AN INVESTIGATION OF CHILDHOOD TRAUMA, INTERPERSONAL FUNCTIONING, AND COPING

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By
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CERTIFICATION OF APPROVAL

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DEDICACIÓN

Este trabajo está dedicado a mí familia. Sin el amor y apoyo que he recibido y continúo recibiendo, no podría estar dónde estoy hoy. Ellos me han demostrado que a pesar de las dificultades que se presenten, teniendo pasión todo es posible para cumplir mis metas y sueños. Me enorgullese ser hija de inmigrantes porque pude ver a primera mano cómo lograron superar las dificultades de la vida para lograr lo mejor para su familia. Aspiro continuar el legado que mí amada familia me inculcó y ser un ejemplo para las futuras generaciones de que si uno se lo propone, sí sé puede!

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ABSTRACT

This study investigated childhood trauma, interpersonal functioning, and coping styles in young adults. The focus of this study was to explore the difficulties resulting from childhood trauma in young adulthood, specifically. Data were collected from 295 participants in the United States who reported experiencing trauma as a child and who were between the ages of 18 and 35. Data were collected through CSU Stanislaus participant pool and Amazon's Mechanical Turk. The study utilized the Childhood Trauma Questionnaire Short Form (CTQ-SF), the Interpersonal Adjectives Scale Revised-Big Five Version (IASR-B5), and the Brief-Cope (B-COPE). Out of the 295 participants, 87.4% reported having experienced trauma as a child. It was found that the most frequently reported form of childhood trauma was physical neglect (M = 12.97, SD = 2.88). It was found that physical and emotional abuse and emotional neglect were significantly correlated with satisfaction with interpersonal functioning while sexual abuse and physical neglect were not. There was no significant difference between genders for perceived low satisfaction with interpersonal functioning. Lastly, there was no significance among adaptive coping and scores on perceived assurance and dominance. Interpersonal factors play a large role in how an individual perceives themselves in the world. This study provides valuable information for mental health professionals working with individuals who have experienced trauma.

INTRODUCTION/LITERATURE REVIEW

Childhood trauma is a serious public health problem in the United States. Trauma during childhood is associated with a range of negative immediate effects as well as a wide range of negative implications later in life. There is substantial research that has identified consistent relationships between childhood trauma and negative outcomes in adulthood (D'Andrea, Ford, Stolbach, Spinazzola, & Van der Kolk, 2016; Harford, Yi, & Grant, 2014; Lowell, Renk, & Havell Adgate, 2014; MacMillan, Tanaka, Duku, Vaillancourt, Boyle, 2012). In addition, there have been various studies examining the relationship between mental health diagnoses (e.g., Depression, PTSD, Anxiety, etc.) as well as acute and chronic childhood trauma (Boyraz, Horne, Armstrong, & Owens, 2015; Chang et al., 2015; Choi et al., 2015; Corcoran & McNulty, 2018; Price, Higga-McMillan, Kim, & Frueh, 2013; Sandberg, Suess, & Heaton, 2010; Seedat et al., 2009; Spinhoven et al., 2009; Van der Kolk, 2005). Effects of trauma are well studied in the literature and are an important factor to consider when studying young adults.

Other important factors to consider in young adulthood are the quality and quantity of interactions with others. Having strong interpersonal functioning is necessary to be able to create and maintain relationships with others, communicate needs, self-advocate, etc. Problems may arise when there is an incongruence between the values and expectations of the self and for others. For example, diverse expectations during childhood coupled with the presence of traumatic experiences.

may manifest in the disruption of interpersonal functioning (Locke, 2005). There is a lack of research in the field examining links between interpersonal problems in young adulthood based on the experience of childhood trauma.

Additionally, it should be noted that each individual's coping style can be influenced by the experiences of trauma and interpersonal problems. This study focused on one conceptualization of an individual's coping style determined as either adaptive or maladaptive. Adaptive coping consists of directly addressing the problem by problem-solving and seeking understanding. In contrast, maladaptive coping consists of disengaging from the emotion, avoiding processing the stressor, and reacting emotionally (Connor-Smith et al., 2000). Research shows that there is a consistent association between the utilization of avoidance strategies to cope with trauma and other distress (Littleton et al., 2007). There is a general lack of research in studying the relationship between type of coping style and its mediation on long term effects of childhood trauma, as well as differences of interpersonal functioning based on genders. The current study evaluated the mediation between coping styles and interpersonal problems in young adults who have experienced childhood trauma as well as evaluating gender differences based on perceived interpersonal functioning.

Childhood Trauma

According to the American Psychiatric Association (2013), trauma is defined as exposure to "an actual or threatened death, serious injury, or sexual violence in one of the following ways: (1) directly experiencing the traumatic event(s); (2) witnessing, in person, as the event(s) occurred to others; (3) learning the event(s)

occurred to a close family member or close friend…; (4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s)…"(p. 271). This study focused on one form of trauma, childhood maltreatment, which includes interpersonal victimization, such as physical, emotional, and sexual abuse, as well as neglect. The direct experience of childhood maltreatment, also known as victimization, relates to the child being a victim of abuse while their rights are being violated (Finkelhor, Ormrod, & Turner, 2009). These violations of social norms create a factor of interpersonal victimization for individuals, and thus, differ from traumas that will not be explored in this study (e.g., natural disasters, car accidents, etc.). Throughout this paper, childhood trauma was noted using the following terms, childhood trauma, childhood maltreatment, and child abuse.

The latest data from Child Welfare Information Gateway (2018) states that in 2017 there were 4.1 million referrals made to Child Protective Services (CPS) in the United States. A child may have duplicate referrals made which may account for the substantial number of referrals reported. Of the 4.1 million referrals made, CPS investigated or provided alternative resources for 3.5 million children. Additionally, most referrals were made by educational personnel (19.4%) followed by law enforcement (18.3%). Approximately 74.9% of the reported CPS referrals involved neglect, 18.3% physical abuse, 8.6% sexual abuse. Also, 7.1% were reported under other forms of maltreatment, such as threatened abuse or neglect or lack of supervision (Child Welfare Information Gateway, 2018, p. 22). Victims who suffered

more than one type of abuse were accounted for in each type of abuse. These statistics are based on the reported cases and do not account for cases that go unreported.

Awareness of child abuse is typically focused on the negative effects that obviously visible in the individual. There is substantial knowledge of the problems that are sustained due to child abuse; however, there is less awareness surrounding the fiscal costs of child abuse. According to the most recent data, national estimates suggest there are 1,720 reported cases of child abuse-related fatalities annually (Child Welfare Information Gateway, 2017). Costs associated with the abuse-related fatalities were estimated at 2.21 billion dollars. Also, the lifetime costs of nonfatal childhood maltreatment which includes child and adult healthcare costs, child welfare, criminal justice, and special education costs, were found to be $121.6 billion in the Unites States (Fang, Brown, Florence, & Mercy, 2012). Having an understanding of the fiscal costs of childhood trauma may be another avenue to raise awareness for the prevention and appropriate reporting of childhood abuse since the costs are not well known to the public. Bringing this information to light may prompt individuals and communities to respond to this critical issue and raise awareness for the prevention of child abuse-related deaths.

Early Experiences of Trauma on Development

Trauma on the developing brain can impact children's development and create short-term and long-term difficulties. Knowing some of the structures of the brain that are activated during a trauma response can be helpful so that immediate reactions from the trauma as well as long-term effects can be conceptualized and understood.

During a traumatic experience, for example, childhood abuse, stress hormones in the body set off an alarm that activates the body's fight, flight, or freeze response; the body's natural reaction to stress. Once the stress has passed, the body's stress hormones trigger the parasympathetic nervous system, calming the body so it returns to a resting state (Helsel, 2015). Prolonged exposure to stress hormones can impact the brain in a variety of ways (Middlebrooks & Audage, 2018).

Difficulties may emerge after a single or repeated exposure to trauma. These experiences may result in a constant state of activation of stress in the brain. Baldwin (2013) states that dysregulation of the dorsal vagal system, part of the trauma response activation, can produce an automatic or default state of hypervigilance, even if a traumatized individual is in a safe environment. This dysregulation of the primitive mechanism creates trauma-related symptoms to be prolonged and appear even when there is no threat present. Brain circuits are essentially rewired to develop a low threshold for stress, resulting in overly reactive responses to stress throughout life (Middlebrooks & Audage, 2018). This may explain how some individuals appear to respond inappropriately to innocuous stimuli as well as having difficulty interacting with others around them (Helsel, 2015). Although the focus on the nervous system and trauma activation is important, it will not be explored in great depth within this study due to the focus being on other factors (i.e., coping styles and interpersonal functioning).

Research is emerging on the notion that children's brains are rapidly developing and therefore are vulnerable to early adverse experiences (Carrion &

Wong, 2012; Schore, 2001). Childhood trauma is correlated with negative outcomes, such as poor mental and physical health, affect dysregulation, disruptions in processing of information, as well as relational and cognitive disruptions in childhood and later in life (D'Andrea et al., 2016; Harford, Yi, & Grant, 2014; Lowell, Renk, & Havell Adgate, 2014; MacMillan et al., 2012; Schore, 2001). Specifically, during the vital range from infancy to age 5, typical development can be vastly interrupted by abuse that is inflicted and can lead to many forms of traumatization. Moreover, Kira et al. (2018) state that early infant and childhood traumas appear to, directly and indirectly, predict other traumas later in life. The researcher suggests the need for a paradigm shift to continued assessment and treatment of early childhood traumas.

"Trauma is something that happens initially to our bodies and our instincts. Only then do its effects spread to our minds, emotions, and spirits" (Levine, 2008, p. 30). Research by Van der Kolk (2005) has shown that children who are securely attached have developed trust in how they feel and understand the world. Secure children can have confidence in their decisions and actions and also understand that they can rely on someone else in their environment, like parents or caregivers, when they do not understand something. When faced with trauma, children attempt to deal with the stress and betrayal, leaving them feeling powerless and stigmatized (Davis & Petretic-Jackson, 2000).

Traumatic experiences in childhood are multifaceted and thus, can leave a child with a wide range of short and long-term difficulties. According to Van der Kolk (2005), childhood maltreatment occurs most commonly at home, where about

80% of the perpetrators are the child's parents. When abuse is carried out by a child's caregivers, the child's ability to regulate and make sense of what is happening is diminished. Not only does this create a discrepancy in the child's sense of attachment, but it can also leave the child thinking that the abuse endured is a normal experience (Van der Kolk, 2005).

Psychological Symptomatology During Adulthood

It is typical to expect and endure stress in life. Some stress is beneficial and necessary for survival (Middlebrooks & Audage, 2018). During childhood, stress allows children to develop coping abilities and skills to manage difficult life stress. When stress becomes too severe, intense, and/or frequent, the negative effects of stress begin to develop into difficulties. Exposure to abuse during childhood can lead to problems later in life, such as alcoholism, chronic health diseases, and psychological disorders (e.g., depression, eating disorders, anxiety, etc.) (Briere & Rickards, 2007; Davis & Petretic-Jackson, 2000; Middlebrooks & Audage, 2018).

Results from the Adverse Childhood Experiences study found that the prevalence and risk for smoking, obesity, lack of physical activity, depressive symptoms, and attempts at suicide increased as the number of traumatic experiences during childhood increased (Felitti et al., 1998). Psychological disorders and disturbances, such as PTSD, depression, and anxiety, are correlated with abuse during childhood (Boyraz, Horne, Armstrong, & Owens, 2015; Briere & Rickards, 2007; Corcoran & McNulty, 2018; Price, Higga-McMillan, Kim, & Frueh, 2013; Teicher, 2002). Psychological distress can include depressive episodes and severe and

persistent symptoms which result in impairment of daily functioning (Strine et al., 2012).

Gender Differences

It is common to think of physical abuse being more likely to occur with young boys and sexual abuse more likely to occur with young girls. Data indeed suggest that a substantial amount of trauma has been reported among women in, for example, South Africa. According to an article by Choi et. al (2015), 39% of girls reported some form of sexual abuse before the age of 18. Within this statistic, 84% of the reported sexual abuse was enacted by men who knew the child (Seedat et al., 2009). In the United States, estimates of the prevalence of childhood sexual abuse range from 15% to 33% (Messman-Moore, Long, & Sigfried, 2000). The results of these forms of abuse have been linked with poor physical health as well as poor psychological outcomes (Choi et al., 2015). In this study, all forms of abuse were measured by severity.

In the United States, there are consistencies in that women report greater degrees of childhood sexual abuse (Walsh, Blaustein, Knight, Spinazzola, & Van der Kolk, 2007), whereas men report more emotional neglect and physical abuse during childhood (Power et al., 2016). Ballard et al. (2015) found that women with a history of childhood trauma were more likely to experience greater global impairment than men. However, men may underreport sexual abuse to avoid stigmatization. There continues to be a lack of consistent systematic representation of males. Kendall-Tackett, Williams, and Finklehor (1993) state, “only the most symptomatic boys end

up in clinical samples" (p. 170). Thus, rates of reported sexual abuse may occur at similar rates for both genders (Larsen, Sandberg, Harper & Bean, 2011; Matta Oshima, Jonson-Reid, & Seay, 2014). Beyond this, there is a lack of consistent research in identifying gender differences in perceived interpersonal functioning.

Interpersonal Functioning

Interpersonal functioning requires communication, problem-solving, decision making, and skills for relationship building. Having strong interpersonal functioning may help individuals foster resiliency against adverse experiences as well as strengths in multiple areas of an individual's life (e.g., social, academic, occupational, etc.). For example, high self-esteem and positive outlook for the future contribute to having high interpersonal functioning, whereas a deficit in interpersonal functioning may result in feeling less connected to others, poor social adjustment (e.g., transitions to school, peers, etc.), and fear and distrust of others (Briere & Runtz, 1993). Although this study will not be addressing self-esteem, it is an important aspect of interpersonal functioning.

Interpersonal traits are multi-dimensional and are cited in the literature as being synonymous with the five factors of normal personality: Extraversion, Neuroticism, Openness to Experience, Agreeableness, and Conscientious (MacCrae & Costa, 1989; Lorr & Strack, 1990; Wiggins, 1979). These personality factors are interpersonal because each of them influences ways in which individuals interact (McCrae & Costa, 1989). Wiggins (1979) describes the importance of being able to specify the different kinds of interactions and how individuals differ from one

another, an example being how they treat each other (e.g., kindness or engagement). Interpersonal traits are specific based on desired interactions, social roles/norms, material traits, temperamental traits, and personal perception. How one perceives oneself interpersonally will have an effect on the individual and on whom they are interacting with (Wiggins, 1979).

This study will be looking at differences in perceived interpersonal functioning using Wiggins' Interpersonal Adjectives Scale Revised-Big Five version (IASR-B5). Interpersonal adjectives are defined as "patterns of dyadic interactions that have relatively clear-cut social (status) and emotional (love) consequences for both participants (self and other)" (Wiggins,1979, p. 398). The basis of Wiggins' work suggests that two bipolar coordinates define interpersonal behavior: dominance and nurturance.

It is suggested that being dominant and assured is one end of a bipolar scale which compromises interpersonal behavior (Trapnell & Wiggins, 1990; Wiggins, 1979). Further, good predictors of the dominance scale are self-identifiable traits of assertiveness, domineering, forceful, bold, and aggressive (Lorr & Strack, 1989). In addition, adjectives in the IASR-B5 allow for mapping across different personality scales (i.e., openness to experience, conscientiousness, and neuroticism). Adjectives on this measure are facets of personality and are viewed as complementary (Lorr & Strack, 1989; Trapnell & Wiggins, 1990). This study will be addressing interpersonal functioning in terms of the five-factor model of personality and subscales using the IASR-B5.

Researchers have described psychological, cognitive, and affective components of abuse as influencing interpersonal problems (Davis & Petretic-Jackson, 2000). Although problems may not immediately be visible, long term effects of childhood trauma have complex manifestations in interpersonal problems. Davis and Petretic-Jackson (2000) described interactional patterns of behavior based on survivors of childhood sexual abuse that include fear and active avoidance, and mistrust with an inability to relate to others. This research suggests that having experienced abuse in childhood goes beyond exhibiting behavioral difficulties, such as anger, avoidance, and passivity to others. Complex interpersonal aspects are affected, leaving some individuals to superficially function adequately, but have deeply rooted interpersonal difficulties (Davis & Petretic-Jackson, 2000). The unresolved internal conflicts can continue to affect individuals' interpersonal functioning in adulthood.

Aspects of interpersonal functioning that may be affected in children who have been traumatized include difficulty being assertive, sociable, and supportive; and being too dependent, caring, aggressive, involved, and open in communicating. In young adulthood, negative outcomes may include, difficulties forming meaningful relationships, affect dysregulation, and identity disturbances (Lowell, Renk, & Adgate, 2014). The experience of trauma can impair an individual's interpersonal functioning during the transitioning stages of young adulthood (Bailey, Abate, Sharp & Venta, 2018).

This study focused on the young adulthood stage to account for changes in interpersonal functioning that may be evident as a result of childhood trauma and to increase the amount of research surrounding interpersonal problems affecting this particular population.

Coping Styles

An individual's coping style reflects "relatively stable and enduring personality, attitudinal, and cognitive characteristics" that are evident during stressful encounters and depict how an individual will handle situational or environmental stressors (Moos & Holahan, 2003 p. 1388). Stress can come in many ways, shapes, and forms. In the case of childhood maltreatment, the increased amount of stress creates the need for a child to choose their individualized coping style. Coping styles, also known as coping mechanisms, are used when an individual is faced with a stressor and feels the need to lessen the stress. There are various ways in which coping has been categorized: active or passive, approach or avoidant, problem or emotion-focused, or adaptive vs. maladaptive/problematic (Carver, 1997; Endler & Parker, 1994; Donald et al., 2017; Roth & Cohen, 1986).

For the focus on this study, research will be analyzed and evaluated using the adaptive and maladaptive/problematic categorization. According to Connor-Smith (2000), adaptive coping strategies can include problem-solving, emotion regulation, acceptance, positive thinking, etc. In contrast, maladaptive coping strategies include intrusive thoughts, involuntary action, emotional numbing, escape, substance use, etc.

Coping styles are developed from a young age and are influenced by early childhood experiences (Connor-Smith, 2000).

In addition, there are several different patterns and strategies children use to help manage difficult or even painful events that can include wishful thinking, problem-solving, and emotion regulation (Donaldson, Prinstein, Danovsky & Spirito, 2000). In general, these are healthier coping styles, but it is also common to see unhealthier coping styles, such as denial, substance use, and self-blame. There can be an array of different ways a child will respond to trauma based on the skills that have been modeled by caregivers and their abilities to deal with stress (Nguyen-Feng, Baker, Merians, & Frazier, 2017). In some cases, the use of healthier coping mitigates the lasting detrimental effects in response to a traumatic experience (Coping Mechanisms, 2018).

Differences in coping styles are evident among individuals who have experienced trauma during childhood. A study by Thompson et al. (2010) suggested that maladaptive coping is associated with depression and decreased levels of coping for both depressed and non-depressed women. There is a relationship between mental health difficulties and the inability to effectively cope. The current study highlights the importance of adaptive coping skills to process trauma and stress to live a functional life after having experienced trauma and/or stress. Additionally, Walsh et al. (2007), suggested that children who have experienced childhood sexual trauma may have lowered perceptions of control coupled with poor coping skills which makes them prone to reexperiencing victimization. The use of functional and adaptive

coping styles may provide individuals with the perception of control which may mitigate being in coercive situations during their adulthood.

Young Adults

There is extensive research in the field that has investigated child trauma concerning the onset of psychological disturbances; however, there is little research identifying the relationship between childhood trauma and interpersonal problems in young adults aged 18-35. Young adults are faced with a variety of stressors that may affect interpersonal functioning, such as problems with peers, romantic partners, career and academic challenges, and a transition to independence from parents ("Young Adult Issues", 2017). Some research suggests young adults become vulnerable to intensified stress due to the intensity of this life transition (Arnett, 2000; Bailey, et al., 2018; Hopwood et al., 2013). There is a need for further research in this area to aid young adults struggling with transitioning during their college years.

Additionally, there is sparse research addressing the relationship between interpersonal problems, having experienced abuse as a child, and the type of coping style used by the individual (Choi et al., 2015). It will be beneficial to learn the different forms of coping each individual has as it relates to childhood trauma and interpersonal functioning.

The Present Study

The present study investigated the relationship between childhood trauma and how it affects the quality of interpersonal functioning among young adults aged 18-

35. Additionally, the study examined whether exposure to trauma during childhood is mediated by coping styles.

The first hypothesis examined the correlation between interpersonal functioning and childhood trauma. It was hypothesized that the severity scores of trauma reported would be negatively correlated with perceived satisfaction of interpersonal functioning, operationalized as lower scores of openness to experience and contentiousness. The higher the severity of childhood trauma, the lower the reported satisfaction with interpersonal functioning.

The second hypothesis investigated whether traumatized men and women differ in terms of overall interpersonal functioning. It was hypothesized that women who reported experiencing trauma, would score higher on self-reported neuroticism than men who reported trauma.

The third hypothesis investigated whether different coping styles mediated exposure to trauma and interpersonal functioning. It was hypothesized that individuals who have experienced trauma and who report higher adaptive coping styles would score higher on the assured-dominant subscale than those who experienced trauma and reported higher maladaptive coping style. Assured-dominant subscale is a primary dimension for interpersonal transactions and will inform the research on how individuals perceive their dominance and feelings of security.

METHOD

Participants

The current study recruited participants living in the United States between the ages of 18-35 who reported having experienced childhood trauma. Eligibility requirements (i.e., experience of childhood trauma and age) were clearly outlined in the description of the study and the informed consent. If participants did not meet eligibility criteria, they were thanked for their interest in the study in a separate message and were asked to exit the survey. Participants were recruited from Stanislaus State University via SONA, the Department of Psychology and Child Development's research participant pool, and additionally, via Amazon's Mechanical Turk (MTurk) system. Participants from SONA received two credits for participating while MTurk participants received seventy-five cents compensation for completing the surveys. After the completion of the surveys, participants from SONA and MTurk were given the option to provide their emails to be entered into a raffle for four fifteen-dollar Amazon gift cards.

Data were collected from 295 individuals (M = 26.27, SD = 7.86) in the United States which included 198 females (67.1%), 91 males (30.8%), 2 transgender individuals (.7%), 3 non-binary individuals (1%), and 1 participant who identified as "other" (.3%). The majority of participants identified as Caucasian (65.4%), while 14.2% identified as Hispanic, 9.2% as Asian, and 7.5% as Black or African American. The highest reported educational status was a Bachelor's degree (126,

42.7%) or some college (111, 37.6%) with the remaining participants reporting high school/GED completion (29, 9.8%) or master's degree or above (29, 9.8%). Of the total participants, 247 (83.7%) reported having experienced childhood trauma, while 18 (6.1%) reported no trauma, and 30 (10.2%) reported being unsure. Individuals who reported being "unsure" about experiencing trauma were included in the analyses but, those who reported no trauma were excluded from the analyses.

The study aimed at recruiting young adults ages 18-35 to look at the effects of childhood trauma on young adults. However, some participants did not meet the age (N = 5) criteria and completed the survey anyway. Although there were participants over the age of 35, the sample is a fair representation of young adults between the ages of 18 and 35 with women's average age M = 26.97 (SD = 4.00), and men's average age M = 27.31 (SD = 3.07).

Materials

Demographics Questionnaire (see Appendix A). A demographics questionnaire collected information on the participant's age, gender, educational status, ethnicity, and whether they had experienced trauma as a child or not.

Childhood Trauma Questionnaire-Short Form (CTQ-SF). The CTQ-SF is a 28-item self-report questionnaire that assesses the history of five childhood traumas: emotional, physical, and sexual abuse, and emotional and physical neglect (Bernstein et al., 1997; Bernstein et al., 1994). The CTQ-SF is copyrighted and thus, cannot be included in this document. The CTQ-SF uses a 5-point Likert scale ranging from 1 (Never true) to 5 (Very often true) to determine the frequency of abuse experiences.

Each category of abuse has a total of five items which are summed, resulting in a range from 5 to 25 (Thombs et al., 2007). There is a 3-item minimization/denial scale to account for the underreporting of abuse (Bernstein et al., 1997). Each type of abuse has different ranges to determine severity: low, moderate, and severe. The cutoff points were 9 or higher for emotional abuse, 8 or higher for physical abuse, 6 or higher for sexual abuse, 10 or higher for emotional neglect, and 8 or higher for physical neglect. The CTQ-SF takes approximately five to ten minutes to complete.

Items about familial support are reversed scored so that a higher score represents less support. The CTQ-SF exhibits criterion-related, convergent, and discriminant validity based on various populations, such as psychiatrically referred adolescents and in-patient drug-abusing clients (Bernstein et al., 2003; Thombs et al., 2007). The CTQ-SF demonstrates high sensitivity and specificity (Bernstein et al., 1997; Bernstein et al., 1994). It also demonstrates adequate internal consistency with Cronbach's alpha ranging from .66 to .92 in clinical and nonclinical populations (Bernstein et al., 1994; Bernstein et al., 1997). Test-test reliability ranges from .79 to .86, demonstrating adequate reliability (Scher et al., 2001).

Interpersonal Adjectives Scale Revised-Big Five version (IASR-B5) *(Wiggins, 1995)* (see Appendix B). The IASR-B5 is a 124-item self-report questionnaire that lists adjectives descriptive of interpersonal interactions associated with the Big Five factors of personality (e.g., conscientiousness, neuroticism, and openness to experience). Participants are instructed to rate themselves on how accurately each word describes them using an 8-point Likert-type scale which ranges

from 1 (extremely inaccurate) to 8 (extremely accurate). Adjectives on the scale include words such as “introverted, assertive, timid, unargumentative, organized, boastful, soft-hearted, etc.”. Adjectives are presented with the definition of each word for clarity for the participants. Adjectives are then summed into the different subscales for personality traits. The IASR-B5 also includes the following subscales following along bipolar coordinates of assured-dominant and unassured-submissive. There are an additional six subscales for further interpretation that will not be utilized in this study since the study is not interested in blends of interpersonal functioning. Some adjectives are reversed coded for each subscale. This scale has been found to have excellent structure on the item level, internally consistent scales, and overall good discriminant and convergent validity (Trapnell & Wiggins, 1990).

Brief COPE (B-COPE) (see Appendix C). This 28-item self-report measure is designed to look at how often and to what extent participants use various coping skills. There is a total of fourteen scales with each scale having two items. Participants are asked to respond on a 4-point-Likert type scale to questions such as “I haven’t been doing this at all” or “I’ve been doing this a lot”. The subscales are summed to yield a range from two to eight depending on the frequency of utilization. Further, coping skills were divided into domains of adaptive and maladaptive coping which were examined in this study.

Items were categorized as adaptive coping if they were considered a result of positive reprisal, whereas maladaptive coping was categorized as behaviors that do nothing to change the situation and often have destructive consequences

(Vashchenko, Lambidoni, & Brody, 2007). Adaptive coping styles included: self-distraction, active coping, use of emotional support, use of instrumental support, venting, positive reframing, planning, humor, acceptance, and religion. Maladaptive coping styles were: denial, substance use, behavioral disengagement, and self-blame. Previous studies suggest adequate reliability with internal consistency ranging from .50 to .90 and test-retest reliability ranging from .46 to.86 (Carver, 1997; Carver, Scheier, & Kumari Weintraub, 1989). In the current study, adaptive coping yielded Chronbach's alpha of .80 and the maladaptive coping had an alpha of .74.

Procedure

Participants from Stanislaus State University who chose to participate in the study logged onto the SONA system participant pool system and were redirected to a Qualtrics survey where they responded to the questionnaires. Participants from MTurk volunteered to participate in the study for monetary compensation. They logged onto the MTurk marketplace, selected the study, and were re-directed to the Qualtrics survey. Both sets of participants received a consent form outlining the possible risks, such as flashbacks or re-experiencing of potential traumas, if applicable. Also included in the informed consent, all participants were reminded that they could opt-out of the study at any point if they felt too distressed. Participants from SONA received the Substance Abuse and Mental Health Services Administration's (SAMHSA) hotline numbers as well as the contact information for the University Psychological Counseling Services. Participants from MTurk received

the SAMSHSA hotline number as well as a national warm line to seek support and services if they are experiencing distress as a result of the study.

To participate in the study, participants needed to meet eligibility criteria that included being between the ages of 18-35 as well as having experienced childhood trauma. Participants who did not meet eligibility criteria were notified that they did not meet the study's criteria and were asked to exit the study. Some participants were still able to complete the survey, even if they did not meet eligibility criteria due to a technical error made by the researcher on Qualtrics. Following the consent form, participants completed the demographic questionnaire, the Childhood Trauma Questionnaire-Short Form (CTQ-SF), the Interpersonal Adjectives Scale Revised-Big Five Version (IASR-B5), and the Brief COPE (B-COPE) questionnaire. Questionnaires were counterbalanced on Qualtrics, displaying the surveys in a randomized order.

After completing the surveys, participants were asked to rate how they were feeling on a 5-point Likert scale from "Extremely well" to "Extremely bad". Individuals who selected "Extremely Bad" or "Bad", were provided the option of contacting additional service providers, or communicating with the faculty supervisor via email. No participants contacted the faculty supervisor. In addition, participants were given the option to respond to a question intended to target positive affirmations, so their thoughts and feelings may be lifted. Examples of positive affirmation included "I accomplished something today" and "I am worthy".

Lastly, participants were directed to a debriefing form (see Appendix D) and were thanked for their time. Participants from SONA received SONA credits. Participants from MTurk were thanked for their responses along with a debriefing form and were given a code to receive compensation through their marketplace account. Both SONA and MTurk participants were given the option to provide their email to be entered into a raffle for four $15 Amazon electronic gift cards

RESULTS

Of the 295 participants, 247 (87.4%) reported having experienced trauma as a child, however; 286 responses were recorded on the CTQ-SF. This indicates that although participants may have denied the experience of trauma, they continued on to the survey and responded to this measure. Based on the scoring cutoffs of the CTQ-SF, individuals reported moderate levels of all the forms of trauma (see Table 1).

Table 1

Means and Standard Deviations of Severity of Reported Childhood Trauma on the CTQ-SF (N = 286)

	M	*SD*
Emotional Abuse	12.48	4.69
Physical Abuse	10.94	5.11
Sexual Abuse	10.49	6.45
Emotional Neglect	16.37	5.11
Physical Neglect	12.97	2.88

Note. Based on the severity of mild, moderate, and severe, the cutoff points were: 9 or higher for emotional abuse, 8 or higher for physical abuse, 6 or higher for sexual abuse, 10 or higher for emotional neglect, and 8 or higher for physical neglect.

The first hypothesis examined the correlation between interpersonal functioning and childhood trauma. It was hypothesized that severity scores of trauma would be negatively correlated with perceived satisfaction, operationalized as lower scores of openness to experience and contentiousness, of interpersonal functioning.

The higher the severity scores of childhood trauma, the lower the reported satisfaction with interpersonal functioning. To test this hypothesis, a series of regressions were calculated using the Statistical Package for Social Sciences (SPSS). It was found that severity scores of reported traumas significantly predicted openness to experience (R^2 = .053, *F*2.85[5, 255], *p* = .016), but not conscientiousness (R^2 = .016, *F*.85[5, 257], *p* = .515). In particular, emotional abuse was a significant predictor of openness to experiences with a standardized regression coefficient of .288.

The second hypothesis examined whether traumatized men and women differed in terms of overall interpersonal distress. Although the demographics questionnaire allowed for more responses related to participant's gender, only men and women were compared for this analysis because there were not enough data to include other reported genders (i.e., transgender, non-binary, and other). McCrae and Costa (1989) suggest that negative affect is associated with neuroticism. It was hypothesized that women who reported trauma would score higher on self-reported neuroticism on the IAS than men who reported trauma. Using an independent t-test, there was no significance found *t*(260) = 1.70, *p* = .091, CI 95% (-.590, 7.96) between men's and women's report of neuroticism. Although there was no significance, the data were trending in the predicted direction for men's (*M* = 74.03, *SD* = 14.44) and women's (*M* = 77.71, *SD* = 16.62) scores.

The third hypothesis investigated whether different coping styles predicted exposure to trauma and interpersonal functioning. It was hypothesized that individuals who had experienced trauma and who reported an adaptive coping style

would score higher on the assured-dominant subscale than those who experienced trauma and reported a maladaptive coping style. Linear regressions did not reveal a significant relationship (R^2 = .004, *F*.96[2, 267], *p* = .328) between adaptive coping and perceived assurance and dominance. Maladaptive coping styles were also not found to be good predictors (R^2 = .000, *F*.00[2, 267], *p* = .991) of dissatisfaction with interpersonal functioning.

DISCUSSION

The present study examined the relationship between childhood trauma, interpersonal functioning, and coping style. Hypothesis 1 investigated the interaction between severity scores of childhood trauma and satisfaction with interpersonal functioning. The higher the severity of reported childhood trauma, the lower the rating of perceptions on the personality factors of openness to experience but, not contentiousness. Emotional abuse was found to be a strong predictor of openness to experience. Bernstein et al. (2003, p. 175) defines emotional abuse as "verbal assaults on a child's sense of worth or well-being or any humiliating or demeaning behavior directed toward a child by an adult or older person". This finding is consistent with literature which suggest emotional abuse can lead to impairments in self-development and interpersonal relationships (Reyome, 2007). It could be hypothesized that individuals who have experienced emotional abuse might feel the need to be have quicker reactions or responses when interacting with people because it might have been adaptive to do so as a child.

The results of hypothesis 1 are consistent with previous studies which indicate that individuals who experienced physical abuse as a child, had a significantly greater prevalence of the wish to be hurt (i.e., they are at a greater risk of repeated patterns of physical abuse because of their wish to be hurt) and experienced others' reactions as rigid, stern, or strict (Drapeau & Perry, 2004). Similarly, Drapeau and Perry (2004) also found individuals with a history of sexual abuse, emotional and physical neglect,

as well as other traumas (i.e., parental separation), reported distorted defense mechanisms, low self-confidence, and distorted self-schemas.

Contrary to Hypothesis 2, there was not a significant difference between traumatized men's and women's reports of satisfaction with interpersonal functioning. While the score for women's satisfaction with interpersonal functioning was lower than men's, this difference did not reach traditional statistical significance. Nazarov et al. (2014) studied differences in interpersonal functioning in a population of women and found that women with a history of childhood trauma had larger deficits than non-traumatized women. Studies have found that women with a history of childhood trauma were significantly more likely to experience suicidal attempts and ideation (Ballard, 2015), low self-esteem, depression, and other related stressors compared to men, in adulthood (Fox & Gilbert, 1991). This finding might not have been significant for many reasons. Because social norms are changing, younger males who elected to participate in the study may have felt more open and comfortable in speaking about their experiences. This is a contrast to older generations of males who might have been raised around notions of masculinity and suppressed feelings.

Differences in gender among the participants in this study may have been washed out meaning that with the shift in social norms, males are beginning to process their experiences in more adaptive ways. When examining the norms reported by Trapnell and Wiggins (1990), the means reported were similar to the ones recorded for this study with women's average scores of neuroticism $M = 76$, and men at $M = 72$. This indicates that the participants who elected to be in this current study

reported about the average amount of neuroticism as reported for the norms. Further than this, there is a lack of research when it comes to delineating the gender differences and satisfaction with the specific personality traits of interpersonal functioning that were used in this study.

Hypothesis 3 proposed that individuals who had experienced trauma and who reported an adaptive coping style would score higher on the dominant and assured scale than those who experienced trauma and have a maladaptive coping style. There was no significance among adaptive coping and scores on perceived assurance and dominance. In light of the particular factors this study explored, this finding was contrary to the literature which suggests that maladaptive coping is often associated with poor interpersonal outcomes (Thompson et al., 2010; Walsh et al., 2007). It could be hypothesized that individuals with maladaptive coping did not identify with such feelings of being: assertiveness, domineering, forceful, bold, and aggressive (Lorr & Strack, 1989). This finding may not have been significant for many reasons, such as the age range that was used in this study, the experience of trauma during childhood, or even the type of coping style that was identified. This study added to the literature in terms of investigating the effects of childhood trauma but may need additional data to further investigate the relationship with interpersonal functioning.

This study has strengths in that there were validated measures utilized as well as addressing factors that are not strongly represented in the literature. Another strength of this study is that it looked at specific eligibility requirements to obtain data to analyze. The study aimed at recruiting individuals categorized as young adults and

who had experienced trauma as a child. Out of the 295 participants, 87.4% reported experiencing childhood trauma and were in the desired age range of 18-35.

Limitations

Although the study had several strengths, there were several limitations as well. Data were collected from SONA and MTurk through self-reported surveys. Self-reported surveys are subject to sampling bias, which means they might not be representative of the general population. Self-report is also subject to responder bias where the individual might respond with the socially desired response or is unable to accurately assess themselves. This study utilized the CTQ-SF which is a retrospective measure and is thus subject to recall bias or the possibility of participants not seeing their experiences as "traumatic."

This study aimed at taking a look at the differences in gender but had an imbalanced representation of the genders. Two-thirds of the sample identified as female (67.1%). While there were a fair number of men (30.8%), there may have been undetected differences had there been an evenly split representation.

Another limitation is the way the questionnaires were scored and interpreted. In this study, the IASR-B5 was scored with a focus on one subscale (assured-dominant) and three personality factors: openness to experience, neuroticism, and conscientiousness. According to Lorr and Strack (1989), the adjectives on the IASR-B5 are facets of personality and are viewed as complementary factors. Future studies should look at the remaining variables (e.g., warm-agreeableness, cold-hearted, extraversion, agreeableness, etc.) to further explore the relationship with childhood

trauma. Although data on these variables were collected, the current study was interested in replicating Trapnell and Wiggins (1990) by using the same variables used to create IASR-B5.

The B-COPE measure is originally scored using fourteen different subscales which indicate different versions of coping (e.g., distraction, humor, positive reframing, etc.). Coping can be difficult to interpret because there are times and places where an adaptive skill may be considered maladaptive and vice versa. For the sake of this study, adaptive coping was categorized using Vashchenko et al. (2007) operationalization were adaptive coping is something that is a result of positive reprisal whereas maladaptive skills do nothing to change the situation and can often have destructive consequences. Since there were a total of ten subscales combined for adaptive coping, there were only four combined for maladaptive coping for the specific scale that was used. Although this study used a division of subscales that is notably found in literature (Connor-Smith, 2000; Vashchenko et al., 2007), future studies should replicate these findings.

Implications

Despite the limitations of the study, there are several implications for future research. Given the significant findings of the study, future research should investigate the hardships that young adults and adults face as a result of childhood trauma. Differences in coping styles could also be studied when considering interpersonal functioning. This study added to the literature that is shedding light on the long-term effects that all forms of childhood trauma may create. Studies, such as

this one, provide valuable information for mental health professionals and the population in general about how often childhood trauma is occurring and how deeply rooted their challenges can be.

When taking a look at how one perceives their interpersonal factors, mental health professionals can assist in potential self-discovery and rewiring of negative self-perceptions. As mental health providers, it is important for us to recognize the importance of assessment of childhood trauma in adulthood. Data from this study suggests that the higher the severity of childhood trauma, the less satisfaction with perceived interpersonal functioning in young adulthood. Childhood is a formative stage for the development of personality and how one views the world. Childhood trauma can have a great life-long impact on later functioning and thus, should be recognized as a standard assessment to potentially processed in therapy. Additionally, mental health providers can aid in helping individuals learn that despite adverse conditions that were endured during their childhood, they may begin to feel that their coping capabilities are not written in stone and can be re-learned to allow them to thrive.

Conclusion

Childhood trauma is an unfortunate occurrence that in reality will continue to occur. It is well established that there many adverse effects in childhood, adolescence, and adulthood. It is important to study the effects that childhood trauma has on deeply rooted personal factors, such as how people perceive their social interactions and their capabilities. The current study demonstrated that individuals with a history of specific

traumas do, in fact, experience dissatisfaction with how they perceive themselves interpersonally. Future studies should look at the relationship between childhood trauma and different aspects of interpersonal functioning such as self-esteem and extraversion/introversion.

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APPENDICES

APPENDIX A

DEMOGRAPHICS

1. What is your gender?
   a. Female
   b. Male
   c. Transgender
   d. Non-binary
   e. Other (specify) _____
   f. Prefer not to answer

2. What is your age? (e.g., 27)

3. Please specify your ethnicity
   A. Caucasian (White/Non-Hispanic)
   B. Black or African-American
   C. Latino or Hispanic
   D. Asian
   E. Native American or Pacific Islander
   F. Native American or American Indian
   G. Other/Unknown
   H. Prefer not to say

4. Educational Status
   a. High school or GED
   b. Some college
   c. Bachelor's degree
   d. Master's degree or above

5. Did you experience trauma as a child?
   a. Yes
   b. No
   c. Unsure/Don't know
   d. Prefer not to answer

APPENDIX B

INTERPERSONAL ADJECTIVES SCALE REVISED – BIG FIVE VERSION

Individuals were provided with the following instructions along with each adjective accompanied by the definition provided on the original scale.

The following words are used to describe people's personal characteristics. Please rate how accurately each word describes you as a person. Judge how accurately each word describes you on the following scale. It is very important that you don't skip any questions. Please answer as honestly as you can to better aid us in the research.

1= extremely inaccurate
2= very inaccurate
3= quite inaccurate
4= slightly inaccurate
5= slightly accurate
6= quite accurate
7= very accurate
8= extremely accurate

IASR-B5 Glossary

1. **Introverted:** feels more comfortable by oneself; is less interested in other people
2. **Assertive:** tends to be aggressive and outspoken with others
3. **Timid:** tends to be fearful or uncomfortable around others
4. **Unargumentative:** tends to avoid arguments or fights
5. **Organized:** efficient, planful; maintains order in possessions
6. **Boastful:** tends to brag
7. **Soft-hearted:** tends to be easy-going or gentle with others
8. **Ruthless:** pursues one's own interests regardless of the effect on others
9. **Kind:** thoughtful and caring for others
10. **Tense:** edgy; "uptight"; worried
11. **High-strung:** skittish; easily annoyed or upset; oversensitive
12. **Cheerful:** happy, usually in good spirits
13. **Unsparkling:** not lively or entertaining with others
14. **Tricky:** can be deceiving toward others in order to get something; able to fool others
15. **Unconventional:** likes to be unusual, "radical", or different from the norm
16. **Inefficient:** often wastes time; doesn't plan well; easily side-tracked
17. **Unaggressive:** tends to be mild-mannered, not forceful around others
18. **Unreflective:** not given to careful pondering of issues
19. **Relaxed:** calm; easy-going;; not easily bothered or distressed
20. **Calculating:** tends to use or manipulate others to your own advantage
21. **Unmoody:** stable moods; even-tempered; rarely gloomy or overexcitable
22. **Anxious:** apprehensive or worried, tense
23. **Abstract-thinking:** theoretically minded; likes to reflect about ideas
24. **Philosophical:** likes to think about profound or "deep" questions about life; abstract
25. **Tender:** warm and loving with others
26. **Hard-hearted:** unconcerned and unfeeling toward others
27. **Unneighbourly:** unfriendly, aloof toward others, avoid contact with others
28. **Worrying:** tends to dwell on problems or troubles; apprehensive
29. **Literary:** interested in refined literature and other scholarly writings
30. **Uncharitable:** dislike helping others; tends to judge others harshly
31. **Uncunning:** not crafty or sly, tends to be straightforward with others

32. **Hypersensitive:** abnormally sensitive; overreacts to real or imagined criticism
33. **Extraverted:** like being with others; outgoing and lively around others
34. **Unphilosophical:** not troubled by or concerned about serious or abstract questions; unreflective
35. **At Ease:** relaxed, comfortable, not easily embarrassed
36. **Orderly:** organized; likes to have everything just so; methodical
37. **Cocky:** self-centred; conceited; thinks highly of one's own abilities
38. **Planful:** likes to plan things out or carefully arrange things beforehand
39. **Dominant:** tends to lead others, like to command, take charge in a group
40. **Unsearching:** not meditative or reflective; not bothered or concerned with "the meaning of life"
41. **Antisocial:** dislike the company of others; behavior not affected by social rules
42. **Perky:** lively, energetic around others
43. **Forceful:** tends to take charge around others
44. **Wily:** crafty, cagey, or tricky
45. **Undisciplined:** lacking self-restraint; easily side-tracked; procrastinating; disorganized
46. **Sly:** crafty, secretive, or cunning in dealing with others
47. **Systematic:** likes to do things following a certain routine, or plan; methodical
48. **Self-conscious:** easily embarrassed; uncomfortable when being observed by others
49. **Iron-hearted:** tends to be stern or harsh with others
50. **Thorough:** does tasks carefully and conscientiously; pays close attention to details
51. **Untidy:** messy, disorganized; sloppy
52. **Unbold:** not daring or courageous
53. **Neighbourly:** friendly; likes to get involved with people around you
54. **Unorderly:** not well organized or arranged; tends to be uncomfortable around others
55. **Shy:** lacking in self-confidence; tends to be uncomfortable around others
56. **Undemanding:** doesn't demand or expect much from others
57. **Meek:** timid, has trouble being assertive or standing up from others
58. **Reflective:** meditative, introspective, likes to ponder questions carefully; enjoys deep thought
59. **Inquisitive:** curious; has wide interests; seems interested in everything; likes to ask questions
60. **Unwily:** not tricky or crafty

61. **Unsystematic:** does things, haphazardly; doesn't stick to plans or pre-set routine; inefficient
62. **Self-assured:** confident, certain of oneself
63. **Dissocial:** doesn't care for the company of others
64. **Jovial:** cheerful; playful around others
65. **Domineering:** tends to control or manipulate others
66. **Neat:** likes to have things in the proper place; tidy, meticulous
67. **Unabstract:** concrete; thinks in a practical, uncomplicated way
68. **Tender-hearted:** easily feels love, pity or sorrow for others
69. **Unworrying:** doesn't dwell on problems; apprehensive
70. **Unimaginative:** not creative or inventive; not original
71. **Tidy:** likes to keep things organized and neat; dislikes clutter or disorder
72. **Warmthless:** has no feeling of pleasure or affection for others
73. **Unsly:** not tricky or cunning; tends to be genuine; sincere; trusting
74. **Enthusiastic:** enjoys active involvement with others
75. **Firm:** steadfast; does not give in easily; gets others to do things your way
76. **Impractical:** tends to consider unfeasible, or unworkable ideas; talks about things rather than doing them
77. **Uncalculating:** doesn't try to manipulate others or maximize one's own gain
78. **Questioning:** information or knowledge-seeking; wants to understand everything; curious
79. **Accommodating:** obliging, tends to do favours for others
80. **Uncheery:** not lively or jolly around others
81. **Uncomplex:** simple, uncomplicated
82. **Calm:** relaxed, tranquil; takes things in stride
83. **Conventional:** traditional; tends to stick to mainstream values of a culture
84. **Individualistic:** unique; independent way of doing things
85. **Friendly:** open, accepting, warm around others
86. **Cunning:** crafty, skillful at manipulating others, devious
87. **Self-confident:** sure of oneself around others, devious
88. **Unauthoritative:** doesn't try to influence others; goes with others' opinions
89. **Uncrafty:** not tricky or sly when dealing with others
90. **Unsympathetic:** not interested or concerned about others' feelings or problems
91. **Charitable:** generous, like to help others
92. **Coldhearted:** have little warmth or feelings for others; unfeeling; harsh

93. **Guilt-prone:** tends to worry about having done something wrong; dwells on mistakes; worrying
94. **Nervous:** uneasy; apprehensive or worried
95. **Broadminded:** enjoys a wide diversity of standards of behavior; liberal-thinking
96. **Distant:** tends to be cold toward others; tends to stay away from others
97. **Forceless:** not forceful with others; timid or weak, find it hard to be assertive
98. **Efficient:** does things carefully and quickly; doesn't waste time
99. **Fretful:** agitated, easily distressed; worrying
100. **Overexcitable:** over-reacts to stress or excitement; overemotional; easily agitated
101. **Gentle-hearted:** warm or kind to others
102. **Disorganized:** tends not to do things in a well-planned or orderly way; untidy or inefficient
103. **Unplanful:** tends not to organize or plan things ahead of time; unsystematic
104. **Unanxious:** not tense or edgy
105. **Unselfconscious:** not easily embarrassed; not uncomfortable or nervous
106. **Unreliable:** Irresponsible; can't always be counted on to do things promised to do; undependable
107. **Outgoing:** enjoy meeting other people
108. **Sympathetic:** feel interested or sensitive to the feelings and problems of others
109. **Boastless:** don't like to brag
110. **Unnervous:** calm, not anxious or edgy
111. **Unliterary:** not especially interested in literature or creative writing
112. **Imaginative:** creative; tends to think of different or original ideas or ways of doing things
113. **Persistent:** doesn't give up even when others think you are wrong
114. **Reliable:** responsible; doesn't forget to do things; dependable
115. **Crafty:** can mislead or manipulate others for one's own purposes
116. **Unagitated:** not worried or upset
117. **Stable:** even-tempered; not excitable or overemotional; well-adjusted
118. **Uninquisitive:** not curious; not especially concerned to know many things
119. **Unsociable:** doesn't enjoy meeting people or being in the company of others
120. **Unartistic:** not creative; not imaginative
121. **Self-disciplined:** good at sustained effort; not easily distracted, not impulsive; tends to work before play

122. **Forgetful:** scatterbrained or absent-minded; tends to forget appointments, dates
123. **Cruel:** able to cause pain and suffering to others; unfeeling
124. **Bashful:** tends to shy away from public attention

APPENDIX C

BRIEF COPE

The following items ask what you've been doing to cope with the stress in your life. Although people deal with things in different ways, this questionnaire is interested in how you've tried to deal with it. Each item is related to a particular way of coping and asks to what extent you've been practicing this particular way form of coping. Respond as honest as you can with the response choices below.

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

_____ 1. I've been turning to work or other activities to take my mind off things.
_____ 2. I've been concentrating on doing something about the situation I'm in.
_____ 3. I've been saying to myself "this isn't real."
_____ 4. I've been using alcohol or other drugs to make myself feel better.
_____ 5. I've been getting emotional support from others.
_____ 6. I've been giving up trying to deal with it.
_____ 7. I've been taking action to try and make the situation better.
_____ 8. I've been refusing to believe that it has happened.
_____ 9. I've been saying things to let my unpleasant feelings escape.
_____10. I've been getting help and advice from other people.
_____11. I've been using alcohol or other drugs to help me get through it.
_____12. I've been trying to see it in a different light, to make it more positive.
_____13. I've been criticizing myself.
_____14. I've been trying to come up with a strategy about what to do.
_____15. I've been getting comfort and understanding from someone.
_____16. I've been giving up the attempt to cope.
_____17. I've been looking for something good in what is happening.
_____18. I've been making jokes about it.
_____19. I've been doing something to think about it less, such as going to the movies, watching TV, reading, daydreaming, sleeping, or shopping.
_____20. I've been accepting the reality of the fact that it has happened.
_____21. I've been expressing my negative feelings.
_____22. I've been trying to find comfort in my religion or spiritual beliefs.
_____23. I've been trying to get help from other people about what to do.
_____24. I've been learning to live with it.
_____25. I've been thinking hard about what steps to take.
_____26. I've been blaming myself for things that happened.
_____27. I've been praying or meditating.
_____28. I've been making fun of the situation.

APPENDIX D

CSU STANISLAUS DEBRIEFING FORM

An investigation of childhood trauma, interpersonal functioning, and coping

Thank you for participating in this study! We are interested in understanding the relationship between childhood trauma, interpersonal functioning, and coping styles. Prior research suggests that individuals who have experienced childhood abuse will report higher levels of interpersonal distress. Additionally, research also suggests that individuals who report childhood abuse and interpersonal distress will exhibit less adaptive coping styles than individuals who have not experienced childhood trauma. We expect to find similar results in our study.

All the information we collect in this study will be kept safe from inappropriate disclosure, and there will be no way of identifying your responses in the data archive or if you decide to go forward in contacting the research supervisor after answering “Slightly Bad”, "Moderately Bad", or "Extremely Bad” on the final question on the study. We are not interested in anyone’s specific responses; rather, we want to look at the general patterns that emerge when all of the participants’ responses are put together. We ask that you do not discuss the nature of the study with others who may later participate in it, as this could affect the validity of our research conclusions.

If you have any questions about the study or would like to learn about the results of the study, you may contact me, Maday Padilla, through our research supervisor, Dr. Kurt Baker, kbaker@csustan.edu. If you have questions about your rights as a research participant, you may contact the Chair of the Psychology Institutional Review Board of California State University Stanislaus at psychologyIRB@csustan.edu. If participation in the study caused you any concern, anxiety, or distress, please contact the Student Counseling Center at (209) 667-3381, the Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/find-treatment, 1-800-622-HELP(4357), and/or the national warm line, http://www.warmline.org/

If you would like to learn more about this research topic, we suggest the following references:

Felitti, V.J. Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V.,

… Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to

many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*, 245-258. doi: 10.1016/S0749-3797(98)00017-8

Spinhoven, P., Elzinga, B. M., Van Hemert, A. M., de Rooij, M., & Penninx, B.W. (2016). Childhood maltreatment, maladaptive personality types and level and course of psychological distress: A six-year longitudinal study. *Journal of Affective Disorders, 191*, 100-109. doi:10.1016/j.jad.2015.11.036

APPENDIX E

MTURK DEBRIEFING FORM

An investigation of childhood trauma, interpersonal functioning, and coping

Thank you for participating in this study! We are interested in understanding the relationship between childhood trauma, interpersonal functioning, and coping styles. Prior research suggests that individuals who have experienced childhood abuse will report higher levels of interpersonal distress. Additionally, research also suggests that individuals who report childhood abuse and interpersonal distress will exhibit less adaptive coping styles than individuals who have not experienced childhood trauma. We expect to find similar results in our study.

All the information we collect in this study will be kept safe from inappropriate disclosure, and there will be no way of identifying your responses in the data archive or if you decide to go forward in contacting the research supervisor after answering “Slightly Bad”, "Moderately Bad", or "Extremely Bad” on the final question on the study. We are not interested in anyone’s specific responses; rather, we want to look at the general patterns that emerge when all of the participants’ responses are put together. We ask that you do not discuss the nature of the study with others who may later participate in it, as this could affect the validity of our research conclusions.

If you have any questions about the study or would like to learn about the results of the study, you may contact me, Maday Padilla, through our research supervisor, Dr. Kurt Baker, kbaker@csustan.edu. If you have questions about your rights as a research participant, you may contact the Chair of the Psychology Institutional Review Board of California State University Stanislaus at psychologyIRB@csustan.edu. If participation in the study caused you any concern, anxiety, or distress, please contact the Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/find-treatment, 1-800-622-HELP(4357) and/or the national warm line, http://www.warmline.org/

If you would like to learn more about this research topic, we suggest the following references:

Felitti, V.J. Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., … Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences

(ACE) study. *American Journal of Preventive Medicine, 14*, 245-258. doi: 10.1016/S0749-3797(98)00017-8

Spinhoven, P., Elzinga, B. M., Van Hemert, A. M., de Rooij, M., & Penninx, B.W. (2016). Childhood maltreatment, maladaptive personality types and level and course of psychological distress: A six-year longitudinal study. *Journal of Affective Disorders, 191*, 100-109. doi:10.1016/j.jad.2015.11.036