFs and that if a child exposed to adversity is immersed in an environment rich in PFs, they have a higher probability of becoming resilient than those who experience a high level of adversity in environments low in PFs (Brinkerhoff, 2017).

**Protective factors have an external and internal component**. Depending on the type of PF, internal or external, PFs are developed or put in place to help individuals navigate the rough patches of life while in childhood (Brinkerhoff, 2017; Dalton et al., 2013; Hamby et al., 2018; Hinduja & Patchin, 2017; Meyers, 2016; Rutter, 1987, Werner, 1989). In fact, the development of PF appears to have more influence on the development of resilience than do the RFs or the experience of CHM (Brinkerhoff, 2017; Shastri, 2013; Werner, 1989). RFs are the situations or circumstances that cause the stressors in the adverse environment; however, RFs have little pull on whether individuals will become resilient during the experience of CHM (Werner, 1989). PFs have been found to defuse the negative effects of the stressful environment, allowing the survivor of CHM to better foster a healthy healing process (Brinkerhoff, 2017; Holmes et al., 2015). Yet, PFs

have come into question as to whether they are more than a contrary representation of

RFs (Hamby et al., 2018). Meaning, although studies of the past have nicely explained

PFs and the development of PFs on an individual's journey to resilience, many of the

established PFs, such as emotional stability and social support, seemingly lack an

inimitable explanation of the process individuals endure to develop resilience to adversity

(Hamby et al., 2018). What seems to have occurred in past resiliency research was the

examination of RFs, such as lack of parental attention, that is associated with attachment

problem, and the application of PFs, such as ample parental attention, that is associated

with healthy attachment behaviors and believed to counteract the associated RFs, have

been inadvertently associated when each aspect should have been examined separately

(Hamby et al., 2018). Hamby et al. (2018) found there to be a need to precisely

differentiate PFs from RFs in a way that will loosen the connection and provide a better

explanation of how PFs are developed in the absence of or separate from RFs and in the

face of adversity.

As individuals grow through the developmental stages, childhood, middle

childhood, adolescences, and adulthood, the risk factors are altered, and the form of

maltreatment fluctuates. Meaning, what puts the individual at risk of suffering

maltreatment changes and the type of abuse may be more or less severe (Shastri 2013;

and Werner, 1989). During this fluctuation process, individuals usually tap into the

external components of developed PF to counterbalance the RF (Shastri, 2013; Werner,

1989). Meaning, women may rely heavily on their external support systems to get

through the spike in life stressors; and when the stress of life declines they utilize their external support systems less (Shastri, 2013; Werner, 1989).

One might view this process as a chain-reaction of sorts, that changes the influence of RF and PF (Werner, 1989). Meaning, as the individual grows from infancy to adulthood, PFs and RFs experience an alteration causing a continuous shift in the balance between the two (Werner, 1989). What is meant by alteration and a shift in balance is the type and number of life adversities will transform based upon the developmental stage and increase or decrease throughout individual's development; therefore, increasing and decreasing the need to lean on established support or community resources.

For example, in midchildhood, the number of adversities faced by the individual may be less in which case there is less of a need to utilize established PFs (Werner, 1989). For instance, the child is spending more time away from home, so the exposure to CHM and other environmental RFs have decreased. However, as individuals enter the late stages of adolescence, they may be faced with more life adversities causing a heightened need to utilize established PFs due to an increased vulnerability (Werner, 1989), The increased use of PFs result in a boost in the individuals' level of resilience (Werner, 1989). However, by the time the women reach the age of 30 their susceptibility to the shift between RFs and PFs significantly declines. Meaning, by the time women reach the age of 30 years they usually have reached a point in life where they are no longer heavily affected by RFs and need to lean less on PFs when faced with adversity (Werner, 1989).

Past research has questioned the long-term effects of protective factors developed in childhood and adolescence on the individual's ability to cope once she reached adulthood (Werner, 1989). The study of resilience lacks empirical studies that readily answer this question. However, research indicates some survivors of CHM develop PF for the intentional and specific purpose of maintaining a relationship with the abuser (Meyers, 2016), which may be an indication of the longevity of PFs into adulthood. In spite of experiencing adversity such as sibling abuse, some survivors desire to stay connected to the abuser as they value the established relationship when the abuse is absent (Meyers, 2016). Werner (1989) implied individuals would more than likely have difficulty coping in adulthood should the RF factors outweigh the person's ability to access her support system or PF. Further indicated, should a person's ability to access her support systems or PF continues to outweigh the adversities of life, she should have few struggles with coping in adulthood (Werner,).

Another view on the long-term effects of PFs can be found from the standpoint of Dalton et al., and Meyers (2013; 2016) who stated if not careful, the developed protective factor could compromise the individual's ability to form, engaging in, and sustain healthy adult relationships. During CHM individuals develop intrapersonal responses which protect them from adversities as well as aids in the development of resilience. The intrapersonal protection can take the form of mistrust of others, constant worrying about abandonment, over awareness of possible harm, and not finding Their self, worthy of being loved (Dalton et al., 2013). The unfortunate part is such PFs may have been

protective in childhood but tends to interfere with the individual's ability to successfully form and maintain relationships in adulthood (Dalton et al., 2013; Meyers, 2016).

Meyers (2016) conducted a study regarding protective factors that contribute to the resilience of women who were abused by their siblings in childhood. Nineteen survivors participated in the study and explained how they implement PF during and post sibling abuse (Meyers, 2016). Meyers set out to better understand how participants utilized protective factors to become resilient as they transitioned into adulthood relationships. Meyers found some of the participants developed PF for the specific purpose of maintaining a relationship with the abuser while others implemented defenses such as emotionally disconnecting from the abuser. The disconnect was initiated to ensure they remained protected from the harm of past adversities (Meyer, 2016). Noted in the conclusion of the study were individuals who had access to a creative outlet as well as a caring relationship with someone such as a therapist in childhood and adulthood, exhibited the most resilience and prospered in life despite their at-risk and adverse situations (Meyers, 2016). Further noted was inquiry should be conducted into how protective factors and defense mechanisms, utilized by survivors impacts or compromises other relationships the individual may later enter (Meyers, 2016). What is clear is a need to understand why some individuals struggle with relationships once they reach adulthood. Gaining an understanding of an individual's ability to apply PF is the key to understanding why some people preserver in the face of adversity and others do not (Rutter, 1987).

**External Components**

  The external components of PF are the aspects individuals have control over when seeking assistance during a time of need (Maercker, Hilpert, & Burri, 2015; Shastri, 2013; Zimmerman, 2013 ). These PF are sought after by individuals seeking to alleviate the pressure of life stressors and are lifelong predictors of a survivor's ability to remain resilience in the face of adversity (Maercker et al., 2015). The component consists of support in the form of friends, therapist, and extracurricular activities, (Howell, 2014; Maercker et al., 2015; Myers, 2013; Rutter, 1987; Shastri, 2013; Werner, 1989). Studies have regularly shown that the use of resources outside of the adverse environment is beneficial to the individual experiencing CHM and crucial to the development of resilience (Chandler, Helitzer, & Glen, 2015; Cleary, 2016; Howell, 2013; Maercker et al., 2015; Meyers, 2016.) All of which will be examined in detail later in the chapter.

  A quantitative study was conducted by Maercker et al. (2015), which examined the longevity of resilience in elderly survivors of childhood trauma who were former Swiss indentured child labors who were forcibly separated from their families. Resilient indicators and predictors were examined (Maercker et al., 2015). The resilience indicators were identified as the satisfaction of life, good health, and the establishment of healthy long-lasting relationships to include marriage and integration into one's community (Maercker et al., 2015). Resilience predictors were identified as negative responses from those in the community when the maltreatment was disclosed, ample social support, and the establishment of successful, supportive relationships (Maercker et al., 2015). A model of comprehensive trauma-specific and coping was utilized and included a context model

designed by Ungar (Maercker et al., 2015). Also viewed were PFs such as resource-rich environments that fostered the development of resilience (Maercker et al., 2015). PFs in this study were also referred to as "decentral factors" (Maercker et al., 2015, p. 2).

The findings of the study were if survivors are to sustain resilience throughout adulthood, the level of their social support at various stages in life, and PF developed during the adverse experience needs to be maintained life-long (Maercker et al., 2015). Further found was, satisfaction in life and absences of mental health dispositions such as depression were predicted by their ability to successfully disclose the trauma to those in the community and be accepted, (Maercker et al., 2015).

Further, examined was the effect PFs had on emotional behavior after the exposure to physical abuse or neglect (Holmes, et.al, 2015). The PFs examined were the child's prosocial skills, internalization of well-being as well as the well-being of the caregiver (Holmes et al., 2015). Studies have found that children who are exposed to maltreatment are at a higher risk of experiencing emotional, behavioral, and social adjustment problems; however, it was noted not all maltreated children suffer the negative outcomes associated with child abuse (Cleary, 2016; Holmes et al., 2015).

Holmes et al. (2015) conducted an aggression and longitudinal study across a period of 18 months with the purpose of understanding "the effects individual and familial PFs on aggression in relation to physical abuse" ( p. 4). A further purpose of the study was to examine which PFs fostered resilience in children with clinical aggression (Holmes et al., 2015). The study was conducted in two waves. The second wave took place 18 months after the first. Secondary data that included 5,501 children who had

reports of child protective services history for abuse and neglect was utilized in the study (Holmes et al., 2015). Data were also gathered through parents completing surveys (Holmes et al., 2015). Also considered was how old the child was at the time of the maltreatment as age was thought to have a role in whether the child would be aggressive after experiencing maltreatment specifically physical abuse (Holmes et al., 2015).

The findings were the younger the child was at the time of the maltreatment the more likely for the child to experience clinical aggression (Holmes et al., 2015). Additionally, found was children who are exposed to physical maltreatment are 1.45 times more likely than their counterparts who were not exposed to maltreatment to display aggressive behaviors (Holmes et al., 2015). Further found was when PFs such as positive prosocial behaviors such as connecting to socials supports outside of the home and internalized well-being was in place the children exposed to maltreatment were less likely to develop clinical aggression. Holmes et al. (2015) noted individual PFs such as self- well-being seem to be more life-long; whereas familial PFs such as the caregiver's well-being did not transcend through development progression and would not last into middle adolescence and adulthood. Even more interesting was a care-givers well-being did not matter as a PF for older children but was significant for younger children (Holmes et al., 2015). The assumption with this finding was there are windows when PF can be fostered across a lifetime (Holmes et al., 2015). Although this study focused on aggression and physical abuse, the assumption was the findings can be generalized to the presence of PFs when addressing other types of abuse as the presence of PFs is crucial no matter the type of abuse if a child is to develop resilience post-CHM exposure.

**Internal Components**

The internal components of PF are the aspects individuals have no control over when facing adversity (Zimmerman, 2013). These PF are seemingly involuntarily developed and implemented. Internal protective factors are the components that seem to cause the most problems in a survivor's ability to sustain healthy relationships in adulthood (Dalton et al., 2013; Wright & Folger, 2017). The internal components consist of interpersonal responses (Dalton et al., 2013 Shastri; 2013; Zimmerman, 2013), which are described as, fear of betrayal and closeness; hypervigilance to potential harm, and low-self-worth (Dalton et al., 2013; Ruff, 1987). However, on the contrary, there are aspects of the internal PFs that include self-esteem, self-control, self-efficacy, and internal locus of control, which all play a part in helping the individual successfully deal with experienced adversities (Hinduja & Patchin, 2017). Not many studies have been conducted specifically regarding internal PFs; however, many studies regarding relationship post-CHM have touched on internal PFs specifically regarding their ability to sustain successful relationships. This aspect of PFs will be further examined later in the chapter. Sliver (2015) found those who have been exposed to CHM experience stunting of their ability to precisely conceptualize their intent as well as the intent of others due to being exposed to problematic relationships, that have affected their internal responses. One could then assume internal PFs are the internal safety net's that protect individuals from what they perceive to be harm (Silver, 2015). For example, a fear of betrayal would cause individuals to have less trust in those whom they may interact resulting in a desire

to maintain a safe distance in an attempt to protect self from potential danger that may not exist (Riggs et al., 2011; Silver,2015).

**Social Support**

Support systems are a significant part of the development of PF, that are needed for the development of resilience. Social supports have been found to drive the resilient level of those exposed to CHM (Folger & Wright, 2013; Sperry & Widom, 2013). The developed connection could be as simple as feeling linked with a person within the familial setting who is safe, or a community connection such as spirituality, extracurricular activities, or a connection to a therapist (Chandler et al., 2015; Folger & Wright, 2013; Howell & Miller-Graff, 2014; Meyers, 2016). The thought process behind social support systems is if individuals have connections to outside sources, they have a buffer against the negative outcomes of having been exposed to CHM (Folger & Wright, 2013; Jaffee, Takizawa, & Arseneault, 2017; Sperry & Widom, 2013). This notion is more true for individuals who have been exposed to excessive amounts of CHM than those who may have been exposed to less severe quantities of CHM (Folger & Wright, 2013). The type of social support needed may vary based upon age, for example, children may rely on the parental unit and as they reach adolescence and adulthood outside social supports such as friends and community connections become more substantial (Folger & Wright, 2013; Sperry & Widom, 2013). No matter the vehicle used to establish a foundation for resilience, navigating the roads of adversity can prove exhausting and have a huge effect on development into adulthood (Glenn, 2014).

In a study conducted by Cleary (2016) it was noted that 50% of the children in the world are affected by some form of CHM, and only 20%-30% of those children reported not experiencing any negative life outcomes post-exposure (Cleary, 2016). Cleary (2016) hypothesized a combination of social supports and the coping style of CHM survivors would drive the relationship between child abuse and the survivor's lifelong satisfaction. Further reported was if individuals possessed the ability to implement "adaptive coping skills" they were better able to avoid negative outcomes regarding a relationship between child abuse and satisfaction of life (Cleary, 2016, p. 69). A second hypothesis was the use of positive coping skills would have a modest effect on the relationships between CHM and their lifelong satisfaction.

Cleary (2016) if survivors of CHM who used "positive coping" and sought out support, the chance of avoiding a negative relationship between child abuse and satisfaction in life was elevated (Cleary, 2016, p. 70). The above was found true for those who experienced emotional abuse during childhood (Cleary, 2016). In addition, there was found to be no significant connection between the establishment of a social support system and how satisfied an individual is in life post-CHM (Cleary, 2016). Further noted in the findings was individuals seemed to be able to become resilient with the implementation of coping mechanisms, that calls into question if external social supports are necessary for survivors of CHM to reach satisfaction in life (Cleary, 2016).

The further question is, how does the ability to implement positive coping skill effects their ability become resilient and engage in and sustain healthy adult relationships

post-CHM and what is the longevity of the effects of CHM into adulthood (Cleary, 2016; Gorraiz, 2014).

Folger and Wright (2013) conducted a study to clarify how social support affected their ability to establish healthy relationship post-exposure to child maltreatment. The goal of the study was to understand if there was a difference in the establishment of a safe and healthy relationship in adulthood and the reason some women can become resilient to the harmful effects of CHM while others struggle to move past the effects even in adulthood (Folger & Wright, 2013). The focus of the study was the cumulative effects on individuals who experienced multiple types of CHM. A further purpose of the study was to understand if the survivors of CHM perception of family and friend support was a suitable PF not matter the level or intensity of exposure to CHM (Folger & Wright, 2013).

Women and men participated in the study. The authors explored support systems comprised of family and friend as well as the relationship between later life outcomes and the experience of exposure to multiple forms of CHM (Folger & Wright, 2013). The authors hypothesized that since a survivor will most likely experience CHM at the hands of family members, a support system comprised of friends would prove to be a healthier PF than a support system comprises of family (Folger & Wright, 2013).

The finding of the study was there was a significant connection between how the survivor of CHM perceived the support of family and friends and later life outcome of psychological and emotional health specifically regarding depression, anxiety, and hostility (Folger & Wright, 2013). Further found was social support provided protection

from the negative effects, that usually follow exposure to CHM (Folger & Wright, 2013).

However, the findings of the study also revealed social support systems comprised of

friends and family regarding women, only acted as a protective factor for those who

experience less severe forms of CHM (Folger & Wright, 2013). The low effects of social

support for those who have higher levels of CHM may very well be associated with the

fact that individuals who experience higher levels of CHM have little to no support

system; that, drives the need for stronger support systems (Folger & Wright, 2013).

Also found is social support may not be sufficient enough to carry a survivor through the

experience of CHM due to individuals not having a strong social connection when facing

a severe amount of CHM (Folger & Wright, 2013). Meaning, these individuals need to

implement other forms of PFs to evade the effects of CHM and build resilience

successfully. Whereas with men, if they had a substantial social support system

comprised of friends, they were less likely to experience the severe consequences of the

effect of CHM regarding depression and anxiety. It was found, social support generally

acted as a protective buffer against the negative outcomes of CHM (Folger & Wright,

2013). Further, no matter the severity of the CHM social support was found to combat

psychopathology and emotional health such as depression and hostility (Folger & Wright,

2013).

Interestingly found for both men and women, was the effects of CHM interferes

with the survivor's ability to feel safe and trust those with whom they entered a

relationship (Folger & Wright, 2013). Many times, resulting in survivors of CHM

experience adverse self-perception and negative perception of others, that can result in

dysfunctional thoughts towards relationships enter in adulthood and adversely affect any support systems that the survivor might attempt to establish later in life (Folger & Wright, 2013).

Jaffee, Takizawa, and, Arseneault (2017) conducted a longitudinal study to understand better how women who were exposed to CHM and later established loyal nurturing relationships were safeguarded from undesirable health outcomes in adulthood. A further purpose was to understand what made some women resilient to the negative effects of CHM while other women could not become resilient to the effects of CHM regarding healthy life functioning. (Jaffee et al., 2017). The study included mothers who had a history of CHM, twin children, and who had engaged in intimate relationships before their twin children reached early adolescence. (Jaffee, et al., 2017). The study took place over a 13-14-year period with the participant completing stages of interviews at the 2, 5, and, 7-year marks, with the initial interviews having occurred in the years of 1999-2000.

Jaffee et al., (2017) found women who have been exposed to CHM compared to their counterparts who were not exposed to CHM had a higher chance of experiencing difficulties in the area of mental and physical health. The difficulties reported were an increase in risky behavior, depressive symptoms, and disruption in sleep patterns. Further, found across the study was if the women exposed to CHM were engaged in healthy supportive relationships they were better able to combat the lingering effect of early CHM has on the physical health and mental well-being, compared to those who were not able to establish a healthy support systems post-childhood adversity.

Further, women who desired to establish healthy adult relationships can overcome the adversity of their abusive environment with the implementation of resources outside of the adverse environment (Dalton et al. 2013, Howell & Miller-Graff, 2014; Meyers, 2016). The resources could consist of therapy, connection with the parental unit, and spirituality, to address interpersonal turmoil post-CHM exposure and build better lifelong connections (Burt & Paysnick, 2012; Dalton et al. 2013, Howell & Miller-Graff, 2014; Meyers, 2016).

In Meyer's (2016) study of sibling abuse, it was found some survivors fight to become resilient and break away from the abuser while others will rely on their outside resources or protective factors such as therapy to rebuild a relationship with the abuser as the survivor wants the relationship to remain viable. Past studies have also noted some survivors seeking relief from a life of adversity, tended to build connection through social and community resources, and were better able to develop resilience resulting in a smoother transition into healthy adult relationships and life habits (Burt & Paysnick, 2012; Chandler et al., 2015; Howell & Miller-Graff, 2014; Jaffee et al., 2017; Sperry & Widom, 2013).

**Spirituality and religiosity as a support system.** Multiple studies speak on the importance of social support and internal stability in the form of spirituality. These aspects have been found to support the building of resilience in young adults who were exposed to CHM and are attempting to successfully reach adulthood (Chandler et al., 2015; Howell & Miller-Graff, 2014; Santoro, Suchday, Benkhoukha, Ramanayake, & Kapur, 2015). Past studies have shown a linkage between childhood adversity and

religiosity and spirituality across a lifespan especially during the adolescence years (Santoro et al., 2015). Religious and spiritual beliefs may provide a buffer against adversity experienced in the adolescent years (Howell & Miller-Graff, 2014; Santoro et al., 2015). Further, adversity experienced during the teenage years influences religious beliefs once the induvial reaches adulthood.

Specifically, Howell and Miller-Graff (2014) conducted a study regarding the resiliency of young adults after being exposed to childhood violence. The purpose of the study was to examine how social support such as spirituality, as well as emotional intelligence, help build resiliency in young adults who were emerging into adulthood (Howell & Miller-Graff, 2014). The study included 321 college students between the ages of 18 and 24 who self-identified as victims of childhood violence ranging from community violence to sibling victimization (Howell & Miller-Graff, 2014). The youth in this study reported on average being a victim of no less than nine acts of violence (Howell & Miller-Graff, 2014). Further noted was the young adults who showed the most resilience where those who had a spiritual connection, higher levels of emotional intelligence, and higher levels of support outside of the family unit. The authors noted the more connected the youth is to therapy and spirituality the better the chance of the young adult building resilience functioning and developing into adulthood successfully.

Another study regarding religiosity and spirituality concerning the building of resilience was conducted by Santoro et al. (2015). A quantitative study was conducted to learn about the connection between religiosity/spirituality and CHM in adolescents in India (Santoro et al., 2015). There were 139 adolescents who participated in the study.

What was found is the experience of CHM was significantly connected to the need for participants to connect to a higher power. The authors spoke of religious coping, that was defined as, the feeling of having a high level of well-being due to having a connection to spirituality (Santoro et al., 2015). Female participants were found to be largely connected to daily spiritual experiences as appose to their male counterparts who just wanted to connect to a higher power (Santoro et al., 2015).

Further found was when levels of adversity were elevated there was a greater desire for the participants to draw closer to a higher power (Santoro et al., 2015). Relational spirituality and personal relationships with a higher power have been identified as a PF against depression in adolescent girls (Santoro et al., 2015).

A contrary finding was although religiosity and spirituality act as a buffer against the effects of CHM; when individuals are recurrently exposed to the experience of CHM, a loss of desire to connect to a higher power as well as a loss in religious and spiritual value occurs (Santoro et al., 2015). Individuals experience this lack of desire to connect to a higher power and loss in religious value due to them blaming the higher power for their continuous experience as well as the belief if a higher power existed they would not continue to experience CHM (Santoro et al., 2015). This contradiction was echoed when Waldorn, Scarpa, and Kim-Spoon (2018) conducted a study regarding survivors of CHM struggling with self-esteem in adulthood in relation to religiosity.

Findings of the study revealed religiosity to be a central PF if one is to successfully fight the unfavorable effects of CHM as when practiced daily, religion had been found to reduce the number of traumatic symptoms. However, no matter the form of

CHM, persons who experienced CHM viewed God as a negative entity and struggled more with the relational connection (Waldorn et al., 2018). The discourse for God was due to individuals believing he was punishing them by allowing the abuse to continue, resulting in pushback from religion. The lack of connecting to religion fostered lower levels of self-worth in adulthood. The authors pointed out only a small number of individuals' who have experienced CHM take up practicing religion despite its importance as a PF against the symptoms of CHM.

Collectively, current studies mention the need for the survivor to enlist the assistance of a therapist or counselor to ensure the development  an maintenance of resilience during the time of adversity and once transitioned into adulthood if they are to establish and sustain healthy adult relationships ( see Burt & Paysnick, 2012; Dalton et al., 2013; Meyers, 2016; Maneta et al., 2015; Wright et al., 2013).

One aspect agreed upon in current literature is that protective factors and support systems facilitate increased resiliency functioning in those who have been exposed to CHM (see Howell & Miller-Graff, 2014; Meyers, 2016; Wright et al., 2013; Orbke & Smith, 2013).

**Resilience**

**Development of Resilience**

Resilience is defined as a person demonstrating an ability to succeed in the face of adversity (Bulk & Kobyl, 2015; Chandler et al., 2015; Rutter, 1987; Shastri, 2013; Werner, 1989). One of the most important points to remember is resilience is not a permanent state of being (Shastri, 2013). The level of an individual's 's resilience

fluctuates depending on the level of adversity, and the access individuals have to their support systems or protective factors (Chandler et al., 2015; Shastri, 2013; Werner, 1989). Resilient people are many times characterized as being emotionally stable and having the ability to cope with stressful situations and higher levels of adversity (Ogińska-Bulik & Kobylarczyk, 2015).

One of the noteworthy gaps found is the lack of understanding why some individuals are more successful at maintaining caring and close relationships to include, intimate, social, or familial, as they emerge into adulthood (Cleary, 2016; Wright et al., 2013). The development of resilience helps an individual view the adverse situation from eyes of understanding and build a mindset of perseverance. A survivor's perception of the intensity present in the adverse environment  tends to dictate how they respond to adult relationships post-CHM (Helitzer et al., 2015; Zimmerman, 2013).

Helitzer et al. (2015) conducted a study regarding how those exposed to adverse childhood events (ACE) to have included physical, sexual, and emotional abuse as well as neglect, perceive the severity of the impact of the ACE and how that perception affects the individual's utilization coping strategies when facing stressors in life. The authors set out to understand if an individual's perception had more influence on one's ability to implement coping mechanisms than if the person developed resilience (Helitzer et al., 2015). Further, the goal was to understand if perception had more to do with how the effect of ACE transferred into the survivor's adult life than the development of resilience (Helitzer et al., 2015). The authors further discussed, how each person deals with an adverse event differently, even if two people were exposed to the same adversity

(Helitzer et al., 2015). Therefore, the outcomes regarding how ACE impacts the individual's adult life will vary (Helitzer et al., 2015).

A case study approach was utilized in the collection of data. The authors had participants who identified as having been exposed to ACE, childhood trauma or resided in a dysfunctional household, completed surveys, and in-depth interviews. The tools utilized were the brief cope to determine demographic baselines, the Health, Happiness, Adversity and Mental Health  study, Ace Survey, and a developed interview guide.

What was found is there were two groups, those who continued to perceive the effects of CHM were negatively impacting their adult life, and those who were able to adjust positively to the effect of CHM and perceived no negative impact to their adult life. Further found was both groups at some point utilized adaptive and maladaptive coping strategies when faced with stressors. However, the participants who reported they were currently experiencing negative fallout from the experience of CHM, were found to use more maladaptive means of coping with the effect of CHM. They tended not to seek out coping mechanisms such as building an emotional support system and leaned more towards blaming themselves as well as distancing themselves from others who could provide positive support.

This study links to the current proposed study in that it begins to shine a light on why some women struggle with sustaining health relationship post-CHM. Additionally, the study clarified the difference between resiliency as the reason a person heals from the experience of childhood maltreatment and the how the individual's perception of the ACE impact how the person implements coping strategies and succeeds in adulthood.

So, it would seem learning to develop a positive outlook of the faced adversity in early

onset is imperative to the development of resilience. Werner (1989) stated the foundation

or the factors that drive the need for resilience begins in the infancy stage of

development. Further, how the individual will handle life adversities are realized by the

time the individual reaches high school graduation, and a better understanding of the

individual's level of resilience becomes even more apparent by the time the individual

reaches the age of 30 and has experienced relationships such as marriage (Werner, 1989).

A seemingly daunting task for survivors of CHM is starting the healing process

and gaining a better understanding of the level of intensity in their adverse environment.

Additional struggle on the journey to resilience seems to stem from survivors needing to

comprehend what is needed in their personal situation if they are to develop resilience.

Even more, people going through the experience of CHM need the ability to understand

how resilient they must become if they are to successfully survive the hardship. Meyers

(2016) found when survivors are looking to feel safe and stable; they begin searching for

a connection to self and other as well as they then start to look for a way to reconcile with

the individual who caused the trauma.

**Sacrifice during the development of resilience.** What is noteworthy is that

children may develop resilience in one area of adversity at the expense of another area of

development (Wright et al., 2013). Meaning, those who have developed the capability of

adapting to stressful situations may struggle with emotional issues like depression,

mistrust, or internal difficulties such as low self-esteem and low self-worth (Cleary, 2016;

Dalton et al., 2013; Meyers, 2016; Wright & Folger, 2017). Even more, the struggle

could carry over into how the person deals with life situations in adulthood. Additional findings were no matter how successful a person becomes in adulthood, they still conceal the childhood abuse within, and struggle with facets such as self-esteem and interpersonal relationships (Meyers, 2016; Wright & Folger, 2017) However, their ability to adapt to their situation aids them in gaining success in "other areas of life" (Meyers, 2016).

Despite the deficiency and sacrifices in developmental areas during the development of resilience, if the individual has strong psychological well-being (PWB), emotional carry capacity (ECC), and experiences post-traumatic growth (PTG), it is possible for them to develop the resilience needed to function in healthy relationships (Oginska et al., 2015; Sagone & De Caroli, 2014; Stephens et al., 2013).

**Resilience and the development of PWB, PTG, and ECC.** The thought is, PWB an individual having autonomy, understanding of environmental surroundings, mastering of purpose in life, positive relationships with others, self-acceptance, and personal growth (Sagone & De Caroli, 2014). PTG specifically  an individual's  ability to develop coping strategies that aid an individual in successfully build a positive perception of self, resulting in the increased perception of personal strength (Ogińska-Bulik & Kobylarczyk, 2015). As well as ECC an individuals'sability to express emotion, that inevitably facilitates relational closeness and heightened resilience (Stephens et al., 2013) has much to do with an individual's ability to develop resilience and find the positive outcome in life postraumatic experiences.

Sagone et al. (2014) completed a study that included middle-aged to late adolescent children to better understand the connection between PWB and the

development of resilience. Oginska et al. (2015) provided in-depth information regarding the connection between PTG, resiliency, and an individual's ability to use a traumatic situation to find the positive in life and Stephens et al. (2013) studied how emotional expression links to the deployment of resilience. It should be noted; although these studies focus on the development of resilience after trauma,  the information and findings should be interpreted with caution as an understanding of the role of gained resilience is still absent. Specifically, these studies do not address how the development of resilience helps women sustain healthy adult relationships post-CHM, which was the focus of this study.

**Psychological well-being (PWB).** Sagone et al. (2014) conducted a quantitative study on PWB in adolescents. Sagone et al. described PWBas an individual having the autonomy, understanding of environmental surroundings, mastering of purpose in life, positive relationships with others, self-acceptance, and personal growth (Sagone & De Caroli, 2014). It should be noted the adolescents in this study were not described as having faced CHM, so the findings should be interpreted with caution. However, the concept of PWB speaks explicitly to the successful development of resilience and establishing a healthy relationship with others if one can find the positive aspect of their trauma. Therefore, one could assume if survivors of CHM established a healthy PWB they are in a better position to develop resilience in the face of adversity.

A significant and positive connection was found between PWB and the development of resilience. The findings of this study revealed if middle adolescent females ages 14-15 years were able to select their protective factors or system of support,

they tended to have a higher level of resilience, which resulted in a higher level of self-confidence and a positive thought process of life (Sagone & De Caroli, 2014). It was noted when girls in this specific age group felt they had control over life outcomes; they developed better relational connections with others (Sagone & De Caroli, 2014).

Mehring (2017) specifically viewed the role the relationship with a father had on his daughter's emotional well-being and ability to successfully move into adulthood post-CHM exposure. Additionally, examined were the roles such a relationship had on individual's s ability to maintain healthy emotional well-being (Mehring, 2014). Information was gathered from 202 emerging adults. The compensatory and protective models, that are derived from the resiliency theory drove the study. The purpose of the study was to understand how the paternal relationship affected survivors of CHM emotional well-being (Mehring, 2014).

The findings of the study revealed a survivor of CHM as a higher level of emotional well-being when they were exposed to a healthy paternal relationship. Participantsreported the paternal relationship had to be direct. Meaning, survivors could not only see the mother and father have a healthy relationship (Mehring, 2014). Survivors had to experience a firsthand healthy relationship with the father and a healthy relationship with the maternal unit did not suffice in fostering higher levels of emotional well-being (Mehring, 2014).

The importance of controlling one situation during adverse experiences and having a strong paternal connection seems to be of importance in the transition to adulthood for those exposed to CHM. Adults who felt they had control over their

situation during and immediately following an adverse situation expressed the feeling of empowerment to not only help themselves but connect with other individuals (Ogińska-Bulik & Kobylarczyk, 2015; Stephens et al., 2013). Not only does control of one's situation help foster higher levels of resilience, but individuals are likely to have an occurrence of PTG.

      **Post-traumatic growth (PTG).** PTG is specifically an individual's ability to develop coping strategies that aid an individual in successfully build a positive perception of self, resulting in the increased perception of personal strength (Ogińska-Bulik & Kobylarczyk, 2015). Increased positive perception of self leads one to reflect on their desire to have compassion for others and engage in more positive, intimate, and familial relationships as well as having a feeling of control and the ability to adapt to traumatic encounters (Mohr & Rosèn, 2017; Ogińska-Bulik & Kobylarczyk, 2015). Ogińska-Bulik and Kobylarczyk, (2015) conducted a study that included 120 men in the paramedic profession who faced many levels of stress and adversity daily. Although the study only included men, it should be noted that PTG studies been completed regarding women facing adversities such as infertility and cancer and it was found positive planning and positive thought about the trauma foster PTG in those women (Ogińska-Bulik & Kobylarczyk, 2015). In addition, although the study only included men the use of the study lines up with the purpose of the study in that the development of PTG is not only fitting for adults and the process can be applied to children as they transition through the developmental stages and continue to face adversities in adulthood. Further,

understanding PGT may also help understand why some survivors of CHM struggle to sustain healthy relationships due to poor perception of their traumatic situation.

PTG has much to do with planned coping strategies and an individual's ability to develop wisdom due to the experience of CHM and the resulting trauma (Mohr & Rosèn, 2017; Ogińska-Bulik & Kobylarczyk, 2015). When an individual has a positive perception, they have a better insight on how to improve their life situation when facing trauma (Mohr & Rosèn, 2017; Ogińska-Bulik & Kobylarczyk, 2015).Ogińska-Bulik and Kobylarczyk (2015) found a strong relationship between resilience and PTG was found. The experienced trauma could be CHM or other situations such as a loss a close relationship or someone experiencing war (Ogińska-Bulik & Kobylarczyk, 2015). Further found was, resilience can foster the manifestation of PTG and positive change directly or indirectly when one implements coping strategies (Ogińska-Bulik & Kobylarczyk, 2015). Resilience may have a direct or indirect effect on PTG as high levels of resilience may help survivors develop coping strategies, such as planning how to handle the faced trauma (Ogińska-Bulik & Kobylarczyk, 2015).Mohr and Rosèn (2017) echoed Ogińska-Bulik and Kobylarczyk, (2015) in that participants found when they had a positive outlook towards their trauma, they were better able to use positive coping strategies such as the use of PFs in the form of reaching out to friends and family which in turn fostered stronger relational ties.

Mohr and Rosèn (2017) completed a quantitative study with the purpose of understanding the relationship between resilience and PTG. The author's further sough to understand if the use of PFs connected the early exposure to CHM and individuals'

ability to experience PTG (Mohr & Rosèn, 2017). The study consisted of 501 college

student who identified as having been exposed to CHM who were assessed for the

experience of traumatic events and PTG through the completion of self-reporting

questionnaires and surveys. The participants were also assessed for the use of PFs in the

face of adversity, the outcomes of PFs use in adulthood, and the level of hopefulness

(Mohr & Rosèn, 2017).

What was found, was no matter the form of CHM, females reported more abuse

than their male counterparts. Further 48% of the participants reported exposure to

multiple types of abuse. 91% of all participants reported experience PTG to include

relying on friends and family, having more trust in others, feeling compassionate, and

found they were more likely to build stronger relational connections. Furthermore, 52%

of participants disclosed experiencing PTG and utilizing PFs such as connection with a

mentor, accepting the incident of CHM occurred, and seeking of emotional support; all of

which increased the survivor's chance of experience PTG.

**Emotional carry capacity (ECC).** Resilience is also an indication of  an

individual's ECC. ECC is an ability to express emotion, that inevitably facilitates

relational closeness and heightened resilience (Stephens et al., 2013). The understanding

of emotional expression is an important key point in the understanding of the

development of resilience (Stephens et al., 2013). Stabilization of an individual's

emotional capacity proves important if a person desire to successfully sustain healthy

relationships. Research has found the development of resilience depends on the

survivor's interpersonal relationship as well as the survivor's ability to connect with

others, connections that could be jeopardized should the person's ECC lack stabilization (Stephens et al., 2013). The possibly jeopardized connection would include but would not be limited to familial, connections in one' social community as well as internal connections to self (see Dalton et al., 2013; Sagone & De Caroli, 2014; Mehring, 2017; Stephens et al., 2013).

Seemingly, the presence of PWB, PTG, and ECC significantly drives how individuals gauge the intensity of their environmental adversity, but also their personal growth and the hope they hold out for the future ( see Oginska et al., 2015; Sagone & De Caroli, 2014; Mehring, 2017; Stephens et al., 2013). The argument could indeed e made that if people lack a feeling of higher resilience at the middle adolescent developmental stage, then the transition into late adolescent and adulthood relationships could result in unwelcomed outcomes.

**Not developing resilience.** Upon reviewing past and current studies, it has become evident individuals  usually works to protect their wellbeing through the development of protective factor and resilience when faced with an adverse situation such as CHM. The focus of this study was to understand what an individual does with the gained resilience when attempting to engage in and sustain healthy and viable relationship post-CHM. However, a disservice would exist if the question was not raised regarding the lack of resilience and entering adult relationships post-CHM.

Studies from Werner (1989) to more recent studies Mehring (2017) and Orbke and Smith (2013) have made mention that not everyone becomes resilient even though they have experienced CHM. The question then becomes, do these individuals just not

move forward in life and avoid adult relationships, and if they do pursue adult

relationships are those relationships successful or do individuals who were not successful

in adapting to adversity fail at every adult relationship attempted post-CHM? A more

pressing question arises which is, have individuals fail to gain resilience or are there life

situations that prevented individuals from successfully adapting at the time of the

aversion? Meaning, was there a delay in the manifestation of traumatic symptoms as well

as the showing of resilient qualities?

What is known is when individuals are faced with adversity they are usually

dealing with multiple risk factors such as poverty, CHM, and other social or

environmental situations (Holmes et al., 2015; Werner, 1989). When multiple RFs are in

play, the experienced adversity not only affects the current situation but spills into other

developmental stages. That spillage makes the prognosis for the development of

resilience and sustainable relationships poor (Maneta et al., 2015; Wright et al., 2013).

Therefore, the prospect of individuals becoming resilient is fleeting until the number of

RFs dissipate, and the individual feels in control of and safer in their situation (Wright et

al., 2013). What has been gathered from the findings is while the RF are high one has

difficulty accessing the PF, which are usually called upon to help with the adaption to a

stressful situation.

As covered in earlier sections, it was established individuals need a connection to

support systems outside of the adverse environment to become resilient. Further, if those

PFs or support systems are interrupted they must be repaired before the person can

resume their status of resilience (Chandler et al., 2015; Dalton et al., 2013; Howell &

Miller-Graff, 2014; Maneta et al., 2015 Meyers, 2016; Wright et al., 2013; Werner,

1989). So, it could be assumed the absences of PFs and support systems disable

individuals from becoming resilient which in turn affects and individual's ability to

maintain positive relationships (Wright et al., 2013). However, there appears to be a

contradiction in presented literature in that other studies have stated if RF increases so do

the use of PF, that increases one resilience level allowing PF to outweigh RF (Holmes et

al., 2015; Werner, 1989). Belief could be had  the above information only applies to those

who have not been able to establish PF, therefore, voiding the possible contradiction.

The lack of developing resilience clearly does not lie in the hands of the one

experiencing the adversity. The number of RFs faced by the individual alongside the lack

of access to support and resources outside of the familial environment should examine in

detail (Cleary, 2016; Folger & Wright, 2013; Jaffee et al., 2017; Maneta et al., 2015;

Ogińska-Bulik & Kobylarczyk, 2015). Doing so will aid in better understanding of the

individual is indeed incapable of developing resilience or has a delay in the manifestation

of resilient qualities (Orbke & Smith, 2013; Wright et al., 2013).

Studies continue to find individual struggle with becoming resilient when they are

overwhelmed with adversities and have complications connecting to the proper support

systems or lack the proper coping skills to deal the faced adversity (Cleary, 2016;

Helitzer et al., 2015; Wright et al., 2013;). Several studies, Brinkerhoff, (2017), Mehring,

(2017), and Orbke and Smith (2013) brought to light the fact that not everyone who has

been exposed to CHM is faced with negative life outcomes. However, those same studies

point out only a fraction of the total population of abused children develop resilience

(Brinkerhoff, 2017; Mehring, 2017; Orbke & Smith, 2013).  Brinkerhoff noted only 10% to 20% of those who were exposed to CHM reported not experience negative life outcomes. Mehring reported only one fourth to one half of the individuals exposed to CHM have will attain some level of resilience post-CHM. Orbke and Smith  reported only one third of the CHM population would develop resilience.

Further found, a disparity in proper connection with the parental unit hinders an individual's ability to connect to those important PFs which have proven important in the establishment of resilience. (Cleary, 2016; Orbke & Smith, 2013; Wright et al., 2013). If the parents are nonstable due to mental illness, substance abuse, or health or social factors, that impedes the individual's parents from being the first line of support (Orbke & Smith, 2013). A person in the childhood developmental stage and even later stages will develop a feeling of unworthiness and struggle to maintain other relationships and appear to be resilient resistant (Orbke & Smith, 2013).

**Functioning in Relationships Post-CHM:**

The purpose of the study was to understand the role of resiliency in the life of women who have been exposed to childhood maltreatment, and how resiliency later affects other relationships the individual may enter. One area not readily covered by current research is what position gained resilience holds in the success or failure of relationships once the survivor is ready to engage in relationships post-CHM. Meaning, from childhood to adolescence, to adulthood, how does the establishment of resilience or the lack of ability to develop resilience affect the survivor's ability to function in relationships? Unfortunately, the studies on this subject remain limited. What is known is

the need to understand what age the CHM occurs, as early onsets of CHM have been found to produce a higher probability of individuals struggling to build lifelong and substantial relationships (Savla, Roberto, Jaramillo-Sierra, & Gambrek, 2013).

Savla et al., (2013 Conducted a study with the purpose of examining if the experience of childhood abuse and adversity affected the survivor's ability to remain emotionally attached to family in middle and later years of life. Secondly, the goal was to understand if survivors could be protected from the effects of early adversities one's if they had access to psychological resources and had stable personality traits (Savla et al., 2013).

Both men and women participated in the study as the authors wanted to understand if gender and age played a role in how individuals were affected by CHM and adversity (Savla et al., 2013). The men and women were either middle age which was identified as 35-49 years of age or older adult which was identified as 50 to 74 years of age (Savla et al., 2013). A total of 2,485 individuals participated in the study and fit into one of the age categories (Savla et al., 2013). Self-reporting of family history of abuse and adversity was utilized as well as the "National Survey of Midlife Development in the United States (MIDUS)" (Savla et al., 2013, p. 388). An Ordinary Least Squares regression was implemented (Savla et al., 2013). How emotional and physical abuse affected the perception of family closeness on the emotional level was examined (Savla et al., 2013).

It was found no matter the age midlife or older life the experience of CHM lingers and effects how individuals operate in relationships throughout life as early CHM has

snowballing effects (Savla et al., 2013). The effects of CHM not only damage the Familia

relationship but trickles into other interpersonal relationships. Further found is there was

no connection between the experience of CHM and emotional connections to one's

familial unit (Savla et al., 2013). The authors speculated this result could be due to the

examination the number of adversities and not type of adversity.

**The Effect of CHM on Relationships.**

What is known is women who have experienced childhood abuse not only endure

emotional suffering but experience discomfort on a psychological level while attempting

to establish healthy functioning relationships (Maneta et al., 2015; Riggs et al., 2011).

The discomfort experienced by women exposed to CHM tends to present as an internal

battle. A battle which includes insecure and avoidance attachment, as well as

interpersonal turmoil such as attachment anxiety as a result of emotional abuse in

childhood, which in turn obstructs their ability to sustain healthy and problem free adult

relationships whether intimate, familial, or social  (Dalton et al., 2013; Maneta et al.,

2015; Riggs Riggs et al., 2011).

To better comprehend the role of resilience in the life of women exposed to CHM,

one must first understand how survivors make sense of or perceive their abusive

experiences. Particularly in the realm of interpersonal relations in that trauma has a large

effect on how a person behaves when in a relationship (Helitzer et al., 2015; Meyers,

2016).

Savla (2013) pointed out that when CHM occurs early on in life, the adversity is

likely to have a devastating effect on how survivors of CHM establish and maintain

relationships whether intimate, social, or familial. Exposure to CHM open individuals to the experience of psychological, emotional, and interpersonal complications causing lifelong difficulties when attempting to establish relationship post-adversity (Helitzer et al., 2015; Savla et al., 2013). Early exposure to CHM has also been found to impend upon individuals' deployment of proper social skills also resulting in hardship when survivors of CHM are attempting to establish adulthood relationships (Savla et al., 2013)

**Intrapersonal difficulties.** It has been recognized, problems such as low self-esteem and disconnects from others are established in the middle adolescent developmental stage when the survivors of CHM may not have felt in control of self, or the establishment of support systems during the experience of CHM (Sagone & De Caroli, 2014; Write & Forbes 2013). Which in turn resulted in survivors of CHM not having high hopes for the future, having the unstabilized emotional capacity, and a lower level of resilience; therefore, jeopardizing established adult relationships (Oginska et al., 2015; Sagone & De Caroli, 2014; Stephens et al., 2013).

One important note, in the process of examining the journey of women who are attempting, who have been successful in, or who have failed at successfully healing from the experiences of CHM is, not everyone handles the crisis in the same manner and an individual 's response to CHM is no different. Some will successfully develop resilience and adapt to the maltreatment and successfully transition into adulthood relationships without a missed step. On the other hand, some will stumble along the way and will have a constant fight with self, which will hinder interactions with others (Orbke & Smith, 2013; ).

What research is largely lacking is explaining which individuals successfully develop resilience and which individuals do not. Questions such a why some are resilient against the effects of CHM and why others are not (Cleary, 2016) remain unanswered. Most studies make it clear that if individuals have a successful support system in place, there is a greater chance for the development of resilience. (Brinkerhoff, 2017; Dalton et al., 2013; Helitzer et al., 2015; Meyers, 2016).

Past studies have shown a need to examine the mechanisms which link early maltreatment such as childhood emotional abuse (CEA) or siblings abuse to women's ability to develop resiliency and sustain healthy relationships (Maneta et al., 2015; Meyers, 2016). The need for further examination stems from the effects of CHM, having been found to leave the survivors combating; attachment anxiety, low self-confidence, absence of a stable foundation, good self-esteem, a sense of self-worth, depression, and fears of abandonment, which interfere with their ability to sustain healthy relationships even if they were able to positively adapt to the adversity of CHM (Maneta et al., 2015; Riggs et al., 2011; Wright & Folger, 2017).

Due to fighting with their self-doubts, survivors of CHM tend to experience difficulties with accurately reading the emotion of the partner and being empathetic towards those with whom they enter relationships (Maneta et al., 2015; Wright & Folger, 2017). Survivors of CHM often view others as untrustworthy or feel other's to be overly demanding, cruel, feel others will judge them based on their past experiences and take advantage of their vulnerabilities. (Dalton et al., 2013; Riggs et al., 2011; Wright & Folger, 2017, 2013). The survivor also tends to look for validation of their actions and

even feelings, which many times leaves the door open for the emotions of trauma to be

triggered, running the risk of harming the relationship (Dalton et al., 2013). The reason

for this potential harm results from the survivor's insecurities, inability to establish strong

emotional bonds with others, lacking an ability to regulate emotions and inability to adapt

due to negative coping responses (Dalton, 2013 ; Riggs, et al, 2011 Stephens et al., 2013;

Wright & Folger, 2017, 2013) all of which are discussed in detail in later sections of the

chapter.

 **Lack of relational stability** Multiples studies have demonstrated the connection

between CHM and women having difficulty sustaining emotional and intimate

relationships in Adulthood, and also having elevated difficulty when entering adult

relationships compared to their counterparts who have not experienced CHM (Chandler

et al., 2015; Dalton et al., 2013; Riggs, et al., 2011; Stephens et al., 2013; Shastri, 2013;

Wright & Folger, 2017, 2013). CHM  has been found to correspond with the presence of

instability in adult relationships to include problems in the areas of intimacy, conflict

resolution,  as well as the ability to self-regulate when faced with undesired situations

(Riggs, et al, 2011; Wright & Folger, 2017). The likelihood individuals would experience

relational struggles increase post-CHM specifically if they experienced weak connections

on the familial and community level in childhood (Ogińska-Bulik & Kobylarczyk, 2015;

Shastri, 2013). Additionally, how the person gauges the intensity of the abuse will dictate

how resilient they become and how successfully they transition into and function in later

relationships. (Dalton et al., 2013; Helitzer et al., 2015).

Dalton et al., (2013) endeavored on providing an understanding of the importance of therapy which addresses the interpersonal turmoil of women who have survived childhood abuse and who are attempting to establish trust in an adult relationship. What was found in the conducting of the study was that emotional focused therapy (EFT) was a fitting and supportive intervention for couples where the woman partner had experience CHM (Dalton et al., 2013). EFT suggested as a specific form of therapeutic intervention to address the intimate problems that stem from the experiences of childhood abuse of the female partner (Dalton et al., 2013). EFT assists the individual who had experienced CHM in successfully facing interpersonal sequelae, which allows the couple to shape a strong relationship built on trust (Dalton et al., 2013).

The study was comprised of 24 couples which were either assigned to a treatment group or control group. What was found was a connection between childhood abuse and the ability to establish and maintain emotionally gratifying adult relationships (Dalton et al., 2013). Further noted, couples who engaged in EFT noticed a noteworthy decrease in relationship distress (Dalton et al., 2013). The conclusion of the study was females in the treatment group who experienced childhood abuse could benefit from EFT to deal with the effects of childhood abuse, which leaks into the foundation of the survivor's ability to successfully function in relationships post-CHM (Dalton et al., 2013). Meaning, many times the effect of CHM whether interpersonal or intrapersonal such as lack of trust in self or other, causes individuals to struggle in adulthood when attempting to engage in relationships (Cleary, 2016; Dalton et al., 2013; Meyers, 2016; Wright & Folger, 2017.

How individuals perceive the adverse situation impact how the person implements coping strategies and the level of success of relationships in adulthood. (Helitzer et al., 2015). Meaning, if the person views the impact of the abuse has devastating, then they will experience difficulty utilizing the developed resilience (Helitzer et al., 2015). Whereas, if a person perceives the impact to be manageable, the individual will more than likely successfully implement developed coping skills and experience a level of success in relationships (Helitzer, 2015; Stephens, 2013). The implemented coping skills are manifested in serval ways, as an individual's ability to find the positive in the situation, connecting with a support system, or successfully dealing with intrapersonal turmoil's, which tend to allow for better connections with other individuals (Stephens et al., 2013).

**Memories of CHM** Further, understood is women's childhood memories have a substantial effect on their ability to properly attach romantically to her partner, and that CHM has a long-lasting effect on adult relationships many time resulting in the relationship experiencing undue stress (Helitzer et al., 2015; Riggs, et al, 2011,). Most current studies point to the fact of a connection between childhood abuse, and the inability to establish and maintain emotionally gratifying adult relationships have been noted. (Dalton et al., 2013; Wright & Folger, 2017, 2013).

Many women who have experienced CHM have a challenging time finding gratification in relationships entered in adulthood, due to not being able to find comfort in a relationship (Dalton, 2013; Riggs, et al, 2011,). The lack of comfort results from the survivor experiencing difficulty with expressing emotions or talk about the past (Goff et

al., 2006; Riggs et al., 2011). The lack of capability to speak about the trauma of the past could lead to an unknowing partner accidentally reintroducing trauma, which might cause the survivor to switch into protective mode utilizing protective factors that could be damaging to the relationship as a whole due to the survivor carrying the residual effect of the trauma into the relations. (Meyers, 2016; Riggs et al., 2011; Savla et al., 2013). Goff et al., (2006); Mantea et al. (2015); and Riggs, et al, (2011), conducted studies which address how CHM tends to transfer into the relationships of adulthood and effects the satisfaction levels.

Goff et al. (2006) conducted a study to understand the effects history of trauma had on an intimate relationship. The participants of the study were 17 couples where at least one partner had a history of trauma exposure. The study did not focus on one particular type of trauma (Goff et al., 2006). Due to the lack of the specification of trauma type, the results of this study should be interpreted with caution as applied to the proposed study. The study focused on interpersonal functioning relationships of people who have survived the trauma and the secondary trauma experienced by the partner or family (Goff et al., 2006).

It was noted the secondary trauma could present in the way of, decreased communication, supportiveness and even increased problems within the relationship (Goff et al., 2006). The authors found even if the trauma survivor fails to disclose past trauma to his or her partner, the trauma could still manifest in the relationship should the partner unknowingly trigger the survivor. The authors further found that past trauma has a large effect on the interpersonal relationship and heavily affected how the trauma-

exposed partner functioned in the relationship (Goff et al., 2006). Although the study did not focus specifically on CHM. The findings apply to the current study in that CHM is a form of trauma has been shown to affect individuals ability to successfully function in adult relationships (Dalton et al., 2013; Meyers, 2016)

Manteaet al. (2015) Conducted a study to examine the association between histories of childhood emotional abuse (CEA) and an individual's current satisfaction with her adult intimate relationships. Mantea et al.also set out to examine whether a partner's ability to accurately read his or her partner's negative emotions was linked to childhood emotional abuse and current marital satisfaction. The study included 156 couples who identified with and experience of childhood emotional abuse. The authors utilized a dyadic approach, survey tool, and recordings of the couple's reaction to one another's response to questions to collect data. The findings of the study proposed a person's experience of CEA relate to an individual experiencing difficulty with accurately reading the emotion of the partner and being empathetic. Further, a partner's inability to properly read the emotions of the other partner attributes to the connotation between CEA and adult marital dissatisfaction.

Riggs et al. (2011) conducted a study regarding how childhood emotional abuse affected a woman's ability to connect with her partner. 155 couples with the woman identifying to have experienced childhood emotional abuse participated in the study. The childhood trauma questionnaire as well as the experiences in close relationships, and the Dyadic Scales tools were utilized in the collection of the data. The conclusion of the study was, a woman's childhood memories have a substantial effect on her ability to

properly attach romantically to her partner, resulting in the relationship experiencing undue stress. The author provided information as to how further researchers could better explain the connection between childhood emotional abuse and issues with adult attachment.

Although trauma has a large effect on how a person operates when in a relationship (Goff et al., 2006), having knowledge that trauma pulls on one's ability to enter relationships and successfully sustain said relationships, superficially explains the struggles women face as they are attempting to move forward in the healing process. The superficiality is based on the fact that not all women fail to sustain healthy relationships post CHM even though they may struggle with intrapersonal difficulties.  In fact, past studies have shown persons with heightened levels of resilience tend to successfully rebound after experiencing trauma and have a better opportunity of entering a successful relationship (Howell & Miller-Graff, 2014; Ogińska-Bulik & Kobylarczyk, 2015; Sagone & De Caroli, 2014; Stephens et al., 2013). However, the question remains if a resilient person still struggles to function in a relationship how or why does the development of resilience matter? One area not readily covered by current research is how the establishment of resiliency affects the survivor's ability to function in relationships. Although current research answers how one gains resiliency in the face of adversity, the question remains, what is the influence of resiliency, in the healing process for survivors, as survivors struggle deeply with emotional issues and adult relationships associated with their exposure to CHM (Meyers, 2016).

## Research Methods

An interpretative phenomenological analysis (IPA) was used for this study used. IPA involves a detailed examination of the participant's world and is concerned with understanding the phenomenon from the personal perspective of the participant as well as gaining a better understanding of how the experience shaped their lives (Roberts; 2013; Smith & Osborn 2007; Pretkiewicz & Smith 2014). While there were no studies found on how resilience helps women who were exposed to CHM heal and sustain healthy adult relationships, many studies have utilized IPA as their methodological choice, when examining how individuals were affected by phenomena regarding healing and being resilient post-CHM.

Through the use of IPA methodology past studies have acknowledged several themes associated with the healing process post-CHM, such as reaching a breaking point, Facing the mirror (facing self), self-nurturing and feeling gratitude for oneself (McCormack & Katalinic, 2016). McCormack and Katalinic (2016) conducted a study which focused on adult survivors of CHM discussing how a support group aided in the ability to not self-blame and still heal from past trauma even in adulthood. Vilencia, Shakespeare-Finch, and Obst (2013) conducted a study which focused on healing post-child sexual abuse and noted the following themes: beliefs about the world and others, turning point associated with healing, and being able to validate one's self through self-disclosure. Additionally, Moheby- Ahari (2014) identified the following themes: Social supports, and emotional regulation strategies. Although the studies mentioned above are not specifically focused on the intended phenomena, the studies hold relevancy in that the

found themes acknowledged, need for healing post-CHM. The studies described how each participant viewed the need to move forward successfully and not blame self for the occurrence of experienced abuse.

## Summary and Conclusions

Comprehensively, the current literature has identified a relationship between CHM and the development or lack of development of resilience. However, the available literature had limited information regarding how resilience helps women sustain healthy relationships Post-CHM. In fact, to this point, many inferences had occurred. Meaning, while reviewing the current literature, when appropriate the findings were generalized to fit the need of the proposed study. The lack of information seemingly presents the notion of healing and sustaining of healthy relationships can be obtained if the person has a proper support group (Brinkerhoff, 2017; Burt & Paysnick, 2012; Chandler et al., 2015; Howell & Miller-Graff, 2014), as well as lack of those same supports, indicates and instant inability to function successfully in relationships (Wright et al., 2013).

Yes, the current literature has proven useful in identifying themes which helped justify the chosen methodological approach of the current . However, the current literature seems to create more questions than provide answers. By speaking with women who have been successful in relationship post-CHM as well as speaking with women who struggle to maintain healthy relationships, the current study filled the research gap. In the next chapter, I discuss the methodology, setting, sample, instrumentation, and analysis.

Chapter 3: Research Method

**Introduction to Methodology**

The purpose of this study was to understand the role of resilience in the life of women who have experienced CHM and how gained resilience later affects their adult relationships, whether intimate, social, or familial. With this qualitative study, I aimed to further understand how resilience influences the healing process and women's ability to maintain healthy relationships while struggling deeply with emotional issues associated with their exposure to CHM (see Meyers, 2016). Researchers have also found not everyone becomes resilient in the face of adversity, meaning they are not able to adapt positively to their adverse environment (Shastri, 2013). Such findings seem to contradict other researchers that reported an individual overcoming the adversity of their environment is possible even for adults who were not able to develop resilience in childhood due to stunting of their emotional development if external resources, such as therapy, are implemented. (Howell & Miller-Graff, 2014; Meyer, 2016; Orbke & Smith, 2013). This study was guided by the resiliency theory. In this study, I interviewed women who self-identified as having been exposed to CHM, using IPA as the research methodology.

The methodology of this study is discussed in this chapter. First, the research design and the rationale are discussed, followed by a description of the role of the researcher. Next, I provide a description of the study methodology, then the matters of trustworthiness and the strategy for how the biases of the researcher will be addressed within the study. Finally, relevant ethical considerations are discussed.

**Research Design and Rationale**

I developed the three research questions in this study in the context of resiliency theory, which has two key constructs: the stability of relationships and PFs. The research questions were as follows:

1. All-encompassing research question: How does resilience assist in women's ability to maintain healthy relationships in adulthood, whether intimate, social, or familial, post-childhood maltreatment?

2. How is resilience developed in women who are exposed to childhood maltreatment?

3. How do protective factors utilized by women exposed to childhood maltreatment later affect other relationships the individual may enter?

**Central Phenomena of the Study**

The central concept of this study was women's ability to sustain healthy relationships postexposure to CHM events, such as emotional abuse, sibling abuse, physical abuse, abandonment, and other forms of abuse in childhood. For the purpose of this study, relationships were operationally defined as familial, social, or intimate relationships in which the survivor had or had not successfully engaged in post-CHM. Central to this study was understanding the PFs that aid individuals in the development of resilience and which may or may not affect how a person will function in relationships entered during adulthood (see Dalton et al., 2013; Meyers, 2016; Werner, 1989) as well as the connected RFs, which were defined as social and environmental aversions which may or may not affect individuals exposed to CHM (Chandler et al., 2013; Werner,

1989). Of further importance was understanding how these two facets affect the development of resilience, which is a process that leads to a person's ability to survive their experiences of adversity, specifically exposure to CHM as they transcend through the stages of development (Smith & Osborn, 2007; Werner, 1989).

**Research Tradition**

In this qualitative study, I employed the research tradition of phenomenology, specifically IPA. IPA involves a detailed examination of the participant's world and is concerned with understanding the phenomenon from the personal perspective and report of firsthand experiences of the participant (Smith, Flowers, & Larkin, 2012; Smith & Osborn, 2007). Interpretation of the individual's reported experiences occurs through what is described as a twofold process: The first aspect of the process being the participants attempting to comprehend the happenings in their world, and the second aspect being the researcher attempting to decode the meaning of the experience as reported by the participants (Pretkiewicz & Smith, 2014). In addition, the selected approach allowed me to concentrate on the participants' personal experiences, and possibly uncover hidden meaning in how they expressed how they understood the meaning of their world (see Pietkiewicz & Smith, 2014).

The qualitative research approach is typically conducted to better understand phenomena from the real-life perspective (Yin, 2015). This approach allows for the examination of a specific context in a rich and in-depth manner (Yin, 2015). I collected in-depth and rich data through having flexibility in the research process, including how the participants were engaged. When a researcher uses other methodologies, such as a

quantitative study, there is less flexibility because the use of surveys and existing data are structured and provide a guideline for what information will be collected (Yin, 2015). Whereas, when conducting qualitative research, the researcher operates with more flexibility in how the interview questions are structured as well allowing for the participant to answer the question in the moment and from their perspective(Yin, 2015). . Furthermore, the qualitative inquiry aims to develop theories that are transferable and not generalizable, which allows for persons reviewing the research to find a connection between the findings of the study and their own real-world experience (Yin, 2015). For example, readers of this study may look at their own experiences with CHM and how such experiences have or has not affected their ability to sustain healthy adult relationships (see Yin, 2015).

Current literature has revealed a relationship between resilience and an individual's ability to sustain healthy relationships postexposure to CHM (Cleary, 2016; Dalton et al., 2013; Meyers, 2016). I further examined this topic by using a qualitative method with an IPA design, which allowed for the collection of the participants' perspectives regarding their experiences with CHM and adult relationships (see Pietkiewicz & Smith, 2014). IPA is a design that requires the researcher to directly engage with the participant, which is important when attempting to understand a phenomenon from the perspective of someone who has first-hand knowledge based in experience (Pietkiewicz & Smith, 2014). The selected design allowed for the collection of data from the participants' firsthand knowledge of CHM, which provided insight into intimate details, subtle nuances, and hidden emotions and led to the collection of richer

data, which could have been overlooked if the data were collected via the use of surveys or existing documented data. Therefore, employing a phenomenological methodology was the most suitable approach for this study.

Yin (2015) presented other qualitative designs, including action research, critical theory, oral history, and narrative inquiry. However, I determined that none of these designs were appropriate for this study. Action research is used in the solving of immediate problems, which was not a fit appropriate for the aims of this study. Since the purpose of this study was to understand and not critique the role of resilience, critical theory was not an appropriate option. Although oral history and narrative inquiry would have allowed me to gather information regarding the participants' history and experiences, those methods do not allow for a deep examination of the meaning of participant responses. For these reasons, a phenomenological study of resilience and healthy adult relationships post-CHM was the most suitable approach.

## Role of the Researcher

As a researcher who has been exposed to CHM, I am fully aware of my existing biases regarding the topic. I have developed resilience and survived what seemed to be one hellish event after another. I entered this study knowing I had to check my biases and remain open to the stories I heard as the journey of each woman was different and the outcomes varied. Biases were checked through my understanding that my role was to listen and ask questions that allowed the participant to answer with profound and rich responses without being guided to the response I wanted to hear. Above all, biases were checked through my understanding that my role was to find answers to the question at

hand and accomplish that task in a way that left the participant as stable as she was when the study began. I remained aware that some of my bias may have seeped through during the interview process and could have affected the outcome of the study. To prevent the unintentional application of biases, I phrased the interview questions in a manner that was impartial and nonleading.

As a solitary researcher, I was the principal tool in the data collecting process, which is the common practice when conducting phenomenological research (see Pietkiewicz & Smith, 2014). As I was the only researcher of this study, I conducted the interviews with the participants either via telephone or Skype, depending on the location and distance of the participant. Each participant selected a location that was comfortable for her.

I was also the person examining the data and presenting the results. While examining the data, I ensured I saw what was presented and did not interject my own opinion. The examination of data was where I most certainly ensured biases did not seep into the process. I remembered these were not my experiences, but the personal and intimate experiences of those who agreed to participate in the study, and that they were being used to help better understand the role of resilience in women's healing process postexposure to CHM.

Qualitative researchers have a requirement to engage the participants of the study interactively. This interactive engagement allowed for a better understanding of the participants' experiences with CHM and adult relationships post-CHM in this study. Due to the requirement of close interaction, it became essential that care was exercised to

properly document my personal views to ensure biases were kept in check during the study as to avoid any unnecessary threats to the research.

To keep control of my biases as the researcher, I remained aware of myself. Through the experience of life, I have learned that without healing, the effects of trauma seep through without warning. My past experiences have educated me that each young girl is affected differently in adulthood regarding relationships. I have seen myself struggle at times in my 24-year long, healthy relationship, and I have witnessed my sisters go through their relationships in a fashion that is foreign to me. I know as I embarked on this journey of understanding what is different from one woman to the next, I may have been biased by my assumptions of what each woman could have or should have done differently. I know this about myself because when I viewed my sisters' relationships, I have found the unknown leaves me with more questions than answers, and I tend to form my own opinion on what could have been done differently in their situations. However, the need for clarification on how three women who grew up in the same environment of child abuse and witnessing domestic violence operate so differently in our adult relationship drove me to study this phenomenon. I had a desire to know how individuals who experienced the same adversaries in childhood can arrive at different outcomes when attempting to engage in adult relationships and wanted to know what can be done to help all girls and women exposed to CHM successfully develop resilience, heal from the trauma, and sustain healthy adult relationships. Keeping a journal allowed me to record my thoughts and/or emotional reactions, which were without a doubt bound

to occur while interviewing the participants. Holding knowledge of my bias assisted in my ability to remove myself and actualize data collection and the resulting interpretation.

## Methodology

### Participant Selection Logic

I used purposive sampling in the selection of the participants in this study. This type of sampling allowed for greater thematic findings and analysis. The participants were all female because the gaps in the current literature called for further examination of resilience from the female perspective.

For inclusion in the study, the participants were required to be women who were 25 years of age and older and who self-identified as having experienced CHM. The reason for the minimum age was the older the participant, the more experience she would have with relationships post-CHM.

Exclusions from the study include college students as the college population saturates the study of resiliency regarding relationships (Howell & Miller-Graff, 2014; Meyers, 2016). Men who have experienced CHM will not be invited to take part in this study as their experiences with CHM may perhaps differ from the female experiences and may not provide a clear and concise answer to the posed research question. Further exclusions were individuals who disclose currently experiencing significant mental health symptoms which means they will find it too distressing to engage in the study. The reason for this exclusion is those with mental health diagnosis are a sensitive population and the chance of reintroducing trauma was high. This inclusion requirement is also be listed in the advertisement which was posted to seek participants and the consent form

Participants were identified through their inquiry to participate in the study. They were contacted by e-mail, and once it had been verified, they meet the criteria for entry into the study they were asked to sign the consent form, once the consent form was signed, participants were contacted via e-mail to schedule an interviewed. Interviews were continued until saturation was reached. One is said to reach saturation when a pattern in the collected data emerges during the interview of participants (Guest, Bunce, & Johnson, 2006). The right sample size must be obtained if one is to reach saturation. The sampled population is too small there is a less likely chance for saturation. Whereas, If the sampled population is too vast one could miss the patterns and therefore collect data beyond necessity and risk overwhelming the dataset (Guest et al., 2006). Guest et al. (2006) suggested minimum participants for the study was six, with a maximum of 12. It should be noted saturation could have been reached at any point during the data collection process.

The method utilized for reaching the desired sample was through social media such as Facebook support groups and Instagram. Further attempted was made to access the sample population through contacting support groups for adult survivors of childhood maltreatment. Reaching the desired population was accomplished through an advertisement, which included a description of the study as well as  my information, and inclusion requirement.

Individuals who state interest in participating in the study were invited to contact me via e-mail. To prevent the assumption of pressure to participate in the study public advertisements were utilized. Meaning, I did not personally approach individuals

regarding the study. The advertisements were placed in support group forums which allowed individuals to inquire about participation in the study freely. Once individuals interested in participating in the study made contact with I, more information regarding the study was provided as well as a consent form and the questionnaire regarding inclusion/exclusion criteria. The consent form and questionnaire can are located in.

Inclusion in the study occurred on a first come first served bases. Meaning, the first individuals to meet the inclusion requirements were chosen to move forward in the interview process. Those who did not meet the inclusion requirements or express interest after the desired sample size had been reached were contacted by e-mail and thanked for their interest in participating in the study and informed the study had reached compacity. Selected participants received an e-mail and asked to digitally sign and return the consent form. Once consent forms were received, the interviews began.

**Instrumentation**

All data were collected from the participant's through semistructured interviews conducted via telephone, or by way of Skype, which was audio recorded for later utilization in the analysis stage with the participant consent . I kept a journal as well as wrote down impressions at the completion of the interviews.

An interview guide was implemented allowing the listing of areas of inquiry, which could have been explored throughout the interview process. Additionally, use of an interview guide as a tool for collecting data allowed a bit of flexibility the low of the interview as well as allowed the participants to feel comfortable while telling their stories and further allowed them to guide the direction of the interview within the bound of the

listed areas of inquiry. Further, Patton (2015) pointed out the process allows for "free conversation." The use of an interview guide served as a reminder during the qualitative interview process as to what needed to be covered to reach the goal of answering the proposed research questions (Yin, 2015).

Questions were developed from current research concerning CHM and the development of resilience. Turner (2010), quoted McNamara (2009) who suggested question posed during a qualitative interview should be open-ended which will allow the participant to provide a wealth of information based upon their experience with the phenomenon. Further, the structure of each question should be such the interviewer can extract rich information from the reported experience of the participant (Turner, 2010). To ensure the comfortability of the participant, I  built rapport through a set of questions which were asked before diving into the researched focused questions. The interview questions as well as the research question they relate to, are listed below:

Initial rapport questions:

1. What is your definition of resilience?

2. At what age did you experience CHM?

3. Tell me about yourself.

Interview questions:

1. What is the role of resilience in women's ability to maintain healthy relationships in adulthood, whether intimate, social or, familial, post-childhood maltreatment?

Will be answered with the following questions:

a. Tell me about your experiences with relationships as you went from childhood to adolescence, to adulthood.

b. How did you view the action of abuse?

c. How do you view the action of abuse now?

d. What aided you in your changed point of view of the abuse (follow-up question if the point of view has changed)

e. How has the experience of abuse shaped your adult relationships whether, intimate, social, or familial?

f. How has your experience with maltreatment affected your ability to trust?

g. How have you overcome the effects of CHM?

2. How is resilience developed in women who are exposed to childhood maltreatment?

   Will be answered with the following questions:

   a. how were you able to work through the trauma of childhood abuse?

   b. What effects if any do you currently feel from your abuse experience?

   c. Who do you believe helped you become strong in the face of CHM?

      i. How did that person help you become strong?

3. How do protective factors utilized by women exposed to childhood maltreatment later affect other relationships the individual may enter?  Will be answered with the following questions:

   a. What coping skills did you develop during the experience of abuse?

   b. How did you develop those coping skills after the experience of CHM?

    c.   Tell me about the support you had outside of the family home and how that support helped get you through the experience of abuse.

    d.   Have your coping skills hindered your ability to sustain healthy relationships

       i.   If yes, how?

       ii.  If no, how have you managed to keep the protective factor from impacting your relationships?

**Procedures for Recruitment, Participation, and Data Collection**

The  method employed for reaching the desired sample was through social media such as Facebook and Instagram. A further attempt was made to access the sample population through contacting support groups for adult survivors of childhood maltreatment. The desired population were reached through an advertisement, which included a description of the study as well as my  information, and inclusion requirement. A consent form was sent to the individuals who qualified to participate in the study  and upon consent, each respondent was assigned an identification number, which was utilized in all corresponding communications between the participant and myself. This method ensured the privacy of each participant.

As the researcher, I collected the data through semi structured interviews which were conducted via Skype or telephone, the interview was audio recorded. The projected time for the interview was no more than 1 hour and 1 half; once the interview concluded, I debriefed the participant and provide a reminder regarding the intended use of the

collected data. Any questions had by the participants regarding the study were addressed during the debriefing. The debrief form can be found in

There may have been a need for follow-up during the study; therefore, the participant was asked if the interviewer could contact them should further need to arise. Additionally, member-checking was utilized to establish the credibility of the collected data and findings and gather feedback from the participants (Yin, 2015). Participants were contacted via e-mail regarding an opportunity to view the summary of their interview to check for accuracy of the documented data.

**Data Analysis Plan**

The strategy was data coding. Data coding is a process which takes place throughout the data collection process and first leads to categories, which are defined and later turn into patterns and themes (Creswell, 2014). IPA guided the coding process which was completed in several stages. Each stage of coding better defined the categories revealing emerging themes (Salsana, 2016). Once all the themes emerged, I proceeded with becoming familiar with and then explain the developed themes (Creswell, 2014) and how the themes answered the research question through the assistance of the narratives provided by the participants. The interviews were recorded and then transcribed verbatim which assisted in the coding analysis process as one is better able to decipher the emerging themes (Salsana, 2016).Analyzing the data began in the interviewing process as the interviewer worked to identify meaning and connection to the all-encompassing research questions as the participants report their experiences (Larkin & Thomas, 2012).

The goal was to present the findings in a way which is clear, concise, and credible (Larkin & Thomas, 2012).

The first step involved reviewing the interview transcripts line-by-line, case-by-case and identifying the emerging patterns (Larkin, 2012). Reviewing of the transcripts assisted the research in better understand the experiences of the participants as well as presenting the data in a manner which highlights the participants as the focal point of the analysis (Larking, 2012).The second step was to document initial findings and begin the coding process of the collected data. This process was vital as it allowed me to become more familiar with the data and pay more detailed attention the nuances of the interview, such as pauses, hesitations in speech, and even nervous laughter. This step also aided in the development of the frame, which demonstrated the connection between themes (Larkin, 2012). Step three was to categorize all emerging themes. The initial findings were reviewed, and all themes which were specifically linked to the lived experiences of the participants were established. Larkin and Thomas (2012) stated that, when conducting IPA, one should first analyze each interview individually regarding themes and then examine themes across interviews. The fourth step was to identify any patterns across all conducted interviews. During this step, the found emerged themes form each of the Interviews containing the reported experiences of each participant was analyzed to understand better how each interview connects to one another (Larkin, 2012). No software was utilized to analyze data.

**Issues of Trustworthiness**

Trustworthiness is a key component in assessing the stability of the study. Trustworthiness included the researcher's ability to clearly address any biases associated with the study as well as any distortions which could have occurred during the execution of the study (Yin, 2015). Further, trustworthiness is based on the need to ensure the collected data an interpretation of the data was completed accurately which helps in the establishment of credibility (Yin, 2015). Even more, Lincoln and Guba (1985) reported, trustworthiness is created when the researcher can establish credibility dependability, transferability, and confirmability.

In this study, trustworthiness was established using multiple methods, to include reflexive journaling, thick description, member-checking, audit trail, triangulation, and prolonged engagement, which is discussed in more detail below.

**Credibility**

Credibility is a key component in the establishment of trustworthiness (Lincoln & Guba, 1985; Yin, 2015). A study which is credible displays the proper collection and interpretation of data (Yin, 2015). This occurs when the experiences of the participants are clearly and accurately presented in the findings and conclusion of the study (Yin, 2015). The establishment of credibility does not begin once the researcher has concluded the collection of data, but upon selecting the design of the study (Yin 2015). Credibility is established by implementing the model of data triangulation, member checking, peer-debriefing, and reflective journaling (Yin, 2015).

**Member Checking.** Member checking is the process of allowing the source of the data review the finding to ensure the information is accurate (Ravitch & Carl, 2016). This can be accomplished by allowing the participants to view a summary of the transcribed interview to assure the information was captured accurately. Ravitch and Carl ( noted Lincoln and Guba stated member-checking is a way to ensure the content is recognizable to the intended audience as "their own realities."

**Peer debriefing.** peer-debriefing is the process of allowing one's peer to view the process of the study and aids in checking any biases and assumptions that maybe had by the researcher, which could affect the how the findings of the study are presented. Lincoln and Guba also stated peer-debriefing is a way for the researcher to "test and defend emergent hypotheses" (Lincoln & Guba, 1985). The peer review was conducted by an ex-coworker who qualified to participate in the study who did not, which allowed for sample validation (Larkin and Thompson, 2012)  and a fellow researcher with whom I had previously worked, both individuals are familiar with qualitative research designs. The makeup of the peer reviewers was one male and one female. The purpose of selecting one male and one female was to ensure the finding was reviewed in a balanced manner regarding gender. Each of the peer reviewers received an original copy of the transcript and findings.

**Reflexive-Journaling.** Reflexive journaling was a way to ensure my biases remain in check through the completion of the study and was a form of "free and open coding" (Larkin & Thomas, 2012, p. 106). Free coding is defined as the researchers collecting their first impressions, which enables them to move forward more efficiently

and dependable (Larkin & Thomas, 2012). The aim is for researchers to keep an open

mind while engaged in the data collecting process and minimize the possible impact of

their biases on the study. The completion of journaling allowed me to improve my ability

to acknowledge my first impressions during the process of data collection, notation of

any emerging patterns, emotional reaction, and potential themes (Larkin & Thomas,

2012).

**Transferability**

To make the transferability of the study clear, Lincoln and Guba suggest using

thick description to ensure a level of transferability. Thick description is the process of

the researcher describing the contextual factors and other properties of the study such as

experience, to build a clear and thorough understating of the data and how it was

collected, which would allow others to decide if the findings apply to their current study

or intended audience (Shenton, 2004). In the study, the experiences of the participants

were clearly documented. This documentation occurred through capturing the nuances

such as any slight pauses or hesitations as the participants are sharing their experiences.

Documenting the described facets allowed readers to not only read the words but

compare their feelings and emotions to those of the participants.

**Dependability**

Dependability is defined as data stability during inquiry processes (Shenton,

2004). Lincoln and Guba (1985) suggested the use of external audits as a check and

balance system when one is attempting to establish dependability of the study. The

process involves allowing a party not connected to the study to review the study and

ensure the outcome of the study is supported by the data (Lincoln & Guba, 1985).

Lincoln and Guba

also noted the process allows the researcher to receive feedback and possible improve the findings due to the ever-changing conditions of the research environment. Shenton (2004) indicated if one can establish credibility they should not be hard press to establish dependability. Dependability in the study encompassed the peer-review process. The individuals who reviewed the data and findings had no connection to the study prior to conducting the review. The completion of a peer-review also allowed the researcher to understand if known biases affected the outcome of the study.

**Confirmability**.

Establishing conformability is important as doing so helps the researcher understand if the findings are based upon the data collected from the research participants or if his or her biases have filtered into the process (Ravitch & Carl, 2016). To establish conformability in the study, I  utilized Reflexivity. Reflexivity is the process of using tools such as memos, research journals, and mapping (Ravitch & Carl, 2016). These tools help the researcher check biases, understand as well as gage the flow and direction of the study (Ravitch & Carl, 2016)

<center>**Ethical Procedures**</center>

Walden University Institutional review board (IRB) approval was required and was obtained prior to beginning the data collection. 10-05-18-0486663 IRB Approval number. The advertisement to participate in the study was placed on a social media platform such as Facebook support groups and Instagram. Candidates of the study were

under no pressure to read or respond to the advertisement request and the researcher had

no relationship with any of the participants. Participants were informed they can

withdraw from the study up to 1week post interview and request any collected data not be

used in the findings of the study.

Explanation confidentiality limitations were provided to each participant and can

be found in the consent form as it is of high importance for each participant to understand

the confidentiality limitations, a verbal reminder of confidentiality limitations was

provided to each participant at the start of each interview. I clearly stated the limitations

of which I could keep disclosed information confidential as it applies to my obligation to

maintain the right to privacy of each participant. The participant was informed privacy

could have been broken should there have been a disclosure of intent to harm self or

others. Further, each participant was informed that due to the confidentiality limitations

and the mandated reporter laws, I would be required to call and file written notification to

the relevant public office, such law enforcement upon disclosure of any of the

aforementioned intents.

Due to the sensitive nature of discussing CHM, there was a chance of

reintroducing trauma due to preexisting emotional susceptibilities such as depression or

anxiety. Some participants may have experience elevated feelings of stress, and anxiety

due to the difficult nature of disclosing personal details regarding their experiences with

CHM. The reintroduction of trauma was not likely since the focus of the study was

resources which helped participant cope with the effects of CHM. However, due to the

nature of the study, mental health resource information and a list of free support were made available to all participants

Participants controlled where, how, when, and they reply to the interview questions. To minimize privacy concerns and ensure levels of comfortability, the participants were strongly encouraged to choose a neutral location for the interview to occur. I encouraged the participants to choose a location that secured their privacy. For the interview that occurred via Skype, headphones were suggested to ensure privacy. In addition, for those interviews occurring via telephone or Skype, the audio was recorded.

The recorded file contains no names or personal information and is only identified by the assigned identification number. To ensure the security of all recorded information, the recordings were encrypted and stored on an external drive when not in use. To ensure every effort to protect the identity of each participant, the identity of the participants will only be known by I. Participants' names or demographic information will not be included to lower the risk of identity exposure. All participants were assigned an identification number under which all related information was stored to include e-mail correspondences in which all identifying information will be removed.

Furthermore, any and all created word document and electronic files were protected with a password on an encrypted storage drive. To ensure the security of all files and documents, the storage drive is locked in a file cabinet in my home office when not in use. The researcher will maintain the data for a total of 5 years at which time the storage drive will be reformatted, resulting in the assured destruction of all data contained on the drive. Other potential ethical issues were considered for this study, but seemed

unlikely to occur, as I did not anticipate any conflicts of interests, and no incentives were utilized.

## Summary

The purpose of this study was to understand the role of resilience and protective factors in the life of women who have experienced CHM and how resilience and the proper use or misuse of protective factors later affects their adult relationships, whether intimate, social, or familial. Chapter 3described the study in detail. The chapter started with a description of the research tradition and rationale, which was followed by a description of the role of the researcher as the primary data collection instrument as well as my personal biases and how those biases will be addressed. Further, the methodology of the study was outlined in detailed. Next, the establishment of trustworthiness was discussed, concluding with an outline of any perceived ethical issues. Chapter Four will provide outline the settings of the studies, the demographics of the studied population, how the data was analyzes as well as the findings of the study.

Chapter 4: Results

**Introduction to Current Study**

Women who have been exposed to CHM are likely to become resilient if they are connected to support systems, such as family and friends, and are exposed to interventions, such as therapy (Cleary, 2016). Women exposed to CHM have been found to develop PFs to aid in the development of resilience; however, it has also been found those same PFs could hold residual effects and prevent women from sustaining adult relationships they enter postexposure to CHM (Dalton et al. 2013; Meyers, 2016). While exposure to CHM has also been linked to women who are unable to become resilient and who continue to struggle through life as a result of being abused in childhood, preliminary research has shown that the introduction of proper support in either childhood or adulthood could foster the development of resilience (Dalton et al, 2013; Meyers, 2016).

The purpose of this interpretative phenomenological study was to gain an in-depth understanding of the role of resilience and PFs in the life of women who had experienced CHM as well as how resilience and the proper use or misuse of PFs later affects their adult relationships, whether intimate, social, or familial. In this study, I also sought to help provide a further understanding of how resilience influences the healing process and women's ability to maintain a healthy relationship in the face of adversities while struggling deeply with emotional issues and adult relationships associated with their exposure to CHM.

The research questions were as follows:

1. What is the role of resilience in women's ability to maintain healthy relationships in adulthood, whether intimate, social, or familial, post-childhood maltreatment?

2. How is resilience developed in women who are exposed to childhood maltreatment?

3. How do protective factors utilized by women exposed to childhood maltreatment later affect other relationships the individual may enter?

The purpose of this chapter was to discuss the current study. I discuss the background of where the study was conducted as well as the demographics of each participant and the data collection procedure. Lastly, an explanation of how the data were analyzed and the study results are provided.

**Setting**

I conducted interviews with the participants that took place via telephone or over the Internet using Skype. Each interview was given a 1.5-hour time slot but were commonly completed within the timeframe of 50–74 minutes, depending on the length of the participant responses with the shortest time being 28 minutes. After participant consents were received the interviews were recorded for later reference during the analysis process. The video for the one interview that took place via Skype was not recorded.

There were no variations or any unusual situations throughout the data collection process that was outlined in Chapter 3. I conducted the study in an environment where I had no previous acting roles and none of the participants were offered any form of

incentive for their participation in the study. To my knowledge, there were no unfavorable conditions present that may have prejudiced participants or their experiences at the time of the interviews and could have possibly impacted the interpretation of the study results.

I conducted each interview in my office where the environment was quiet and secure from any interruption or violation of the participant's privacy. The background was quiet as to ensure the recordings were clear. Each participant chose the environment in which they felt comfortable completing the interview. For the most part, each participant reported being in their home in a room free of distraction and interruption. One participant did have a slight interruption but that did not affect the flow of the interview. One participant reported at the start of the interview that she was in a store environment but that was okay with her because she is proud of her story. That interview concluded while the participant was driving.

### Demographics

The participants consisted of seven adult females who were 25 years of age or older and self-identified as having experienced CHM. The youngest participant was 29 years old, and the oldest participant was 94 years old. Two of the seven participants resided in the United Kingdom, with the remaining five residing in the United States. Five of the seven were or had been married and had sustained long-term marriages. Two of the participants had never been married. The length of the abuse was from birth through early adulthood which was 19 years of age the abuse experienced ranged from

abandonment to sexual abuse. Five of the seven participants experienced two or more

forms of CHM/abuse.

## Data Analysis

The data and themes appeared to reach saturation with the sixth participant;

however, I accepted a seventh participant for confirmation of saturation. The seventh

participant confirmed data and theme saturation. At the conclusion of the analysis

process, five main themes and 13 subthemes emerged.

I used the interpretative phenomenological method, as outlined by Larkin and

Thomas (2012), in the analyzing and coding of all data. Under the guidance of this

method, interview transcripts were analyzed individually. Once each transcript was

individually analyzed, all transcripts were then analyzed together to assess the

relationship between the established data sets. My analysis began with intentional

immersions of self into the data, where I studied the interview transcript multiple times to

confirm the focus of the analysis was aimed at the participant (see Larkin & Thomas,

2012; Pietkiewicz & Smith, 2014). Ensuring the analysis was properly focused also

enabled me to better grasp intimate and important details shared by the participants. The

goal was to not only understand the participants' told experience as an outsider but also

to place myself in the shoes of the participants to better understand the phenomena from

their perspective (see Pietkiewicz & Smith, 2014).

My second step was to make initial notes on the transcripts via comments in an

electronic Word document. Initially, the transcripts were analyzed in separate Word

documents, then all documents were transferred to a macro document. Once transferred

to the macro document, all like comments were sectioned together, which made handling of the data sets more effective. This was the most time consuming and important step of the process as it allowed for an in-depth examination and exploration of language and contextual clues. I developed detailed notes during this step as well as during the interview, which were based on the face value along with pauses, hesitations, metaphors, other descriptive phrases, self-reflection, and the nonverbal emotional communication of the participant (see Larkin & Thomas, 2012; Pietkiewicz & Smith, 2014).

 The third step was to categorize emerging themes. My initial notes including precoding, which was conducted during the process of the interviews, were reviewed to identify any themes that were most directly associated with the lived experiences of the participants. IPA commands that each interview is analyzed individually proceeding the examination of themes across all interviews (Larkin & Thomas, 2012; Pietkiewicz & Smith, 2014)Step 4 proceeded with the identification of any connection between the emerged themes; the connections were found through the use of several strategies including abstraction, comparing and contrasting, and contextualization (see Larkin & Thomas, 2012; Pietkiewicz & Smith, 2014). The use of these strategies aided in connecting the themes as well as assisted in mapping them, which supported the analysis process. The fifth step was to conduct Steps 1 through 4 with each of the transcripts (see Larkin & Thomas, 2012). Step 6 was the final step where emergent patterns across all interviews were identified and identified themes from the experiences of each participant were analyzed for commonalities and relationships.

**Data Verification**

According to Pietkiewicz and Smith (2014), phenomenologists view verification and standards as largely related to the researcher's interpretation. To verify data in this study, I used the procedures of member checking, reflective journaling, and peer review. After the interviews were transcribed, the participants were e-mailed a summary of their responses and themes to ensure their views had been properly captured. This additionally ensured the information was captured and interpreted correctly and helped to obtain additional information for clarification of information provided during the interviews (Ravitch & Carl, 2016).

Upon the completion of analyzing and interpreting the data, I engaged an ex-coworker who qualified to participate in the study but did not, which allowed for sample validation (see Larkin & Thompson, 2012), and a fellow researcher with whom I had previously worked. Both individuals were familiar with qualitative research designs, including participating in the peer-review process, reviewing the data, and ensuring an unbiased analysis of the themes occurred. The peers reviewed the themes to ensure I remained objective during the interpretation process. Completion of the peer-review process aided in checking any biases and assumptions that I may have had, which could have affected how the findings of the study were presented.

**Themes Identified**

Five major themes emerged from the analysis of the interview transcripts: definition of residence, healing properties of time and intervention, issues with trust, the

importance of support systems, giving of self, and the effects of CHM and PFs. From these five main themes, 13 subthemes emerged (see Table 1).

Table 1

*Themes and Subthemes*

| Trauma results in resilience and healing through helping others | Time and interventions heal perception of abuse | Guarding trust to avoid hurt as the effects of CHM lasts a lifetime | Support is key then and now: Family, professional and spiritual | The effects of CHM and protective factors/coping mechanisms intrapersonal PFs effects healthy adolescent and adult relationship |
|---|---|---|---|---|
| -An ability to bounce back<br>-Using the experience of CHM to help others who are exposed to the same experience | - From misplaced blame to no longer blaming self for abuse<br>-Familial and Social support, and acceptance<br> -Residual effects remain in current life | -The rate of trust is either slow or careless<br>-CHM effected Childhood relationships<br>-Have not overcome the effects of the abuse | -When to introduce therapeutic services<br>-Absences of support in and outside of the home<br>-Healing through Familial spiritual connection | -Protective factors and Coping just happened<br>-Developed PFs and coping skills effect relationships |

## Evidence of Trustworthiness

In this study, I confirmed trustworthiness using multiple methods, including prolonged engagement, member-checking, reflexive journaling, triangulation, thick description, and an audit trail. The credibility, dependability, transferability, and confirmability of the study were established through the utilization of these methods.

## Credibility

Credibility is a key component in the establishment of trustworthiness (Lincoln & Guba, 1985; Yin, 2015). In this study, I established credibility through the participants' recognition and acknowledgment of their experiences having been presented clearly and accurately in the findings of the research. Further, the participants' acknowledgment of the shared experiences as the truth of how they knew and experienced the phenomenon also aided in establishing credibility.

To strengthen credibility, I used the following activities: prolonged engagement, triangulation, member checks, and external audits. To establish prolonged engagement, the researcher is required to invest time in awareness and rationalization of any falsifications that may have come about due to the participant experiencing some level of discomfort . The experience of discomfort may be the result of the participant sharing sensitive experiences with an individual considered an outsider to the community (Lincoln & Guba, 1985). To meet this requirement, I spent time building rapport with each participant prior to asking the interview questions. I took the time to share part of my story, letting each participant know that I am a survivor of CHM as well and ensured each participant that no judgments would be made, and they were in a safe and secure environment and situation.

I used reflexive journaling to ensure my biases remained in check through the completion of the study. A journal is a form of "free and open coding" or the collection of my first impressions, which enabled me to move forward more efficiently (see Larkin & Thomas, 2012, p. 106).

This study had several participants whose experiences created a homogenous sample as well as reports from diverse cultural backgrounds and environmental standpoints, resulting in triangulation. Triangulation is the use of no less than three methods or sources to verify and corroborate data and findings and examine phenomena (Yin, 2016). This is a strategy to strengthen credibility and can assist in the development of a comprehensive understanding of the phenomena and experiences presented (Yin, 2016). In addition, member checking was used to evaluate the precision with which I

captured the participants' shared experiences by allowing the source of the data to review the findings to ensure the information is accurate (see Ravitch & Carl, 2016).). Once each interview was analyzed and interpreted, the participants received a summary of their responses and themes via e-mail to ensure their views were properly captured.

**Transferability**

To make the transferability of a study clear, Lincoln and Guba (1985) suggest ed using thick description to ensure a level of transferability. Thick description is the process of the researcher describing the contextual factors and other properties of the study such as experience, to build a clear and thorough understating of the data and how it was collected, which would allow others to decide if the findings apply to their current study or intended audience (Shenton, 2004). In the study, the experiences of the participants were clearly documented This documentation occurred through capturing the nuances such as a laugh, any slight pauses or hesitations has the participants are sharing their experiences. Documenting the described facets will allow readers to not only read the words but compare their feelings and emotions to those of the participants.

**Dependability**

Dependability is defined as data stability during inquiry processes (Shenton, 2004). Lincoln and Guba (1985) suggested the use of external audits as a check and balance system when one is attempting to establish the dependability of the study. The process involves allowing a party not connected to the study to review the study and ensure the outcome of the study is supported by the data (Lincoln & Guba, 1985). Lincoln and Guba  also noted the process allows the researcher to receive feedback and

possibly improve the findings due to the ever-changing conditions of the research environment. Shenton (2004) indicated if one can establish credibility they should not be hard press to establish dependability. Dependability in the current study was encompassed in the peer-review process. The individuals who reviewed the data and findings had no connection to the study prior to conducting the review. The completion of a peer review allowed the researcher to understand if known biases affected the outcome of the study.

**Confirmability**

Establishing conformability is important as doing so helps the researcher understand if the findings are based upon the data collected from the research participants or if his or her biases have filtered into the process (Ravitch & Carl, 2016). To establish conformability in the study, I utilized reflexivity. Reflexivity is the process of using tools such as memos, research journals, and mapping (Ravitch & Carl, 2016). These tools help the researcher check biases, understand as well as gage the flow and direction of the study (Ravitch & Carl, 2016)

<div align="center">

**Results**

</div>

The purpose of this study was to understand the role of resilience and protective factors in the life of women who have experienced CHM, and how resilience and the proper use or misuse of protective factors later affects their adult relationships, whether intimate, social, or familial.

Interviews were conducted via telephone and Skype. The interviews consisted of 19 sub questions developed to reply to each of the three research questions: All

participant samples were through Facebook social media support groups for adult survivors of childhood maltreatment where advertisements were placed. After each participant consented to participate in the study, the time and date of the interview were agreed upon by the researcher and participant. The interviews were generally conducted within a 35-74-minute timeframe depending on how much detail was provided in the response of the participants. Only two of the interviews were less than 50 minutes in duration. The remaining interviews were conducted within 50-74 minutes. The audio portion of each interview was recorded. Sixteen questions were posed to each of the seven participants. After reviewing the content of each transcript several times, five themes emerged:  resilience is the ability to bounce back; time and interventions heal perception of abuse; guarding trust to avoid hurt as the effects of CHM lasts a lifetime; support is key then and now family, professional, and spiritual; healing through helping others; the effects of CHM and protective factors effects healthy adolescent and adult relationships

When working to identify the themes, I searched for patterns phrases in the responses of the participants. The patterns and phrases which emerged most often and fit a particular theme were included in the study. Further, during the process of identifying themes, there were patterns and phrases which were not applied to the main themes and categories. These patterns and phrases are stated as "discrepant findings" and are identified and discussed later in this

chapter.

**What is the Role of Resilience in Women's Ability to Maintain healthy Relationships in Adulthood, Whether Intimate, Social or, Familial, Post-Childhood Maltreatment?**

**Theme 1: Trauma results in resilience and healing through helping others.** Four of the seven participants stated experiencing childhood maltreatment (CHM) helped develop their resilience. P1 stated, "My abuse happened to prepare me to help someone else later in life, so through tears and pain I became strong." P2 stated "The more the abuse, the more resilient I became like I'm going to fight you. I decided nobody is going to take my choice away from me." P7 shared although she only began her journey towards healing resilience in 2014 CHM has "Helped me find the best versions of me."

*Sub-theme: 1.1 An ability to bounce back.* When the participants discussed whether they believed themselves as resilient, all seven women said yes, some with confidence and some with hesitation, which was noted by slight pauses, nervous laughter, and the words "I don't know" proceeding the yes answer. Although the verbiage used to express their understanding of resilience differed, all of the women expressed a need to face fears, let go of the past, accepted that the abuse occurred, go through the worse and still be able to stand strong. One of the most profound answers came from P6 who stated, "Resilience is a bounciness. It gives me the bounceies. It's being able to bounce back after you've been hit. Whether it is the emotional, physical, or, spiritual. It's the ability to pick the pieces up and carry on." P7 stated resilience is the ability to "function on a level that is enough; enough for friendships, relationships and that sort of thing. But, then also spiritually emotionally. Umm, It Encompasses everything."

*Sub-theme: 1.2 Using the experience of CHM to help others who are exposed to the same experience.:*

The participants were asked what aided them in their change in perception, all of the participants were very clear helping others, whether people they did not know, their own children or other family members overcome injustice or to prevent what happened to them from happening to others, not only helped them become resilient but solidified their feeling of resilience. They felt there was no other choice but to accept the occurrence and move forward if they were going to become that proverbial hero.

> *P1:* Talking about my abuse helps me heal. I have learned to step out of
> that shell a little bit and learn to stand up for other people where I wasn't
> able to stand up for myself which is very healing. Umm, I don't know how
> to explain it, because had it not happened to me, I would not have been
> able to help that little girl.

P4: shared,

>  There are times  I would say I feel emotionally strong" where I have
> much resilience considering what I had gone through and considering
> what I have become at this point in my life. I really believe God has
> blessed me with a lot of amazing things. I've had certain influence in my
> work environment to where it's helping children and families.

**How is Resilience Developed in Women Who are Exposed to Childhood**

**Maltreatment?**

To better understand the role of resilience there is importance in understanding how said resilience is developed in the midst of and post the experience of CHM. Not only do we need to understand what helps the transition to the other side of the traumatic event, but there also needs to be a clear understanding as to the residual effects that may sometimes creep back in and cause a slight pause in and individula's ability to remain in a posttraumatic state of existence.

*Theme 2: Time and interventions heal perception of abuse.* Each of the participants was asked their perception of the abuse in childhood and now as an adult, there were mixed feelings and responses regarding who holds the responsibility for the act of the abuse. Six out of seven participants outright stated feeling they were to blame for the abuse. Three of the participants empathized with the actions of the abuser by stating they have an abusive past of their own. One of the participants stated she never thought the abuse was her fault, but later stated if her abuser had not died she is not sure what she would believe. What was largely unanimous was time, interventions, and separation from the abuser caused change to the perception of the abuse. Some of the participants are only just relieving themselves of the blame. Understanding if the participants took on the blame of their experienced abuse and if and when they released themselves from that blame, helped better understand any delays in the fostering of resilience. What has been seen with the responses of the participants, is their development of resilience is spoken in the present. Meaning, when they speak about

feeling resilient, they speak about what they have done in adulthood to reach their level of resilience. Further understood from the responses of the participants, the release of the blame heightened their feeling of resilience.

*Sub-theme 2.1: From misplaced blame to no longer blaming self for abuse.* The participants reported in childhood they believed they were to blame for the actions of their abuser(s). Much of the self-blame reportedly stemmed from them lacking the understanding of why they were experiencing the trauma or from being told their abuse occurred due to their behaviors. However, as the participants grew into adults, the feeling of blame fell off. For some, this process occurred in late adolescence and early adulthood. Where some have recently, within the past 2 to 5 years, began to drop the weight of self-blame. The participants were asked their perception during the time of the abuse as well as their current perception of their experience and if there was a change in their perception what helps them get there.

P6: shared she was told her abuse occurred due to how she behaved "I was taught to blame myself. It happened because I was wrong, I was naughty, and I was bad. They were, they were, punishing me, they were, they were, disciplining me to make me, make me a better person." P6: further shared her current perception of the abuse "My goodness, it's perverted. My stepfather used to get pleasure out of beating me. If they were still alive now, I'm hoping I would have the courage to confront them." P6 further share it took her 52 years to stop blaming herself and that was accomplished through therapy. She said, "It woke me up, it empowered me, it made me stop being a doormat."

P1: shared she blamed herself in childhood and that she felt bad for reporting on the abuser.

> "I felt like, you know like I was punishing him for something that he did, and I don't know why he did it. The more questions asked by adults and the CPS cases, the more I felt reclusive in conversations about it because I felt like I was the one in trouble."

P1: shared her change in perception was "very empowering and very sad all at the same time."

> Three years ago, I changed from victim to survivor to be the voice of a little girl who I had hardly met. Now, even through the tears, even through the pain, even though the struggle, I can see that no matter what, what happened to me shouldn't have happened.

*Sub- Theme 2:2 Familial and Social support and acceptance*

All participants were asked how they were able to work through the trauma of child abuse. Some were able to work through the trauma by way of therapeutic services, some through allowing time to heal the wounds, and some through accepting the act of abuse occurred. No matter the vehicle, each participant was able to say they are living on the other side of the trauma.

> P2: "When I was 12, he told me that I wasn't my brother. I use that as an incentive. I was like, oh, well I'm going to show you. Nothing is going to make me say enough, I give, I quit, not ever. Like, I'm going to come out on top.

P6: "Long pause, well, therapy worked. Therapy started it, talking about it, and acknowledging it. Sitting down with the fear and the pain and facing it instead of avoiding it mmm, because alcohol, I think the alcohol the drugs were just little bandages to avoid having to look at it.

P5: "Umm Accepting It. Actually, just kind of yeah, accepting what I went through."

The participants were also asked who they believed helped them become resilient in the face of CHM. Four out of the seven participants stated outside support helped them reach their level of resilience, while three of the participants stated their belief they help themselves become resilient.

P2:Well, the interesting thing is a lot of it is my mom, which is so wild considering what she came from. My mother always told me, always, from the time that I was, I mean, I can't never remember her not saying; You are wonderful, you are, you know, you can do anything. That was the main thing, you can do anything whatever you set your mind to whatever you want, you are in control of your life."

P3: My uncle, my uncle, he's the big Swedish man who raised me. That man was wonderful. His wife wasn't bad either. My mother's sister. They're the ones that took care of me all those years. If it hadn't been for them I would ever have had the strength to raise my kids like I did. And, from what my children keep telling me, I did a damn good job.

The other participants stated their trauma and self-power caused them to be resilient. The mere fact that they faced a traumatic event is the reason they are resilient. P1: found her

level of resilience in the past three years after her abuser who is her stepfather and her husband's uncle abused the husband's niece and she was subpoenaed into court to testify about her abuse. She shared she had never met the niece prior to being subpoenaed. "I was my biggest advocate. Advocate for standing up for myself and for his niece. So, I think. the trauma made me resilient and the aftermath of the trauma made, me."

>P5: "While going through it, nobody. Yeah, it was very, very difficult to feel like anybody was really there. Umm kind of had to do it on my own. I was a stripper at 13 years old and I was on my own on the street for about a year."

>P6: "You know, I going to go ahead and take the credit for that. With guidance from, from the counselor, and from all the spiritual things, and the medications, and all that ha-ha. But ultimately, I think it's down to yourself. That's the resilience in me, it's the wanting to be alive, the wanting to thrive."

*Sub-Theme: 2:3 RQ 2 Residual effects of CHM remain in current life.*

Participants were asked what if any effects do they currently fell from the experience of CHM. There was not one kind of effect that resonated across the sample, however, what did resonate is the presence of residual emotions from the exposure to trauma in childhood from all seven participants.

>P1: I do. Actually, I do. In the sense of grievance due to the reliving of all the trauma three years ago has brought up a lot of issues in the last three years. So, it's hard for me to sleep at night. I have Post-traumatic

nightmares. Like I relive it, every so often I relive the trauma. If my

husband moves too fast or my husband touches me, or you know, in play

he does something that triggers me I break down.

P6: Hummm, I do, I do feel an effect because I feel a responsibility to, to

be vigilant, to actually watch out for other people for younger people. A

sense of responsibility. I think towards children especially woman of the

future not as a victim, but more as a victor. More of a victor.

P4 "I feel like I could say a couple of effects. There are times that I would say that I can

find myself feeling emotionally fragile.

*Theme 3: Guarding trust to avoid hurt as the effects of CHM lasts a lifetime*

Trust is an important part of building strong and healthy relationships. All seven

participants reported their experience with CHM has caused them to experience issue

trusting others. P1 told me "You know I researched you to make sure you were who you

said before I agreed to participate. I had to make sure you were okay, and I could trust

you."

*Sub-Theme 3.1: The rate of trust is either slow or careless*

Participants were asked how their experience with CHM affected their ability to

trust. All of the participants reported having some level of trust issues which resulted

from their experience of CHM.

P3: I really don't fully trust people. I look for reasons why are they doing

this, why are they doing that and that's not fair. I never opened up like this

to anybody before. I am sharing things with you I have never shared with

anyone.

P6: shared a stance of trust that was cause for pause "Oh, umm, I have trust issues, yes. Scary, (Long Pause) frightening, it is because I always expect to be let down. P5: took a different stance, she believed her experience with CHM caused her to be dangerously trusting.

I feel like because of the things that I went through and how I went

through them. I get to the point where like I'm overly seeking that

confirmation, overly seeking someone to fill those voids so I actually trust

more than I should.

*Sub-theme: 3.2 CHM affected childhood relationships*

The participants were asked to talk about their experiences with relationships as they grew through the developmental stages (childhood, adolescents, and adulthood). All seven participants experience some form of disconnect in childhood and adolescent relationships resulting from exposure to CHM. The disconnect included, but was not limited to, feeling unworthy of relations, interference caused by family dynamic, to the feeling of needing to stand on her own and not wanting to build emotional connections.

P6 stated shared she learned to "color within the lines." She explained that meant she learned to be obedient and do what she was told, to be perfect in the eyes of her abusers who she believed took joy in punishing her,

I was very, very, very submissive. I experienced abuse very early so I

quickly learned to color in the lines. I had an adoration of my authority

figures and was extremely obedient. I believed everything someone in

authority said and blindly followed directions.

P3 stated "I felt I had to stay alone. I had the ability and the strength just on, it was on

me, I was responsible." P7 shared, "As far as I'm concerned, up to the age of 13 I didn't

have those relationships. I was bullied a lot."

*Sub-Theme 3.3: Have not overcome the effects of the abuse*

Overcoming the effects of CHM is a hill many of the participants are still

conquering all seven participants reported they have yet to fully overcome the fallout

from being exposed to childhood maltreatment. When asked if she had overcome the

effects of CHM. P3: stated, "No I don't think I have. I don't think I ever will. I think

something like that follows you through life forever and you always have the questions."

P6I guess. (Long Pause) Ummm, I don't think I'm quite over it yet. But, I

have compacted half the cupboard. We will call it the messy cupboard

where we're going to take everything out, deal with a small part, folded the

rest up, and put it back in, and I'm halfway through. I'm not as emotional

with it now. Umm, I could say at one time I wouldn't be able to sit with

you and have a conversation.

**How do Protective Factors Utilized by Women Exposed to Childhood Maltreatment**

**later Affect Other Relationships the Individual may Enter?**

PFs are mechanisms which are put in place by individuals who are experiencing

trauma to survive an adverse environment and drives the development/implementation of

resilience as well as how a person will function in adult relationships (Dalton et al., 2013;

Meyers, 2016). As evident by the participants' responses, PF encompass environmental supports such as therapy, family and social connections, and religion, all of which have been found to better foster the development of resilience and support an individual's journey towards healthy and sustainable adult relationships (Brinkerhoff, 2017; Chandler et al., 2015; Werner, 1989). The PFs also encompassed intrapersonal protective mechanisms such as withdrawing within self to avoid the outer environment, self-doubt, and the feeling of unworthiness which are identified as the PFs that are uncontrolled reaction of the individual exposed to trauma which seeps into the adult relationships causing the individual difficulty in sustaining those relationships (Cleary, 2016; Dalton et al., 2013; Helitzer et al., 2015; Myers, 2016; Wright & Folger, 2017; Zimmerman, 2013) all of which have been reported by participants.

What was found  through the responses of the participants is,  the reason these PFs have a detrimental effect on relationships later entered by the participant, is because while; the lack of trust, withdrawal into self, easily giving in to avoiding bad consequences, and avoidance of adverse situations was helpful in keeping them safe in childhood; as they enter adult relationships those same PFs tended to push those who try to get close away.

> P1: shared  My husband is my closest relationship. I think it's hard for him to understand why I'm the way I am. And I think it's hard for him to understand why I can't just be open. I've lost friends and I've lost relationships due to just not being able to open up

This outcome is indicative of the participants having not learned how to cope differently in adulthood

All participants reported positive and negative effects of the utilized PFs regarding how they have been able to function in relationships. The effects ranged from not having the ability to sustain healthy relationship whether intimate, social or familial, to maintaining healthy long-term marriages but struggling to let others in the tight circle developed with the immediate family structure. Participants also reported some of the PFs/ coping skills developed in childhood, specifically interpersonal PFs, such as the feel of unworthiness, withdrawing into self, and lack of trust all which lead to avoidance, have seeped into their adult relationships whether intimate, social, or familial causing occasional and in some cases drastic results in the negative direction.

> P7:shared "I married my husband and we've made it, we've made 20 years
> so we're very happy. My other relationships such as friends, I don't have
> many friends. Ummm, I don't trust people. I'd rather just be in a house
> with my kids and my husband, you know."

*Theme 4: Support is key then and now Family, professional and spiritual/ external PFs*

All participants reported either relying on family members to help foster resilience or having participated in therapeutic service whether while in the midst of the abuse or in later years. Based upon the responses of the participants, family, professional assistance, and/or connection to a higher power has much to do with the development of resilience. Six Out of the seven participants reported having received some level of therapeutic services at some point in their journey. Several of the participants questioned

the existence of a higher power asking if there was one, why they had to face the experience of CHM. Some participants reported they later turned to spirituality to find comfort and some stood fast with not being religious or wanting a higher power connection. Although some of the participants take full credit for becoming resilient, at one point all participants reported receiving family support whether to remain strong in the face of adversity or to remain safe in drastic situations.

*Sub-Theme 4.1:  When to introduce therapeutic services*

Six out of the seven participants received therapeutic services whether in childhood or as an adult. Three  out of the seven received therapy only because they were part of the foster care system, and all three who received therapeutic service while in foster care stated they were not positively affected by the offered services. The remaining three participants received therapeutic service in late adulthood within the last 4 years to be exact. One thing all participants agreed upon was early therapeutic service, in childhood, would have served them well and aided in better fostering of resilience. Specifically, therapeutic service which does not focus on the behaviors born of the abuse, but the trauma which triggered the behaviors.

P5 "I did actually, in behavioral boarding school it allowed me to be able to assess my feeling and actually express them when I became an adult." P6 shared she entered therapy at the age of 49 by way of marriage counseling which morphed into an unexpected road to healing from her exposure to CHM. "I entered therapy at 49, 2014, It made me stop being a doormat. It's very, very powerful." When asked if she believed should she have had therapy in childhood would she have felt better sooner P6 shared,

"100% because I believe a child cannot understand logically what is happening to them emotionally. And I believe a child tends to make it their fault. I believe all these years of hurting, bad hurting, could have been avoided."

*Sub-theme 4.2 Absences of support in and outside of the home:*

The participants were asked to share regarding support outside of the family home and how that support helped them get through their experience of abuse. Although the responses were mixed it was important to show and highlight a sniped from each type of response as support outside of the family had been readily linked to the fostering of resilience. Three of the participants stated they had support outside of the family home and found they were better confident moving forward in life post-CHM. Two of the participants stated they did not have support of any form outside of the family home and the support came from within the environment. One participant stated she had people she could talk to outside of the home, but they were not constant and was not really there to help her through her experience of emotional abuse.

P2: Ummm not when I was younger. Well yeah. No, I really, I didn't have any of that. When I was younger we moved away from my family. I think it was the abuser isolating us, getting us away from the family support and the people who would be Keeping an eye out on us.

*P5:* I was in a youth Leadership Ministry. So, one of the ministers that ran that program, I never forget this man he was a great, great factor, he was really there for me. He saw the heart that I had. definitely was a great,

great, great, great support factor. And I would say that was the ONLY,

ONLY Support factor I had whatsoever.

P1: I didn't really have a lot of support outside my home. As a child, it was

just me and my mom and my sister. And then years later it was my brother

and my grandma. My grandma lived with us until she died when I was 13.

Outside of the home though, I've never really had help, ever. School

activities never happened because we were broke, and never had the

money.

*Sub-Theme 4.3 RQ2 Healing though Familial and spiritual connection*

P4: "At the age of 26 I gave my life to Christ. I became a Christian and through

the Christian faith, I've come to grow and learn to forgive them."

*P6:* In my particular instance, growing up in a fanatically religious

household, God was a very scary, judgmental, punishing figure who

would see me thinking and you know, (laughter by both) and punish me.

So umm, very scary. In the past 10 years or so, I realized that humans

make up the rules, and I found a spiritual connection with what I think to

be God and that has helped me a lot.

P3: I think just living with my uncle and aunt and with their three kids. I

was surrounded by family. Yeah, it was my family. My uncle's family,

they accepted me as if I belong to them you know, I was not alone."

*Theme 5: CHM and protective factors/coping mechanisms intrapersonal PFs affect*

*healthy adolescent and adult relationships*

All participants were asked to share coping skills they developed during their experience of CHM. Although the term coping was used in the questioning, it should be noted the coping mechanisms were, in fact, PFs developed by the participants in childhood to ensure they were safe from the abuse or the emotional fallout caused by the abuse such as anxiety or fear. What was found is the goal of each participant was to avoid the experience of uncomfortable situations, so they would find a way to mentally escape their external environment.

P2: shared,

I can remember when I was 10 and it was really bad. Umm, in this

situation, I would go in our front yard and I would climb to the top of a

magnolia tree and (short pause) find peace, up in the tree, by myself.

P4: shared,

When my mom would scream and yell, and name calling, I would be in

my room and  I really got caught up into music. Sometimes even got into

my own little fantasy world and my mind was just like,  my body was

there, but my mind was somewhere

Further found was the type of abuse seems to drive the type of coping mechanism. For example, the participants who experience sexual abuse were more prone to using alcohol, drugs, and sexual rebellion as a way to cope with the sexual abuse, those who experience emotional and physical abuse appeared to withdrawal within to avoid the external environment. While some had an overwhelming need to please the abusers to ensure their safety. Participants reported being hyper-aware of possible abuse even if there was no

present danger. For those participants who were exposed to multiple instances of abuse, the coping was a combination of substance abuse and avoidance.

> P1: So as a child I learned to cope with fear by hiding it. And I learned to cope with anxiety by chewing on things. Which is a little odd, but whatever. I guess as a child that's where I was. That is, the fear and anxiety were the two main things that had gone on for so long. I learned how to hide it, So I would hide. I would hide from myself, but I would also hide it from my mom. So, instead of telling her, like, mom I'm scared, I'd be like mom what are you doing can I do it. Can I jump on your bed, can I do this or that? I would push that fear feeling out of my system until I was ready to deal with it. Or go back to it or, whatever."

P6: shared in childhood she experienced both physical and sexual abuse and indicated she felt most protected when she was sure those in authority were happy with her as it stopped the "beatings," she later turned to the use of sex and alcohol as a way of feeling safe, she stated,

> I had an eagerness to please. Never saying no, going the extra mile to make people around me happy. I turned to substance abuse and promiscuity because it was an easier form of coping. Because, I, believe that if you, if you gave somebody what they wanted with a smile, then they aren't going to hurt you."

*Sub-theme 5.1: Protective factors and coping just happened.*

The participants were asked how they developed their coping skills/PFs. All participants shared they could not explain how they knew what to do to protect themselves from their experience of CHM. They explained their actions just happened, which lean towards PFs being an innate part of those who are fighting to survive a traumatic situation. P2: "it's hard now because you don't have those thoughts as a kid. like it wasn't a conscientious thing I was doing. I was just doing it." P4: "It just happened

*Sub Theme 5.2: Developed  coping skill effect relationships*

All seven of the participants reported their developed PFs affected their adult relationships in one way or another, most of the effects were felt on a negative level hindering how they engaged in relationships. Avoidance of situation was the PF that stood out among the participant responses of five of the participants. This aligned with the participants need to avoid danger in childhood and the PFs developed to help them feel safe at that time. Some shared they are better able to sustain intimate relationships but struggle to maintain healthy social and familial relationships. Whereas, others stated they struggle with their PFs having a negative effect on intimate relationship, but they are better able to keep those same PFs from interfering with familial and social relationships. One participant was not sure if her PFs had much to do with how she engaged in any relationships but knew she was very cautious with whom she allowed in her space whether intimate, social or familial.

P5:"I was always looking to fill the void of my father and that affected my relationships. I always entered unhealthy relationships and through the abuse in those

relationships was oaky. P5: also shared she felt she was protecting herself by filling the void caused by the absence of her father. Until she realized continuing to utilize her childhood PFs in adult relationships was not working and was causing her to repeatedly enter unhealthy relationships. However, once she realized she no longer needed to fill the void of her father she gained a voice, which allowed her to sustain healthier relationships in recent years P2: shared her PFs of trying to see the best in everything, which helped her emotionally deal with adverse situations,  has transitioned into her adult life, as she replaces the negative with positive. She also shared those PFs have hindered her ability to sustain healthy relationships due to her frame of mind. She explained

> Because, (Short Pause Sigh,) I try to, I try to look at the situation for what
> it is. I'm going to ask you straight out like, hey are you throwing a lot of
> attitude, did something else go on, or what's going on.

P2: stated she has lost many friends due to this mindset as many times it is viewed as combative. P1: shared her PFs of hiding from her fears and anxiety in childhood, which help her avoid uncomfortable situations, have caused damage to her adult relationships.

> I think the hiding one does. Because. Instead of communicating openly I
> tend to be reclusive and I hide in myself. So instead of talking about my
> problems, I tend to internalize them a lot and in relationships both physical
> and or just friend relationships it's hard." P6 "I believe it, I've never had an
> equal relationship. In friendships, if somebody upset me instead of telling
> them and talking through it calmly, I would avoid them. And, nobody
> likes their friend to disappear on them for a month or two months. But, if

it were a romantic relationship, I was, I was like a cowering, shameful

(laughter), innocent victim.

P6: shared this was a subconscious act in stressful situations.

## Summary

The sample for this study consisted of seven adult females who self-identified as having experienced childhood maltreatment. The participants were recruited from social media groups for survivors of CHM via an ad placed within the groups. After consent was provided, semi structured interviews took place via Skype and the telephone. Throughout the interview process, numerous themes arose to answer the research questions. Trauma results in resilience and healing through helping others, time and interventions heal perception of abuse, guarding trust to avoid hurt as the effects of CHM lasts a lifetime, support is key then and now family, professional and spiritual, the effects of CHM and protective factors affect healthy adolescent and adult relationships.

Chapter 5 provided an interpretation of the results, strengths, limitations, implications for social change, recommendations, and conclusions. It also includes an explanation of how the findings of this study can influence social change as well as the implication it may have for future researchers and clinical practitioners who treat those who have been exposed to trauma and have experienced CHM. Finally, the limitations of the study are discussed as well as how the uniqueness of this study can assist in moving the field forward.

**Chapter 5: Discussion, Conclusions, and Recommendations**

**Introduction**

My goal with this interpretative phenomenological study was to gain an in-depth understanding of the experiences of the role of resilience in women's ability to sustain healthy relationships postexposure to CHM. Furthermore, my goal was to help provide an understanding of how women develop resilience through the use of PFs, whether external (i.e., social, familial, or therapeutic) or intrapersonal (i.e., self-worth, behavioral action, or subconscious avoidance) and how those PFs could affect the outcome of adult relationships. While everyone who experiences trauma has a desire to be free of the aftereffects, many people continue to struggle, and even those who can reach some level of resilience struggle with the development and sustainability of healthy, nonaffected, adult relationships. The participants reported they continue to struggle to sustain relationships even though they consider themselves resilient.

While external factors, such as therapy or community support, have proven to assist in the better development of resilience, prior studies have shown the perception of the abuse drives how individuals emotionally cope while in relationships (Helitzer et al., 2015). Participants have reported feeling "emotionally unstable" even now in adulthood, and this emotional instability impacts how they approach relationships and who they allow in their circle of trust.The seven participants in this study self-identified as having experienced some form of CHM. Five main themes and 14 subthemes emerged from my continuous comparing and analyzing of the data collected from participant interviews. In this chapter, I will review the data relative to current research and literature. I will also

summarize the research results, discuss the limitations of the study, provide some clinical implications of the results of the study, and provide suggestions for future research.

## Interpretation of the Findings

My review of the extant literature revealed a lack of studies that focused on the resilience of women post-CHM. While several studies presented information regarding the development of resilience and the need for PFs and the effects child abuse has on an individual's ability to sustain relationships, none of the prior literature specifically addressed the role of resilience in a person's ability to sustain healthy relation post-CHM. The five main themes that emerged during the analysis of the data were: trauma results in resilience and healing through helping others; time and interventions heal perception of abuse; guarding trust to avoid hurt as the effects of CHM lasts a life time; support is key then and now: family, professional, and spiritual; and the effects of CHM and PFs affect healthy adolescent and adult relationships.

### Trauma results in resilience and healing through helping others

Participants of this study described resilience as the ability to have faced trauma and been able to "get up" and continue with life. All the participants stated they felt resilient after their exposure to trauma; however, many of the participants reported they did not reach the feeling of resilience until they were in their adulthood and had received intervention in the form of therapy. This finding line up with those of previous studies, which indicate that if women do not reach resilience in childhood, they have an opportunity to foster that resilience later in adulthood with help from therapeutic

interventions (see Orbke & Smith, 2013). Several participants stated engaging in therapy liberated them from the feelings they had been carrying for many years.

Additionally, previous researchers stated only a small percentage of those exposed to CHM ever become resilient (Burt & Paysnick, 2012; Shastri, 2013). Specifically, only one fourth to one half of the individuals exposed to CHM have or will attain some level of resilience post-CHM (Brinkerhoff, 2017; Maneta et al., 2015; Mehring, 2017; Orbke & Smith, 2013). This is notion appears to be true according to the reports given by participants of this study who stated having not reached a level of resilience until they reached adulthood. Six of the seven participants reported being well into adulthood before they felt resilient and were able to bounce back from their experience of trauma with the assistance of a support system such as a therapist, family outside of the abusive environment, or feeling connected to a higher power. The reports of the participants fall in line with previous findings that highlighted the fact that adults who did not develop resilience in childhood can overcome adversity if external resources such as therapy are implemented (Howell & Miller-Graff, 2014; Meyer, 2016; Orbke & Smith, 2013). However, the participants reporting reaching a level of resilience does not seem to negate past findings that only a fraction of those who are exposed to CHM become resilient. Previous researchers also found only 10% to 20% of those who were exposed to CHM reported not experiencing any negative life outcomes (Brinkerhoff, 2017), which did not align with the responses of any of the participants of this study because all reported some form of residual impact from their experience of CHM. Although the participants reported now feeling resilient, many of the participants spent

decades reliving the trauma and the effects of their CHM experience, having never developed resilience in childhood. As suggested by previous studies, most people facing adversities in childhood  tend to lead a life of relived traumas as they move from relationship to relationship, never building strong bonds and healthy, sustainable life habits (Burt & Paysnick, 2012; Shastri, 2013). Even the participants in this study who self-identified as resilient reported struggles in the areas of building strong bonds; relationships; and healthily, sustainable life habits.

One thing not accounted for in previous studies was the willingness of CHM survivors to utilize their life adversities in the healing of others, resulting in a fostering of their own resilience. Participants reported using their experience of CHM to help others and that sharing this act alone helped them develop resilience later in life. Many of the participants reported that they believed they experienced the trauma, so they could later help someone who would encounter the same trauma, stating "it happened for a reason." It seems those who have experienced CHM need to help others who could possibly or have shared the same experiences in which they felt a lack of control; their reason behind this need was feeling "obligated" to prevent others from feeling helpless. The reported selflessness speaks to the participants' PWB, PTG, and ECC, all of which have been found strongly linked to the development of resilience (Ogińska-Bulik & Kobylarczyk, 2015; Sagone & De Caroli, 2014; Stephens et al., 2013). When implementing selflessness as an aid for coping with the effects of CHM, an individual is demonstrating their levels of PWB, PTG, and ECC through their desire to have compassion for others and find the positive outcomes in life posttraumatic experiences. (Ogińska-Bulik & Kobylarczyk,

2015; Sagone & De Caroli, 2014; Stephens et al., 2013) These previous researchers mentioned compassion for others as an attribute to the development of resilience but did not speak specifically to an individual using the events of their trauma to help others avoid or survive traumatic experiences and reach a level of resilience.

**Time and Interventions Heal Perception of Abuse**

From the responses of the participants, I found that the perception of the abuse they suffered in childhood has much to do with how the individual enters relationships in adulthood, even if their perception of the abuse changes later in adulthood. This finding seems to answer the questions posed in a past study about whether perception had more to do with how the effect of an ACE transferred into the survivor's adult life than the development of resilience (Helitzer et al., 2015). Many of the participants stated they perceived themselves to be the blame of the abuse and found the abuse to be harsh. For many of the participants, the perception of blame impacted how they interacted in relationships regarding their worthiness for a healthy relationship until they stopped blaming themselves. This feeling was explained in the findings of a previous study, which reported survivors of CHM experience adverse self-perception and negative perceptions of others, which can result in dysfunctional thoughts towards relationships entered in adulthood (Folger & Wright, 2013).

One participant called her experience "perverted" as the abuser took joy in inflecting the trauma. The perception of the abuse had bearings on the ability to trust in all participants, which later impacted how they interacted with others as they attempted to establish relationships. As suggested in previous studies, the perception of the abuse in

childhood drives the level of resilience and how the individual later functions in adult

relationships on an emotional level (Helitzer et al., 2015; Zimmerman, 2013).

Many of the participants shared their perception of the abuse did not change until

they enhanced their support system by way of therapeutic services, connected with family

members, or utilized their adverse life experience to help others. A change in perception

seems to speak to the participants' PTG, which in a past study was defined as specifically

an individual's ability to develop coping strategies that aid them in successfully building

a positive perception of self, resulting in the increased perception of personal strength

(Ogińska-Bulik & Kobylarczyk, 2015).

**The effects of CHM and PFs Affect Healthy Adolescent and Adult Relationships**

What is clear is the effects of CHM lingers. Several participants stated, "it lasts a

lifetime." The participants reported that in adulthood they continue to experience feelings

born of their experience of trauma. The responses of the participants were echoed in the

findings of past studies which noted that CHM has a long-lasting effect on adult

relationships, many times resulting in the relationship experiencing undue stress (Helitzer

et al., 2015; Riggs et al., 2011). I also found that interaction with others unknowingly

triggered the feelings caused by their exposure to CHM. Several participants stated they

find themselves interacting with others and being triggered unexpectantly, which pulled

at their relationships in a negative manner. The experiences shared by the participants are

in line with previous findings that revealed those who are exposed to physical and

psychological trauma are more likely than others to carry that trauma with them through

adolescence and adulthood, risking the suppressed emotions seeping out and impacting

the survivors' ability remain in stable relationships (Dalton et al., 2013; Kidsdata, 2017; Riggs et al., 2011;).

Child abuse has been found to impact participants' relationships starting in childhood by evidence of the response of the participants of this study. One participant said she did not have any form of friendships or relational connections until she was in late adolescence. As noted in past studies, weak familial and community connections in childhood increased the likelihood of individuals experiencing relational struggles post-CHM (Ogińska-Bulik & Kobylarczyk, 2015; Shastri, 2013).

The theme that resonated across the participants' response was the abuse affected their relationships because they did not feel worthy of relationships because the exposure to abuse made them feel less than and "unworthy" of such connections. Several participants stated the exposure to CHM caused them to make poor relational judgments and enter unhealthy and sometimes abusive relationships whether social, familial, or intimate. The sentiments of the participants were also found by previous researchers and were acknowledged as emotional stunting, emotional suffering, and psychological discomfort, all of which act as a roadblock to experiencing healthy and appropriate adulthood relationship as well as causes those exposed to CHM to emotionally remain at the age where the trauma occurred (Orbke & Smith, 2013; Riggs et al., 2011). One participant shared there are times she finds herself "feeling like that kid again." Emotional stunting occurs in those who have failed to reach a level of resilience (Orbke & Smith, 2013). The responses of the participants proved this to be true in that until they reached a level of resilience in adulthood, they continued to view life situations through

the lenses of when the abuse occurred in childhood (i.e., they continued to blame themselves for the abuse and approached all relationships with caution due to fear of being mistreated, which also impact a survivor's ability to trust others).

**Guarding Trust to Avoid Hurt as the Effects of CHM Last a Lifetime**

Six participants stated they have issues with trusting others and indicated they enter relationships with caution due fearing people will do them wrong. The expressed feeling of mistrust and fear of being harmed was described in the findings of a previous study which noted, During their experience of CHM, individuals develop intrapersonal responses which protect them from adversities which can take the form of mistrust of others, constant worrying about abandonment, over awareness of possible harm, and not finding one's self, worthy of being loved (Dalton et al., 2013). What was not accounted for in other studies was the response of one participant who stated she is overly trusting as she was "always trying to fill a void," which caused her to make poor relational decisions and continue to accept abuse in her adult relationships.

Trust presented as a huge factor for the participants' ability to move forward in adult relationships. They shared struggling with believing those with whom they may or have entered a relational situation with has their best interest in mind, many times "looking for a reason not to trust others." Past researchers found fear of betrayal would cause individuals to have less trust in those with whom they may interact, resulting in a desire to maintain a safe distance in an attempt to protect self from potential danger that may not exist (Riggs et al., 2011; Silver, 2015).

The lack of trust and the impact the lack of trust has on relationships, as reported by the participants, was noted as a possible hindrance for survivors of CHM attempting to establish healthy and sustainable adult relationships. What has been established by past researchers is the effects of CHM interfere with the survivor's ability to feel safe and trust those with whom they entered a relationship, causing them to; worry about abandonment, experience over awareness of possible harm, have dysfunctional thoughts towards relationship entered in adulthood, and find themselves not worthy of being loved, ultimately, interfering with the individual's ability to successfully form and maintain relationships in adulthood as well as adversely affect any support systems the survivor might attempt to establish later in life . (Cleary, 2016; Dalton et al., 2013; Folger & Wright, 2013; Meyers, 2016; Riggs et al., 2011; Silver, 2015; Wright & Folger, 2017).

**Support is Key then and now Family, Professional and Spiritual**

Participants described how the experiences of therapeutic interventions and development of familial relationships, or connection to religion helped them release the feelings of blame and start feeling resilient in their situation. Much like suggested by previous studies, the development of a solid foundation of support in the form therapy, being in tune with spirituality, or a support system outside of the adverse environment, assist in the development resilience and the ability to sustain healthy relationships (Glenn, 2014; Howell & Miller-Graff, 2014; Meyers, 2016).

Many of the participants reported receiving subpar or no therapeutic service in childhood or adolescents. Participants stated should they have received interventions earlier in childhood, they, "could have avoided many years of undue pain." The

participant notion that early involvement in therapy would have better assisted them in the early development of resilience, coincides with the findings of past study findings which noted, youth who has a solid connection to therapy or spirituality has a better chance of foster resilient functioning as well as developing into adulthood successfully (Howell & Miller-Graff, 2014). Participants reported feeling "empowered and freed" once receiving therapeutic interventions in adulthood.

Another aspect not covered in past studies is the concept survivors would identify themselves as the reason for their development of resilience. Several of the participants stated they are the reason they became resilient. Participants stated they had to stand on their own while facing the adversity and the strength they had inside is what pulled them through. Although a few participants stated they helped themselves reach a level of resilience, all participants reported having some type of connection to support outside of the adverse environment which assisted them in fostering a level of resilience which is coupled with the findings of past studies which revealed, support systems facilitate increased resiliency functioning in those who have been exposed to CHM (Howell & Miller-Graff, 2014; Meyers, 2016; Wright et al., 2013; Orbke & Smith, 2013).

The use of external and internal protective factors is highly linked to the development of resilience postexposure to CHM. Past studies have found internal or external, PFs are developed or put in place to help individuals navigate the rough patches of life while in childhood (Brinkerhoff, 2017; Dalton et al., 2013; Hamby et al., 2018; Hinduja & Patchin, 2017; Meyers, 2016; Rutter, 1987, Werner, 1989). All sevens participant reported having external protective factors either in childhood or adulthood,

which helped them in their time of need. Participants provided examples of relying on "the love of family," "having a caring therapist," or delving into spirituality to deal with the experience of CHM. Werner (1989) reported support systems outside of the familial setting assist the individual in understanding she is more than her situation and that she has control over her life outcome, which in turn develops resilience.

It was said that women tend to lean less on their external protective factor once they were absent of risk (Werner, 1989). Though the completion of this study, Werner's notion was found to not be completely true in those who identify as being resilient. What was found is leaning on one's external protective factors is a lifetime event. The participants stay connected to their external protective factors even in the absence of risk as a way to keep risk factors at bay. Participants reported always being aware of possible risk even if there is no need to be on heightened alert. The need to forever utilize PFs could very well be linked to the finding of past studies which noted, women who experience excess internal emotions such as fear of closeness, fear of betrayal, and, negative views of self and others have to deal with the fact these emotions unexpectedly emerge or are inadvertently triggered by those around them, causing them to feel as they need to rely on their develop PFs to remain safe (Dalton et al., 2013; Riggs et al, 2011; Traue, et al., 2016). Therefore, the therapeutic services, connection with family and friends, or spirituality will forever be needed to maintain their level of resilience. Additionally, the continued emersions of past emotions and the continued use of PFs may very well be why past researchers of resilience believe that many people fail to become resilient in the face of adversity (Burt & Paysnick, 2012).

Internal PFs have been strongly linked to the coping mechanisms utilized by the participants in childhood to foster a sense of security during their exposure to CHM. As suspected by previous studies, the internal PFs have a negative impact on adult relationships if carried from childhood into adulthood. (Dalton et al., 2013, Meyers, 2016). The interesting thing is in childhood the internal PFs do not present as internal, they are actions or behavior taken or acted out by individuals to withdrawal within and later are unintentionally presented as roadblocks to the sustainability of healthy adult relationships. These PF are interpersonal responses which are seemingly involuntarily developed and implemented and found to cause the most problems in a survivor's ability to sustain healthy relationships in adulthood (Dalton et al., 2013; Shastri; 2013; Wright & Folger, 2017; Zimmerman, 2013), This takes the form of being hyperaware of situations, lack of trust, avoidance, being overly communicative, and lack of self-worthiness as reported by the participants. past studies have described the internal PFs as fear of betrayal and closeness; hypervigilance to potential harm, and low-self-worth (Dalton et al., 2013; Ruff, 1987).

Although past studies have collectively agreed individuals exposed to CHM need to enlist the assistance of a therapist or counselor to ensure the development and maintenance of resilience during the time of adversity and once transitioned into adulthood if they are to establish and sustain healthy adult relationships (Burt & Paysnick, 2012; Dalton et al., 2013; Meyers, 2016; Maneta et al., 2015; Wright et al., 2013), none of those studies mentioned the deficit in a survivor of CHM ability to address life adversities in adulthood in a manner different from how they handled life stressors in

childhood. Nor did past studies mention what therapist or counselors would need to address regarding the deficit if individuals are to successfully function in adult relationships. What is found in this study was, the participants never developed a skill set which would have assisted them in responding differently in adulthood when they encounter adverse situation than they did in childhood when experiencing the abuse. Therefore, they implement what worked in childhood in adult situations, which cause difficulties in adult relationships. The finding was resonated in previous research findings, which noted, although such PFs may have been protective in childhood, the use of said PFs tend to interfere with the individual's ability to successfully form and maintain relationships in adulthood (Dalton et al., 2013; Meyers, 2016).

One thing not accounted for by previous studies is that the transfer of internal PFs from childhood to adulthood is not equally applied by survivors of CHM regarding their ability to successfully engage in adult relationships. Meaning, some can successfully maintain healthy intimate relationships and struggle with social or familial relationships, while others are better able to sustain familial and social relationships but have continued struggles with maintaining or even entering intimate relationships, and some participants struggle with entering and maintaining any relationships intimate, social, or familial due to the implementation of coping mechanisms utilized in childhood. This finding perpetuates the question of past studies, why some are resilient against the effects of CHM and why others are not (Cleary, 2016)? Participants reported they either wanted to stay connected to their nucleus family and not deal with outsiders as they better able to handle life stressors in that environment, or stating they better handle discomfort in

situations when they are dealing with family or social relationships but struggle to successfully start or maintain intimate relationships, while some admitted to struggling to sustain healthy relationships across the spectrum of relational interactions, social, family, and intimate.

Most of the participants stated when faced with or even before an adverse situation arises, they revert to the use coping mechanisms (i.e., intrapersonal PFs) utilized in childhood to ensure they avoid hurt depending on the type of relationships they are attempting to establish. Noted in past study findings was if individuals possessed the ability to adapt their coping skills to their situation, they were better able to avoid negative outcomes regarding a relationship between child abuse and satisfaction of life (Cleary, 2016). Unfortunately, this reversion leads to difficulty in the sustainability of their adult relationships.

Shared from the findings of past studies was resilience is present due to the development of PFs. (Brinkerhoff, 2017). This study confirmed resilience is fostered due to the development of PFs whether internal (i.e., intrapersonal) or external. The participants shared their level of resilience and quality of life increased once they entered therapeutic services, connected with a higher power and established strong social and familial supports and stopped self-blaming. Some participants never participated in therapeutic service but reported "being surround by the love of family," aided in the fostering resilience. Others stated through entering therapeutic services later in life, specifically within the past 3 to 5 years, they were able to foster a sense of resilience, while some shared internal strength carried them to the other side of the adverse

experience. The reports of the participants contradict the findings of a study which noted no significant connection between the establishment of a social support system and how satisfied one is in life post-CHM (Cleary, 2016).

Completion of this study has uncovered, although the participants developed and utilized PFs in childhood, many of the participants were not resilient. As reported by the participants, they made it through childhood, adolescences, and adulthood relying on coping mechanisms which caused them to avoid any situation that could trigger their unresolved trauma as they did not feel they could handle adverse life situation after exposure to CHM, which is the definition of resilience. The shared experiences of the participants confirm past study findings, which revealed women who were exposed to CHM and failed to develop resilience still have an opportunity of becoming resilient in adulthood with the help of therapeutic interventions (Orbke & Smith, 2013).

What was further established from the responses of the participants was the answer to the overarching question of  what the role of resilience and protective factors in the life of women who have experienced CHM as well as the question of past studies, what is the longevity of the effects of CHM into adulthood (Cleary, 2016; Gorraiz, 2014). Although one becomes resilient in the face of adversity, resilience does not completely enhance their ability to sustain healthy adult relationships or break free from the effects of CHM. This is evident in that not one participant could say they have healthy relationships across the spectrum of relational engagements, to include intimate, social or familial. Meaning, even if they can establish intimate relationships, the effects of CHM and the implementation of PFs utilized in childhood, hinders how they can function in

familial and or social relationships. It seems that resilience is just the starting point after the experience of CHM. Becoming resilient is what allows survivors to begin their internal examination and begin dealing with the trauma and as one participant stated "Finding, who I am beyond the abuse" and another stated, "find the best version of me." Resilience is the stage of "unpacking" what occurred, dealing with it, and then leaning to deal with others beyond the effects of the trauma.

## Theoretical Framework

The study was guided by resiliency theory. Werner (1989, p. 72) defined resilience as "successful adaptation following exposure to stressful life events." In resiliency theory, one is looking to see how positive outcomes are managed after a negative experience such as CHM has occurred. Resiliency theory also provides an understating of how women manage to cope with adversity in a way which develops characteristics of resilience (Sagone & De Caroli, 2014). Resiliency theory further examines the development of tools and skill, which help those exposed to CHM persevere in the face of adversity (Sagone & De Caroli, 2014).

Throughout the study, all participants identified as having experienced some form of CHM. Six participants reported feeling they had reached a level of resilience once they reached adulthood. One participant reported she never felt at fault for the abuse and therefore felt she was resilient in childhood. The participants reported they reached some level of resilience once they were connected with resources outside of the family home. Which line up with the findings of Werner's (1989) study which reported connections the individual had outside of the family home contributed to the development of resilience.

Participants stated they were better able to cope with the experienced trauma once they received therapeutic intervention, which helped them to see they were not at fault for the abuse. Many of the participants stated they currently utilize their PFs to maintain a level of resilience even in the absences of risk or danger, which is a contradiction of Werner study finding where it was stated, by the time women reach the age of 30 years they usually have reached a point in life where they are no longer heavily affected by RFs and need to lean less on PFs when faced with adversity. The findings of this study revealed PFs are tools a survivor of CHM will utilize lifelong when dealing with adverse situations in life. These findings seem to answer the lingering question regarding the long-term effects of protective factors developed in childhood and adolescence on the individual's ability to cope once she reached adulthood (Werner, 1989). Participants surely learned how to cope with the experience of abuse and foster the characteristic of resilience in childhood by turning within to avoid the outside environment, which transitioned into how they dealt with uncomfortable situations in adulthoods. This finding calls into questions find of past studies which noted by the time the individual reaches the ending of high school they were viewed as possessing a positive self-image and control over situational outcomes see Werner (1989). Many of the participants are just reaching this stage in resilience in adulthood where they feel a sense of situational control. Further noted was, most of the adverse life events which would significantly contribute to a lack of resilience will have occurred in the infancy and childhood developmental stages (Werner, 1989). However, participants reported experiencing adverse life events which

required the development of resilience through the use of PFs at minimum until early adulthood.

## Limitations of the Study

The following limitations of the study are noted. Participants presented their stories from their perspectives which required them to recall the timeline of events, which was vague depending on what they were attempting to recall. The problem with this is some people tend to block out trauma, which may cause the participant to piece together the information provided during the interview vaguely. Although the participants in this study were able to clearly recall events of the CHM experience, there were areas in which they struggled to recall information. The focus of the interview was not specifically geared towards the experience of CHM, but explicitly addressed how the participants dealt with the abuse, the effects of exposure to CHM, and the utilized PFs all of which has been found to explain the development of resilience.

Self-selection bias is noted as a limitation as well. It was found potential participants did not want to participate in the study as they were still dealing with the emotion connected to their experience of abuse. This was seen as I had an opportunity to be part of the adult survivors of CHM groups where the advertisement for the study was placed and observed many individuals  who would have added more depth to the findings of the study but opted out of the study due to them not being ready to individually discuss their trauma. The nonparticipation of eligible individuals is viewed as a limitation because there is a possibility the information they would report would differ from those who agreed to enter the study and share their story.

Also considered a limitation of the study was the availability of resources. Although studies have addressed the development of resilience in the past; the topic regarding how resilience aids in the sustainability of healthy relationships post-CHM is a relatively new area of study. Due to the study examining a fairly new topic, the availability of literature published in the past 5 years was minimal. To address this limitation, the researcher utilized literature which addressed hardships in relationships after sibling abuse, childhood adversity, and the use of resources such as therapy to develop resilience.

Finally, the length of a few of the interviews may perhaps have limited information gathered during data collection as they were too short. This limitation is due to some of the participants frequently providing quick and shallow responses to the questions asked due to various reasons of not being recall how they felt in a certain situation which would have allowed for more in-depth responses. I realized upon completion of the study, more in-depth follow-up questions would have possibly assisted the participants in better responding to the questions more profoundly. For future studies, this is an area that could be explored in more depth.

## Recommendations for Future Research

As mentioned throughout the literature review, empirically supported research on resilience is still in its early development and a topic with many lingering questions. Although not the main part of the study, the topic of entering foster care due to abuse arose with several of the participants. It would be beneficial not only to the psychological field but the field of social services would benefit from further empirical studies

regarding how entering the foster care system due to CHM impact an individual's ability to become resilient as well how does the lack of proper therapeutic service in the foster care system impact the fostering of resilience and ability to sustain healthy relationships as an adult.

Further recommendation for future research is better understanding why survivors of CHM have difficulties establishing sustainable relationships across the relationship spectrum  as well as why does the utilization of PFs developed in childhood impact how they engage in some relationships but not others? Such a study could help better guide the kind of services needed to help foster resilience in those exposed to CHM.

## Implications and Social Change

This research offers several important clinical implications for social change. The goal of the study is for therapeutic practitioners to grasp the importance of early interventions, Participants repeatedly reported what helped them reach a level of resilience was the connection to therapeutic services and family connection. Many of them entered therapy in adulthood and noted had they received those services in childhood they would have become resilient earlier in life. Responses reflect therapeutic services need to be entered soon after the encounter of CHM the sooner the better in the fostering of resilience. Further, therapeutic service needs to be trauma-informed. Meaning, therapists need to not focus on the individual's behaviors or the actions of the individual which is causing disruption in the environment, but on the trauma, the antecedent to the behavior, this is truer for practitioners who are servicing individuals

who have come in contact with the child welfare system. Participants stated repeatedly, they felt judged for their behaviors when entering therapy through the foster care system and only received service to address their behavior, which caused them to reject the services. One participant reported, "I felt like I was the one who did wrong." There is a need for the individual to be heard and ensured that the abuse was not their fault and that they are able to overcome the experience and live a healthy strong life. Further participants reported feeling if their trauma had been addressed their disruptive behaviors, such as sexual promiscuity, drug, and alcohol use and defiant actions would have been less prevalent.

This study has shown that the establishment of resilience can help women function in intimate, social, or familial relationships post-CHM. However, the fact remains the ability to sustain healthy relationship across environments (familial, social, or intimate) is not established even in those who consider themselves to be resilient. The hope is this study will guide practitioners in helping individuals exposed to CHM whether they are seeking assistance in childhood or adulthood to address traumas in a way which will cause healing and foster the ability of full resilience. Further, the hopes are practitioners will understand the need to provide assistance in developing coping mechanisms in their child patients, which will not impact adult relationships negatively. Additionally, should the individual enter service as an adult, helping foster coping skills which are protective and will allow individuals to deal with adverse situations in adulthood without reverting to the use of PFs established in childhood, which is shown to be detrimental to the establishment of healthy adult relationships.

Additionally, the findings of the study could inform social service workers of the importance of referring all their clients to age-appropriate therapeutic services with the goal of addressing the trauma which brought them to the attention of the child welfare system. Also, the reported findings could provide the Departments of Child and Family Service with an understanding of the importance of contracting with practitioners who operate trauma-informed practices. Contracting with said practitioner could better ensure those who have been affected by abuse are properly treated and prepared to live a healthy and sustainable lifestyle.

Furthermore, noted in the results of the study, resiliency is established when the survivor establishes a support system outside of the childhood home (Dalton et al., 2013; Meyers, 2016; Riggs et al., 2011). Thus, there are important implications for positive social change. The reported findings could lead to the development of interventions or community resources, which would be established specifically to address the needs of those who have disclosed CHM, and which would aid in the process of developing resiliency. These community-based resources could be safe-haven community centers where those experiencing abuse can go for support in their time of need, or support groups for adult survivors of CHM all of which would be designed to address trauma, and development of social support, which leads to the proper establishment of resiliency and resilient factors that do not come naturally to all women.

## Conclusion

My goal was  to extend the current literature about understanding the role of resilience and protective factors in the life of women who have experienced CHM, and

how resilience and the proper use or misuse of protective factors later affects their adult relationships, whether intimate, social, or familial. This interpretative phenomenological research permitted for in-depth responses from a specific population of women who identified as having been exposed to at least one form of CHM.

There were five main themes which emerged and included: trauma results in resilience and healing through helping others; time and interventions heal perception of abuse; guarding trust to avoid hurt as the effects of chm lasts a lifetime; support is key then and now family, professional and spiritual' and the effects of chm and protective factors affect healthy adolescent and adult relationships. The emerged themes can serve as additional recommended research for future quantitative and qualitative studies as well as and can inform mental health professionals, social service workers, and other community partners on ways to improve the of resilience through appropriate therapeutic services and ample community connections.

Ideally, this research will initiate filling of the current gaps in research on resilience, more specifically, on the role of resilience in those who have been exposed to child abuse and the lifelong effects of said abuse. Furthermore, foster more in-depth communication on the role of resilience as a starting point on one's journey to healing after the experience of a life-changing event such as CHM, which strongly impacts an individual's ability to function in healthy and meaningful adult relationships.

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