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The Effects of Relationship Satisfaction with Primary Caregivers on Adult Relationship Conflict in Survivors of Childhood Abuse

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Abstract

It has been shown in research that childhood abuse can be detrimental to children and their abilities to cope, function at school, understand social situations, and even to communicate in their adult romantic relationships (Coleman & Widom, 2004; Haskett & Kistner, 1991; Perry, 2009). As a child that has been abused grows and forms relationships as an adult, the abuse can affect these relationships in negative ways (Unger & Luca, 2014; Coleman & Widom, 2004). However, close relationships that provide safety and attunement can help create healthy attachments that foster coping skills to counteract the effects of the abuse (Siegal, 2001). Data was taken from the intake assessment used in a clinic that serves individuals, couples and families. Individuals were used who were currently in a relationship. The results of this study indicated that those with a history of reported abuse and domestic violence in their childhood had statistically significant correlations between the satisfaction with their primary caregivers and conflict within their adult relationships. This study also found that abuse and domestic violence and satisfaction with primary caregivers predicted adult relationship conflict.

The Effects of Relationship Satisfaction with Primary Caregivers on Adult Relationship Conflict in Survivors of Childhood Abuse

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Introduction

It has been shown that children who experience trauma may experience effects on their brain due to continuous stress that others may not experience. As Perry (2009) has shown through his research, the brains of individuals who are commonly exposed to stress appear to begin to prepare for a life that is filled with stress. It makes the person more capable of surviving in this environment, but can make it more difficult for individuals to adapt to less stressful situations later on. One reason that this occurs is because the regulation of cortisol and ACTH, both stress hormones, become more sensitive. Children who have experienced higher levels of stress or trauma may release this hormone more quickly with less stimulation so that they are more likely to respond more quickly, and with more defense than others may (Perry, 2009).

An important element in childhood that helps to establish coping strategies and self-soothing is relationships with caregivers. Children learn to understand their internal states, and also how to control them through their primary care figure (Siegal, 2001). As children become older, if they were unable to develop a healthy level of stress response, it can make it more difficult for them to relate and react to peers appropriately. For example, a child who has been abused is more likely to view a neutral interaction as negative or threatening (Perry, 2009), and is more likely to explode or freeze than other children (Van der Kolk, 2006). As children continue to grow, primary caregivers continue to play an important role for abuse victims. Rosenthal, Feiring and Taska (2003) showed that sexually-abused children and adolescents who were more satisfied with their caregiver were less likely to be depressed and had higher self-esteem at the time of the assault, as well as a year later.

Difficulties in relationship with others continue into adulthood. In adult romantic relationships, experiencing trauma as a child is a risk factor for divorce and walking out of a relationship. Women who were abused are also less likely to see their partners as warm, caring

and open to communication (Colmanna and Widom, 2004). However, children who are able to learn coping strategies and have social support are much more likely to be better-adjusted as adults as measured by self-esteem and psychological symptomology (Runtz & Schallow, 1997).

Greater interpersonal violence has been shown to be more likely for survivors of abuse (Daignaeault, Hebert, & McDuff, 2009), but it is unclear if satisfaction with caregivers is a protective factors for conflict in adult relationships. Having a more clear understanding of the role that primary caregivers have in healing from trauma can be important in better being able support abuse survivors.

Literature Review

It has been shown in several research studies that prolonged stress can affect the brains of children in negative ways. Shown through research (Perry, 2009; Rick & Douglas, 2007), the brains of individuals who are commonly exposed to stress appear to begin to prepare for a life that is filled with stress. Under normal life circumstances, children experience stress on a day-to-day basis, but it is most often not harmful to the brain. Extreme stress, or stress that occurs for a prolonged period of time, can begin to be toxic for the brain. Stress is toxic to the brain due to heightened levels of hormones that are released at higher rates into the brain that can change receptors and sensitivity in the brain (McEwen, 1999; Perry, 2009).

When an individual experiences a stressful situation, blood flow to the frontal cortex (which takes in information to decide on an action) is diminished, and more survival-type tendencies take over (Van der Kolk, 2006). The three common responses to stress are: flight, fight or freeze. When an individual is threatened, and is able, they will fight the threat or run away from the threat. Often for children, they are overpowered and neither of these options exists, and they can enter into a freeze response. In this state, children want to both run and fight,

but may have the ability to do neither, so their bodies are torn between states. Children who experience this multiple times may begin to make it difficult to continue to have appropriate amounts of emotion because of the overwhelming nature of stress, and may begin to feel stuck, which can lead to numbness. As a result, individuals who experience abuse at a young age may not have the ability to understand emotional states and react appropriately (Van der Kolk, 2006). This may continue into adulthood, where deciphering emotion can be difficult, which makes mounting an appropriate behavioral response more difficult.

Many circumstances can cause a child to experience heightened stress, two being physical and sexual abuse. It has been shown that children who experience physical or sexual abuse may experience effects on their brain due to continuous stress that others may not experience. Studies have shown that stress changes several structural elements of the brain including: the hippocampus, the amygdala, the corpus callosum, cerebral vermis and the cerebral cortex (Caldji, Francis, Sharma, Plotsky, & Meaney 2000; Lauder, 1983; Rick & Douglas, 2007; Thatcher, 1992). Each area supports an important function to the individual. Specifically, the amygdala deals with emotional memory, as well as the center for the flight or fight response. It has been shown that when under stress, individuals with PTSD will experience greater response from the amygdala than others do (Rauch et. al., 2000).

The biological changes in the brain are manifested in externalizing behaviors that are reported by parents, teachers, other adults and peers that interact with abused children. These behaviors are theorized to be related to the changes in the brain that make emotional regulation more difficult. Thompson (1994) defined emotional regulation as "… internal and external processes involved in initiating, maintaining, and modulating the occurrence, intensity, and expression of emotion" (p. 27). This definition has been used in order to better describe more

concisely emotional regulation. Children who have been abused have more difficulty in managing stressful situations in their intensity and the way that they express the experience. Hence, external behaviors often occur that give clues the biological changes that have occurred inside the child. Abused children are more likely to be withdrawn, aggressive, impulsive and lack personal control (Feldman, Greenbaum, & Yirmiya, 1999; Hasket and Kistner, 1991; Perry, 2009; Siegal, 2001).

Dysregulation often occurs in relationship with other individuals. Porges (2001) showed that reaction to facial features is embedded in the brainstem of individuals. The vagus nerve that exits the brainstem runs to many organs in the body, such as the heart and digestive tract to control heart rate and digestion, as well as to the facial muscles. In times of stress, signals are sent for the heart rate to increase or decrease, and digestion to slow or maintain. One of these signals that the brain stem interprets are facial expressions of others. These facial expressions help a person to react quickly without using the logical centers in the frontal cortex to determine danger or safety. If individuals have become hypersensitive to stress, and are more likely to experience interactions as neutral or negative (Perry, 2009), this circuit is going to be more sensitive as well.

Higher levels of stress often cause changes in threshold for release of hormones that makes it easier for children to become dysregulated. Children who have experienced higher levels of stress or trauma may release stress hormones more quickly with less stimulation so that they are more likely to respond more quickly, and with more defense than others may (Perry, 2009). It is as if their brain gets signals that the world is a dangerous place and that they must be prepared to react to danger, and thus the brain becomes more sensitive to stress to react more

quickly. It makes the person more capable of surviving in this environment, but can make it more difficult for individuals to adapt to less stressful situations later on.

As children become older, if they were unable to develop a healthy level of stress response, it can make it more difficult for them to relate and react to peers appropriately. For example, physically abused children in a daycare setting are less likely than their peers to initiate positive interactions with their peers (Haskett & Kistner, 1991). This is further explained by Perry (2009) that a child who has been abused is more likely to view a neutral interaction as negative or threatening. In these instances, Van Der Kolk (2006) showed that these children are also more likely to freeze or explode than their non-abused counterparts. This can make it even more difficult for other children to have positive interactions with abused children. They were more likely to be anxious and withdrawn, less-well-liked by their peers, and were less likely to have their initiations of interactions reciprocated (Haskett & Kistner, 1991). The likelihood that an abused child will see interactions as more negative and are less likely to initiate positive interactions at with peers, makes forming connected and trusted relationships more difficult.

As children grow into adults, it appears that their bodies continue to experience heightened stress signals related to the abuse that they experienced (or are experiencing). Individuals who have experienced childhood abuse are more likely to experience mental and physical problems, including eating disorders, low self-esteem, depression and anxiety (Mullen et al., 1996; Weiss, Longhurst, & Mazure, 1999). When faced with stress, adult women who are survivors of sexual abuse continue to excrete higher levels of ACTH than women who are not survivors of sexual abuse. Women in these scenarios continue to be more sensitive to signs of stress than women who did not experience sexual abuse (Heim, et al., 2000). Holsboer and Isling

(2010) have also shown that if stress hormones are persistently hyper-secreted, individuals are significantly more likely to experience depression and anxiety disorders later in life.

Furthermore, their symptoms were not isolated to their bodies, but continued to affect their relationships with others. They are more likely to experiences domestic violence, rape, separation, divorce, as well as sexual problems (Fleming, Mullen, Sibthorpe, & Bammer. 1999). Anger specifically has been found to be associated with abuse up to forty years following the abuse (Springer, Sheridan, Kuo, & Carnes, 2007).

Since stress hormones continue to be altered in adults who experienced abuse as a child (Trickett, Noll, Susman, Shenk, & Putnam, 2010), it may change their ability to relate to others as well. Just as children had a difficult time relating to peers and reacted more negatively towards peers, individuals continue to have problems in their adult relationships. DiLilio and Long (1999) showed that childhood sexual assault (CSA) survivors were less satisfied with their current partner, had less trust, and perceived communication as poorer. The survivors also had poorer conflict management skills. Colman and Widom (2004) study indicated that individuals who had experienced childhood neglect or abuse were significantly more likely to divorce or walk out of a relationship than adults who did not have a history of abuse. Childhood abuse or neglect was a higher predictor of walking out of a relationship than either having divorced parents or SES status (Colman & Widom, 2004). Women who were abused are also less likely to see their partners as warm, caring and open to communication (Colmanna & Widom, 2004). The longer the abuse, the less likely the woman would be in married or co-habitating relationships (Cherlin, Burton, Hurt, & Purvin, 2004). Women who were sexually abused were also twice as likely to be re-victimized sexually or physically later in their life (Trickett, Noll & Putnam, 2011).

It has been shown that adult survivors of childhood abuse are also more likely to experience violence in their adult relationships (Daignaeault, Hebert, & McDuff, 2009; & Renner and Whitney, 2012). Males who had suffered abuse were significantly more like to be perpetrators of abuse, or experience bidirectional violence. Women who had experienced physical abuse were significantly more likely to experience intimate partner violence (IPV) (Renner & Whitney, 2012, Trickett et al., 2011). Whitfield, Anda, Dube, & Felitti, (2003) showed that women more likely to experience IPV if they were physically abused and 1.8 times more likely if they were sexually abused. Even if the women did not experience physical abuse, but did experience domestic violence, they were still twice as likely to experience IPV as women who did not experience abuse or domestic violence. This shows that three different types of abuse and violence can lead to the same end result of IPV, which indicates that something similar is occurring in the individual, even if the events are different. When faced with stressful situations in adult romantic relationships, survivors of abuse and domestic violence are more likely to escalate than their counterparts who did not experience these stressful situations in childhood (Whitfield et al., 2003). In interviews with men who were perpetrators of domestic violence, men did not necessarily believe that certain traumatic experiences influenced their current patterns of behavior, but all discussed abuse or family issues in their childhood: sexual abuse, physical abuse, neglect and/or IPV between their parents (Watt & Scrantis, 2013).

However, children who experience abuse do not always have the same outcome. One variable that has been shown to be a protective factor is supportive relationships (Afifi & MacMillan, 2011). Trauma induces stress, which is relieved by social support and caregivers who are reliable to reestablish safety. As Chiao et al. (2008) has shown, when we experience fear we turn to those of our own "clan" to establish if the situation warrants fear, or if there is safety.

As children, we turn towards our adult caregivers to understand our fear and to receive comfort and sooth our stress response. An important element in childhood that helps to establish coping strategies and self-soothing is relationships with caregivers. When children are infants they cannot attend to their own needs of hunger, thirst or fear, but rely on an adult to serve these needs. When infants cry in pain or in fear, they are soothed by their caregivers through rocking, holding, etc. Children learn to understand their internal states, and also how to control them through their primary care figure (Siegal, 2001). If the child experiences constant stress without the soothing relief of a caregiver, children may experience "alexithymia," where they are unable to understand physical signs of emotion. Feldman et. al. (1999) showed that increased reciprocity between the caregiver at three months, increased self-control at 2 years. Caregivers being able to reflect their infants emotions and sooth them, helped their children to have more control over their emotions later in life.

As children age, they may be able to sooth themselves when they encounter more basic stresses, such as hunger or thirst, but still look to their caretakers during more stressful situations. Caregivers help to establish that the individual is safe, and thus hormone levels can return to pre-stress levels. In the absence of caregivers, it is more difficult to decrease the release of stress hormones. A meta-analysis by Afifi and MacMillan (2011) indicated that family stability and supportive relationships were traits most associated with resilience for children that were abused. The analysis was done both longitudinally and cross-sectionally, as well as on children, adolescents and adults.

Children's perceptions of their caregivers are also correlated with their abilities to regulate. Shields, Ryan, & Cicchetti (2001) showed that maltreated children represented their caregivers in a negative/constricted and less positive/coherent than their non-maltreated peers. In

this study, negative/constricted and less positive/coherent narratives were significantly correlated with being more likely to be rejected by peers and more likely to be reported as being emotionally dysregulated. This study indicates that the child's representation of their caregivers is correlated with their emotional dysregulation and relation to their peers.

As children continue to grow, primary caregivers continue to play an important role for abuse victims. Rosenthal, Feiring and Taska (2003) showed that sexually-abused children and adolescents who were more satisfied with their caregiver were less likely to be depressed and had higher self-esteem at the time of the assault, and children who had positive parenting were also shown to have a smaller amount of dissociation (Trickett et al., 2011). Being able to confide in a female caregiver was shown to be a protective factor for childhood abuse survivors in adulthood as well. Adults who reported having had a female caregiver that they could confide in had lower negative outcomes on several measures including anxiety and depression (Mullen et al., 1996). Children who are able to learn coping strategies and have social support were found to be better-adjusted as adults as measured by self-esteem and psychological symptomatology (Runtz & Schallow, 1997).

Furthermore, violence has often been shown to be intergenerational (Ehrensaft, et al., 2003; Trickett, et al., 2011). Forty-five percent of mothers of sexually abuse children reported having been sexually abused themselves. Unlike the 55% of the mothers who had not been sexually abused, the sexually abused mother's had more separations from their families, and lowest support from the families of origin as adults (Kim, Noll, Putnam, &Trickett, 2007).

Both children and adult survivors of physical and sexual abuse experience similar difficulties in relationships with others. Both appear to have difficulty relating to others and are more likely to experience others as having negative intentions (Colmanna and Widom, 2004;

Dililio & Long; Haskett & Kistner, 1991; Perry, 2009; Van der Kolk, 2006). It appears that as children who have been abused continue to have difficulty in relating to others as they continue into adulthood.

It has been shown that children who do not have consistent caregivers that help to alleviate stress, and establish healthy relationships early in life, may have more difficultly forming healthy, helping relationships (Perry, 2009). Adult survivors of physical or sexual abuse are less likely to have family support, or a network of friend support, than their non-abused counterparts (Cherlin et al. 2004). These relationships have been shown to be important in helping individuals self-sooth and regulate their emotions (Morris, Silk, Steinberg, Myers, & Robinson, 2007; Rosenthal et al., 2003; Afifi & MacMillan, 2011).

Therapies are beginning to be developed for couples with a history of abuse and trauma (Johnson & Courtious, 2009; Nasim & Nadan, 2013). However, understanding preventative measures that can help the process of healing earlier in the lives of these individuals can help to create earlier intervention for survivors of abuse. In 2012, Child Protective Services had 681,000 substantiated cases of abuse (USDHHS, 2012). Having a better understanding of how to decrease levels of continued IPV and conflict is important for individuals to break the pattern of abuse.

It is unclear if satisfaction with caregivers is a protective factor for conflict in adult relationships. Having a more clear understanding of the role that primary caregivers have in emotional regulation following abuse can be important in better interventions to support abuse survivors.

Research Question

This study aims to find if conflict in adult relationships is inversely correlated to satisfaction with primary caregivers in childhood abuse and domestic violence victims.

Method

Participants

Participants (179 individuals; 50% females, 38% males, 5.6% transgender, 6.4% other) are individuals who receive services from a therapist training clinic at a university. Inclusion criteria for the study are individuals who are at least 18 years old, and who are currently identify their relationship status as dating (31), open relationship (3), committed relationship (40), engaged (12), married (79), civil union/domestic partner (2), polyamorous (1), and/or living together (38). The majority identified as heterosexual (82.3%), but participants also indicated sexual orientation as gay (1.6%), lesbian (4.8%), bisexual (4.8%), asexual (.5%), queer (3.2%), questioning (.5%) and other (2.1%). Seventy-two percent of participants were white/Caucasian, 15% African American/Black, 5% Hispanic, 3% Latino, 3% Native American, and 1% Asian American, Asian, Middle Eastern and other.

Figure 1.1. Types of Relationship

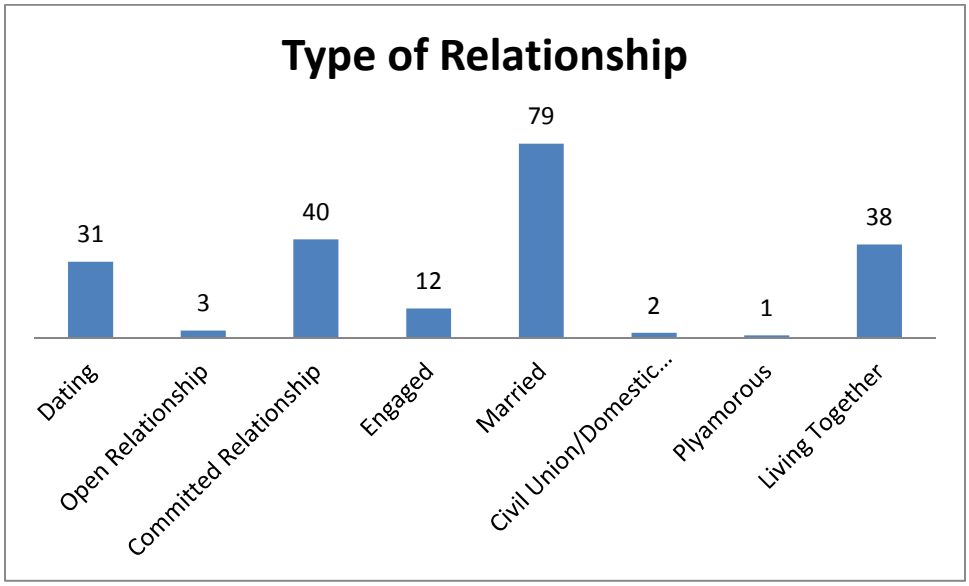


Figure 1.2. Sexual Orientation of Participants who did not identify as Heterosexual

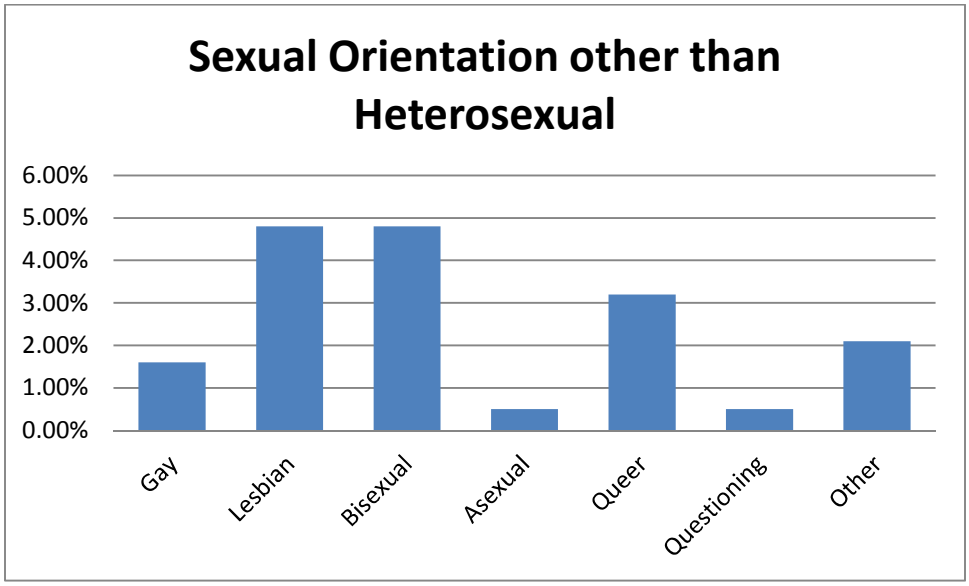
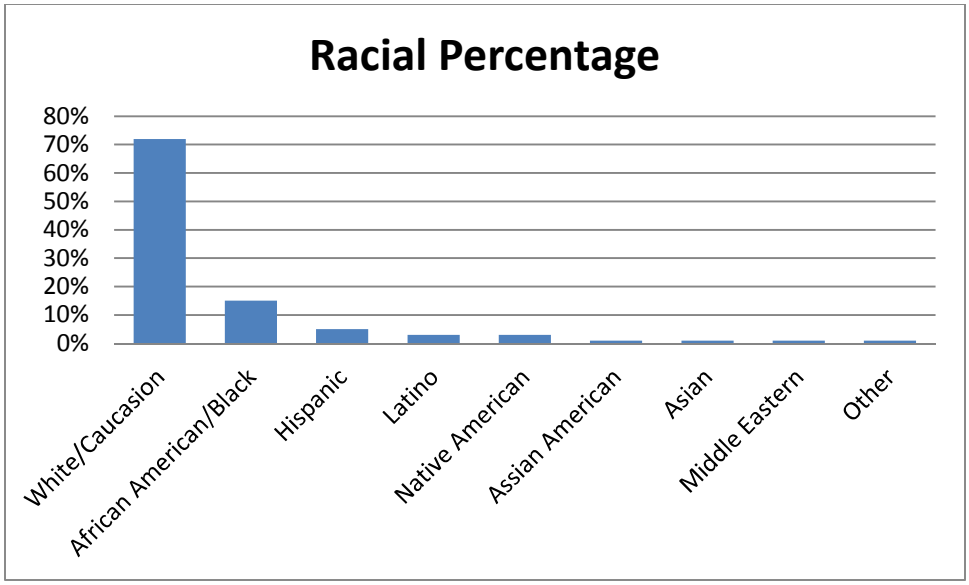


Figure 1.3. Racial Percentages of Participants



Participants had a diverse background in education level and social economic status. Participants ranged from some elementary school education (.5%) to graduate degrees (11%), with the most common educational backgrounds as some college (23.7%) and Bachelor's degree (24.3%). Participants' income ranged from less than $10,000 (12.3%) per a household per year to more than $90,000 (8.4%) per household per year.

Instruments

The assessment used in this study is a compilation of other scales used in an intake assessment clients in a university clinic setting. The assessment consists of 62 multi-part questions to assess the following areas: demographic data, health, current family, current relationship information, family of origin history, life satisfaction and presenting problems. This study utilized information from current relationships including conflict and violence, satisfaction in childhood relationships, childhood abuse and domestic violence, and demographic data. To access current relationship conflict, participants were asked fifteen questions regarding the problem areas in their relationship. Childhood abuse and domestic violence were assessed using questions such as: While you were growing up, how often did conflicts which led to physical acts like kicking, hitting hard with fists, beatings, or hitting with objects happen to you?, How often did sexual abuse (being touched in inappropriate places, or being forced or coerced into performing sex acts) happen to other children in your home while you grew up?, etc. Participant satisfaction with primary caregivers was assessed through direct questions regarding satisfaction with caregivers named. SPSS was used to analyze the data.

Data Collection

This study is part of a larger study of data collection at a university therapist training facility. Data was taken from the intake assessment used in a clinic that serves individuals, couples and families. The data was de-identified and did not require IRB approval. Questions were used to assess childhood physical abuse, sexual abuse, and domestic violence, perceived problematic conflict within the current relationship and satisfaction with primary caregivers (see appendix A). Demographic data was also included regarding gender, race, sexual orientation, SES status and education level.

Definition of Physical Abuse

Physical abuse is defined as physical acts of violence that occurred to the individual who is taking part in the assessment process. Examples given are: kicking, hitting hard with fists, beatings, or hitting with objects happen

Definition of Sexual abuse

Sexual abuse was defined as being touched in inappropriate places, or being forced or coerced into performing sexual acts.

Definition of Domestic Violence

Domestic violence was defined as physical abuse that occurred towards others children that were in the home or between caretakers.

Procedure

Every client of the university clinic took part in the assessment process with their new therapist. The assessment process occurred in the first session with the therapist for each client. Each client was alone with only the therapist during the assessment process. The assessment process included three separate measures. Clients use a computer to fill out the Self-Report Family Inventory and Brief Symptom Inventory. For the more in depth assessment, clients were asked the questions out loud that are used in the assessment process together with their therapist including information regarding: demographic data, health, current family, relationship information, family of origin history, life satisfaction and presenting problems. The data has been collected from January 2014 through January 2015. Participants obtained services as individuals, couples or families, however, assessment procedures require that they take the assessment alone.

The study is a between subjects design. The independent variables are satisfaction with primary caregivers, and abuse and domestic violence experienced in childhood, and the

dependent variable is conflict in adult relationships. A Pearson correlation was run to analyze if caregiver satisfaction and relationship conflict are related. A Pearson correlation was also run for those who have experienced a 1 or higher on the abuse scales, and those who score a 0. ANOVA was run to access if relationship satisfaction is related to relationship conflict for childhood physical and sexual abuse survivors.

Hypothesis

It is expected that:

- Low satisfaction with primary caregiver in childhood abuse and domestic violence victim is correlated with high conflict in adult
- Domestic violence and abuse is correlated to relationship conflict in adults
- Satisfaction with primary caregivers and abuse and domestic violence are predictors of adult conflict in intimate relationships
- Childhood abuse and domestic violence is correlated to current interpersonal violence and sexual abuse

Results

Childhood abuse and domestic violence

Out of 179 participants, 81.6% experienced abuse or domestic violence in their childhood (M = 3.99, SD= 3.42, R = 15), with the highest possible score of 25. More males experienced childhood violence and abuse, (84.3%) than female (78.5%). However, females experienced a higher average score of violence (M = 4.13, SD = 3.52, R = 13) than females (M =3.91, SD = 3.44, R = 15).

Participants reported frequency of domestic violence, physical and sexual abuse. Participants reported 15.1% had experienced sexual abuse, and 11.1% reported knowledge of

sexual abuse occurring to other children in their home. Physical abuse in childhood was significantly related to domestic violence and sexual abuse in childhood and adulthood. A majority (68.2%) of respondents reported that that they had experienced physical abuse in childhood (74.3% of males, 64.5% of females), with 24.6% reporting that they experienced it fairly often or very often. Domestic violence was a slightly less common experience for participants with 63.7% experiencing domestic violence (65.7%, 65.6% of females), with 46.3% of children experiencing domestic violence between their parents, and 48.6% experiencing other children in their house experiencing physical abuse. Physical abuse perpetrators were most commonly a parent (46.9%), followed by a sibling (9%), someone who was not related (7.3%) and another relative (6.2%)

Sexual abuse was broken down into those who experienced sexual abuse, and those who had other children in the house that experienced sexual abuse. Participants experienced sexual abuse at a similar rate to other studies, (this study = 26.3%, other studies average 25.3%) (Pereda, Guiller, Forns & Benito, 2008), and 11.1% were aware that other children in their homes experienced sexual abuse. Males reported that they had experienced less sexual abuse (12.1%) than females (32.3%). Males also reported that they were aware of only 1.4% of other children in their household experiencing sexual abuse, whereas females reported knowledge of sexual abuse in their household at a much higher rate (16.1%).

Primary Caregiver Relationship Satisfaction

Participants named primary caregivers and were asked how satisfied they were with the relationship, and were able to name up to four different individuals. For each individual that they named as a primary caregiver, they stated how satisfied they were with their relationship: Very Satisfied, Satisfied, Neutral, Dissatisfied, Very Dissatisfied. Relationship satisfaction was then

scored -2 (very dissatisfied) to 2 (satisfied). Participants could name up to four primary caregivers, and thus it was scored on a scale with a possible range from -8 to 8, and the participants ranged from -8 to 8 (*M* = 1.37, *SD* = 2.49). See table 1.1. Females scored lower on primary caregiver relationship satisfaction (*M* = .95, *SD* = 2.47) than males (*M* = 1.96, *SD* = 2.38).

Adult Relationship Conflict

For relationship conflict, participants ranged from scores of 6 to 62 with the highest possible score of 75 (*M* = 31.35, *SD* = 12.11). See table 1.1. Males reported a higher average conflict (*M* = 32.14 , *SD* = 11.38), than females (*M* = 31.49, *SD* = 12.79). The most common reported area of conflict was communication (87.2%). Fifteen different areas of conflict were assessed, and 91.5% had a statistically significantly correlation to other areas of conflict.

Table 1.1

	Mean	**Median**	**Std. Deviation**	**Range**	**Minimum**	**Maximum**
Relationship Conflict	31.352	31.00	12.11	56	6	62
Violence	3.9944	3.00	3.42	15	0	15
Relationship Satisfaction	1.37	1.00	2.50	16	-8	8

Current Relationship Violence

Participants also reported current relationship sexual and physical violence. Participants reported 33.5% had been physically violent towards their partner in the last 12 months, with 1.1% reporting it occurred fairly often or more. Participants also reported that 33.6% had experience violence from their partner in the last 12 months, with 3.4% reporting violence fairly often or often. Six percent reported that they had pressured their partner into sexual favors in the

last 12 months, and 7.3 percent reported that they had been pressured by their partner into sexual favors.

Females and males reported similar rates of violence in their relationships. An exception was violence towards the participant was experienced by a greater number of males, 24.3% versus 17.2% for females.

A bivariate Pearson correlation was run and current relationship physical and sexual violence had a statistically significant correlation to violence in childhood ($r = .191$, $n = 179$, $p = .01$). When broken down by types of childhood violence, current relationship physical and sexual violence was statistically significant to childhood physical violence ($r = .204$, $n = 179$, $p = .006$) and childhood domestic violence ($r = .177$, $n = 179$, $p = .018$), but not to sexual abuse ($r = .017$, $n = 179$, $p = .824$), or knowledge of sexual abuse of other children ($r = .006$, $n = 179$, $p = .940$). Current relationship physical and sexual violence did not have a statistically significant correlation to satisfaction with primary caregivers ($r = .-.044$, $n = 179$, $p = .560$).

Relationship status

Of the complete sample, 77% met criteria for the sample to be included. Those who were single were discarded from the sample. The majority identified as heterosexual (82.3%), but participants also indicated their sexual orientation as gay (1.6%), lesbian (4.8%), bisexual (4.8%), asexual (.5%), queer (3.2%), questioning (.5%) and other (2.1%).

A majority of participants reported that their relationship was in trouble (80.6%), and 68.2% reported that they had thought seriously about breaking off their relationship, 18.4% having thought about it more than six times. Nearly half had broken off their current relationship (43%), with 4.5% having broken it off more than 6 times.

Analysis of Relation Satisfaction and Current Conflict in Relationships

A Pearson correlation was run to understand the relationship between the variables. Violence experienced in childhood was statistically significant to current relationship conflict (r = .233, n = 179, p = .002) and statistically significant to relationship satisfaction with primary caregivers (r = -.202, n = 179, p = .007). See Table 1.2. A linear regression was also run to better understand relationships between the variables. See table 1.3. The variable explained 7.1% of the outcome which indicates that abuse and domestic violence that was indicated, and relationship satisfaction with primary caregivers explained 7.1% of the conflict in adult relationships.

Table 1.2 Correlations between abuse and domestic violence experienced in childhood, satisfaction with relationship with primary caregivers, and current relationship conflict in adult relationships

		Violence	**Relationship Conflict**	**Relationship Satisfaction**
Childhood domestic violence and abuse	Pearson Correlation	1	.233**	-.347**
	Sig. (2-tailed)		.002	.000
Adult Relationship Conflict	Pearson Correlation	.233**	1	-.202**
	Sig. (2-tailed)	.002		.007
Primary Caregiver Relationship Satisfaction	Pearson Correlation	-.347**	-.202**	1
	Sig. (2-tailed)	.000	.007	

**. Correlation is significant at the 0.01 level (2-tailed).

Table 1.3 Linear Regression

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	29.647	1.623		18.270	.000
	Violence	.657	.275	.185	2.392	.018
	RelSat	-.669	.376	-.138	-1.779	.077

a. Dependent Variable: RelConflict

Violence versus No Violence

Groups were then separated by those who had experienced childhood physical and sexual abuse, and those who scored 0 on the domestic violence and abuse questions. For those who reported 0 on the domestic violence and abuse questions, relationship satisfaction with primary caregivers no longer had statistical significance with adult relationship conflict ($r = -.226$, $n = 33$, $p = .207$), however, those who scored greater than 0 on the domestic violence and abuse questions continued to have a statistically significant correlation between primary caregiver relationship and adult relationship conflict ($r = -.175$, $n = 147$, $p = .035$).

Types of Childhood Violence

Looking at the types of violence experienced in childhood separately, childhood physical violence has a statistically significant relation to adult relationship conflict ($r = .288$, $n = 179$, $p = .000$) and childhood domestic violence between caregivers ($r = .160$, $n = 179$, $p = .032$), but not to childhood sexual abuse ($r = .001$, $n = 179$, $p = .994$) or to sexual abuse experienced by other children in the household ($r = .137$, $n = 179$, $p = .068$).

Gender

Further analyses were run to better understand other relationships between variables. Gender indicates the participant's gender identity as chosen by the participant. When looking at only females, the relationship remained statistically significant for all variables, ($F(2, 90)= 4.586$, $p < .013$) however, the Pearson correlation remained statistically significant for relationship satisfaction with primary caregiver ($r = -.414$, $n = 93$, $p = .004$), but childhood domestic violence and abuse were no longer statistically significant at the .05 level ($r = .196$, $n = 93$, $p = .06$). See Table 1.4. Males on the other hand showed opposite results. Overall, the model remained statistically significant, $F(2, 67)= 3.538$, $p < .013$), but the correlation for primary caregiver relationship satisfaction was no longer statistically significant, ($r = -.150$, $n = 70$, $p =.217$) however, violence continued to have a statistically significant correlation ($r = .306$, $n = 70$, $p =$ 010). See table 1.5.

Table 1.4 Females correlations for Relationship satisfaction, domestic violence and abuse, and Adult Relationship Conflict

		Violence	**Relationship Conflict**	**Relationship Satisfaction**
Violence	Pearson Correlation	1	.196	-.414
	Sig. (2-tailed)		.06	.000
Relationship Conflict	Pearson Correlation	.196	1	.-293
	Sig. (2-tailed)	.060		.004
Relationship Satisfaction	Pearson Correlation	-.414	-.293	1
	Sig. (2-tailed)	.000	.004	

Table 1.5 Males correlations for Relationship satisfaction, domestic violence and abuse, and Adult Relationship Conflict

		Violence	**Relationship Conflict**	**Relationship Satisfaction**
Violence	Pearson Correlation	1	.306	-.354
	Sig. (2-tailed)		.010	.003
Relationship Conflict	Pearson Correlation	.306	1	-.150
	Sig. (2-tailed)	.010		.217
Relationship Satisfaction	Pearson Correlation	-.354	-.150	1
	Sig. (2-tailed)	.003	.217	

Discussion

This study shows that the relationships with the primary caregivers and violence experienced in childhood were both important factors in adult relationship conflict. It indicates that relationships with primary caregivers and abuse and domestic violence experienced in childhood may be predictors adult intimate relationships; specifically that primary caregiver relationship may be an important resource for children that may lead to less conflict in later relationships.

Current analysis support previous research that indicates that primary caregivers have an effect on victims of abuse and violence (Afifi & MacMillan, 2009; Perry, 2009; Mullen et al., 1996). This study showed that perceived satisfaction with primary caregivers played an important role for developing relationships as adults that had less conflict, and that abuse and domestic violence were important factors. The lessened conflict supports the main hypothesis in this study. This suggests that primary caregivers may play part in helping individuals to be able to form relationships where there is less conflict, especially if they have experienced trauma. One of the possibilities for the reasons that this occurs is because of the regulation skills that

caregivers help to establish in their children. As studies have shown, the brain under stress begins to wire in such a way that allows the child to be able to survive in a world that is stressful through changes in brain areas and hormonal changes (Perry, 2009; Siegal, 2001; Van der Kolk, 2006), which has been shown to continue into adulthood (Heim et al., 2000). This study indicates that this higher sensitivity to stress may make conflict more likely in adult romantic relationships for survivors of childhood domestic violence and abuse, but that conflict is less if the child has a primary caregiver that is satisfactory.

Several studies have indicated that experiencing violence as a child can be highly correlated to experiencing violence in adult relationships (Renner & Whitney, 2012; Whitfield et al., 2003), however, few studies have looked at the wider idea of conflict in a relationship that goes beyond physical violence. Dysregulation not only indicates outward expressions of emotion, but also withdrawal or dissociation. In children for instance, it has been shown that those who experience trauma not only act out violently, but could also be emotionally dysregulated in other ways such as: difficulty making friends, easily irritated, and have difficulty with empathy (Shields, 1997). Koopman et al. (2004) showed that adolescents with a history of trauma not only had higher heart rates during stress tasks, but those with dissociative symptoms also had lower heart rates than the comparison group in a stress task. This dichotomy suggests that the body may react physiologically in two different directions in order to cope. This shows how individuals can have many different coping mechanisms and reactions to their traumatic experiences. In relationship, both ways of coping may create more conflict in a relationship. Violence in adulthood is not the only way a couple can have conflict. Withdrawing and shutting down is a common response to trauma (also known as freeze or flight) (Van der Kolk, 2006), which can also cause conflict in a relationship because the person becomes difficult to

communicate with, which can be mistaken for something else such as stonewalling, for example. Violence is the most common behavior noted for maladaptive coping; however there are several other ways to show maladaptive coping, which was indicated in this study as overall conflict being higher, not simply violence.

Colman and Windom (2004) showed through their research that survivors of abuse were more likely to walk out on their relationships and more likely to divorce, but did not study the reasons that behaviors are likely to occur. This study indicates that adults with a history of childhood abuse may struggle in their relationships in several ways. This study looked at how an individual viewed fifteen different areas that are commonly difficult areas for couples to navigate in their relationships. This study indicated that couples, who have experienced violence in their childhood, indicated higher scores of conflict within their relationship. In addition, the various areas of conflict were highly related to one another as well. This statistic would indicate that when one area of conflict is high, the other areas are also likely to be high. This would mean that the topic of conflict is not necessarily important, but the way in which the couple relates may be conflictual overall. If an individual has become more sensitive to stress, then it would make it more likely that their hormone levels are going to rise, and it will be more difficult to remain fully aware with full judgment (Siegal, 2001).

Violence in Childhood versus Caregivers

The linear regression indicated that violence had a larger effect on adult relationship conflict than primary caregiver relationship, but that both had an important effect on adult conflict. This could indicate that dysregulation of physical abuse and domestic violence have a larger effect than the caregiver relationship, and that satisfactory relationships have an effect but to a lesser degree. However, this dynamic could be complicated for several reasons. For one, if

the abuser is also the primary caregiver because the same individual could be dysregulating the child, as well as helping to sooth them at different points in the child's experience. Another possibility is that the child was removed from an abusive household and placed with another person, but this study did not indicate which individuals should be included as primary caregivers, so who the person chose could affect the data. It could also indicate that when children experience abuse and domestic violence, there are other variables that were not accounted for that are also likely to co-occur, such as violence in their neighborhood. This finding does highlight the important role that physical abuse and domestic violence play on adult conflict in relationships, as well as indicates the importance caregivers play in this dynamic.

Individuals with a history of Childhood Domestic Violence or Abuse

This study also indicated that for individuals with a history of abuse or domestic violence, satisfaction with caregivers remained statistically significant, but if the individuals did not have a history of abuse or domestic violence, the analysis ceased to be statistically significant. This would indicate the caregiver relationships are very important if the person experiences abuse or violence in their childhood. Children who do not experience abuse or domestic violence are less likely to live in situations of uncontrollable stress, which lead to hyper arousal and sensitivity to triggers (Hasket & Kisner, 1999; Perry, 2009; Van der kolk, 2006). Children who experience violence in their childhood homes have high need for coping skills and ability to regulate their emotions. Children begin to understand their internal states early in life, and use these same self-soothing strategies as they age (Siegal, 2001). It appears that if stress continues to occur through violence in the home that continued relationships that are satisfactory in the child's memory are needed for a child to continue to be able to cope with the stress and be able to form regulatory strategies that carry into adulthood and intimate relationships. This

information is incredibly important to abuse and domestic violence survivors, it highlights how important and transformational a satisfying relationship with a primary caregivers can be. As Hardy, Power, & Jaedicke (1993) showed, even children who experienced little structure in their homes had a wide array of coping strategies if they had supportive parents. This study continues to support this research that relationships within the context of the situation are extremely important part of children's ability to cope.

As findings in this data showed, caregivers were important in helping to create adult relationships that have less conflict, which could mean that childhood relationships, even if individuals experienced childhood domestic violence and abuse, could be a protective factor in stability of adult relationships. This study helps to further explain the research by Colman and Widom (2004) that showed how relationships were much more likely to be unstable for adult survivors of childhood abuse. They indicated that individuals who experienced abuse were much more likely to see their partners as uncaring and unloving. As Van der Kolk (2006) and Perry (2009) have shown, children will become attuned to others reactions more so than their non-abused peers than others if they have experienced abusive situations. If intimate relationships did not bring comfort (soothing and reassurance) in childhood, then it could make it more likely that a person will see an interaction with a significant other more negatively than they would have if they had not been abused. This can continue into adulthood due to the neurological pathway in childhood that close relationships can be wired to higher levels of stress. However, the results indicate that this can be reversed, or halted, through interactions with adults who care for the child.

Gender Differences

When the genders were separated, findings differed for each of the genders. Before discussing difference in gender, it is important to note that 5.6% of the population did not identify as male or female, so the following breakdown is not inclusive of everyone in the sample. However, the number of individuals that did not identify as either male or female was not enough to run an analysis.

The relationship overall for the model remained statistically significant for both genders, however, correlations told a different story. For females, relationship with primary caregiver remained statistically significant to relationship conflict, but childhood violence became less influential. For males, the opposite was true, childhood violence remained statistically significant with relationship conflict, and relationship satisfaction with primary caregivers was no longer statistically significant. This could indicate that the different genders may experience violence and/or relationships with primary caregivers differently physiologically. For instance, primary caregiver relationships may be more important for regulation for females than for males, or that more emphasis is put on females connecting with others. Also, violence may be more dysregulating for males than for females. Males also experienced more violence than females in their childhood, as well as in their current relationships. Females were more likely to be unsatisfied with their primary caregiver relationship. Other studies have shown that women who were abused were more likely to be unsatisfied in their intimate adult relationships (Colman & Widom, 2004). This may indicate that females seem to be more cautious to relationships both in childhood and adulthood.

Conflict in Current Relationship

It is worth noting that although several indicators differed by gender, the amount of conflict overall in their current relationships was similar for both males and females. The highest area of conflict was communication. Communication is often a broad topic brought into the clinical setting by couples, but gives very little information. For example, several of the other categories that were indicated in the scale require communication to navigate. However, this study shows that even when one topic was rated highly, most other topics were also highly rated. This indicates that the topic may not the cause, but more so that the conflict exists in any form points back to the hypothesis of this study that it may be more difficult for domestic violence and abuse survivors in stressful situations to continue to engage with others. As Heim (2000) has shown, adults can remain more sensitive to stressful situations and release more hormones.

Sexual Abuse

For sexual abuse, females experienced a much higher rate of sexual abuse than males, and a much higher rate of being aware of others experiencing sexual abuse in their households (16.1% vs 1.4%). The Adverse Childhood Experience (ACE) study which gathered information from more than 17,000 individuals, indicated that 24.7% of females and 16% of males experienced sexual abuse in their childhood. This study indicated a similar percentage of sexual abuse for both genders (females= 32.3% and males = 12.1%).

Looking specifically at each type of abuse and current relationship conflict, relationship conflict is correlated with experiencing physical violence and domestic violence as a child, but is not correlated with experience of sexual abuse as a child. In this study, sexual abuse alone was not significantly related to relationship satisfaction or current conflict in the relationship. This finding is contrary to other findings (Colman & Widom, 2004; Dililio & Long; Trinckett, Noll &

Putnam, 2011). Dililio & Long (1999) who found that conflict management skills and communication was poorer for survivors of SA. This finding could have occurred for many reasons. In a study by Trickett et al. (2011), duration of the abuse and victims relationship to the perpetrator was found to be significantly different several years following the abuse in continuation of symptomology. Females who were abused by fathers, or close relatives, were more likely to have early onset, and were more likely to be significantly different than the control group five years later. Only 3.4% of perpetrators for sexual abuse in this study had their father as their perpetrator, while the majority was a non-relative.

Previous studies have indicated that females experience childhood sexual abuse at a rate three times that of males (Pereda et al., 2009). This study found a 3 to 1 ratio for females to males; however, this study also indicated that males and females report similar amounts of physical abuse and domestic violence in their homes. Females on the other hand report a much higher percentage of other children in their homes being sexually abused. This could be explained by several factors. It was statistically significant that individuals who were abused as children also reported other children in the house that were abused, and a majority of those that reported sexual abuse were females. It is possible that if an individual is sexually abused, they are more likely to be aware of others in your home that are being sexually abused, or that they will occupy a house where others are sexually abused. The only question would be if males, or those who are not sexually abused, are aware of others being sexually abused in their household.

Intimate Partner Violence

This study supported previous studies that childhood violence is correlated to intimate partner violence (Whitfield et al., 2003; Renner & Whitney, 2012; Watt & Scrantis, 2003). This relationship remained statistically significant for domestic violence, as well as physical violence

experienced in childhood. Current violence was not statistically significant to satisfaction with primary caregivers. This finding is curious because conflict in a broader sense is significantly related to satisfaction with primary caregiver relationship, but actual violence between the couple is not. For this study, the question specifically asked about violence within the last twelve months. It is likely that the person would be reporting violence for the current relationship, and only in the past 12 months. It is possible that this would be under reported for several reasons: the study is not anonymous, participants report lower numbers to protect of themselves or their partner, or may be in denial of the amount of violence that occurs in their relationship. Domestic violence is highly stigmatized, and can be difficult for a person to be fully aware of the problem. Another possibility to consider is that abuse experienced is easier to see removed from the situation, so looking back on childhood, than when you are currently living in the relationshp. Also, Renner and Whitney (2003) found that females and males who experienced sexual abuse as children were more likely to experience IPV as adults, this study showed no statistically significant results for sexual abuse as a child and IPV or conflict.

Importance of Recognizing Family of Origin Violence

The sample for this study had a significantly higher reporting of physical abuse than was reported in the ACE study, 68.3% versus 28.3% (CDC, 2014). This is an important indicator that clients who may seek therapy may have a much higher likelihood of having experienced physical abuse, or domestic violence. As has been shown in the past, and this study adds to the evidence, maltreatment can have lasting effects on people that can then manifest themselves later in life. An important factor that was shown in this study was that the percentage of clients that experienced childhood abuse and domestic violence is much higher than that reported in the general population. Many studies have shown that experiencing childhood trauma puts

individuals at a higher risk for a serious mental illness, and that if they have a serious mental illness, their symptomology is significantly more likely to be severe (Muesera, Rosenberga, Goodmanb, & Trumbettac, 2001). Other studies have also shown a much higher rate of childhood trauma in clinical samples as well, (Jacobson, 1989; Muenzenmaier, Struening, Ferber, & Meyer, 1993; Muesera, 2001). In this study, the questions regarding abuse were asked out loud by a therapist, not in an anonymous survey, or with an individual with whom the participant anticipates no future relationship. This could make disclosure feel more possible because it could feel as if it is part of trusting relationship. Secondly, the participant is in the process of beginning therapy, and this could make disclosure of abuse more likely because they have decided to come to a place to seek help.

Perceived Satisfaction with Primary Caregiver

This study chose to use the perception of the caregiver relationship because the information was 1) readily available, and 2) can be readily available to any therapist, counselor, or researcher who will use the information given in this study. Perceptions are not objective; however, it is important to know how a person perceives their caregiver, and how this is correlated to the above factors. This is especially important therapeutically. Therapist may not have access to information regarding the actual relationships that an individual had, but they can more easily access how the individual perceived this relationship. The perception of the client is often an extremely important signal of better understanding the experience of the client in a therapy room. A lot of research has been conducted on the adult attachment inventory, which has shown exceptional results in predicting certain behavior in adults (Bakermans-Kranenburg, & van IJzendoorn, 2009). This gives more evidence that reported caregiver satisfaction is also significantly related to broader couple conflict.

This study is important in two ways. Firstly, for children who are victims of abuse, having a caregiver that continues to support them and help them to cope is extremely important. This study indicates that this factor can make a difference to children as they continue to be in relationship with others into adulthood. Most importantly, it can give people who work with those who have experience abuse and violence hope that they can heal, and that they have an avenue that makes this possible. Secondly, when working with couples, it shows how important it is to assess family background. It can easily be overlooked, especially when the problems at hand are much more glaringly obvious, but it is important to consider, or order to get to the root of the current stressors that a couple may face. Therapies on working with couples who have experienced trauma are beginning to developed because it has been shown that childhood violence and abuse affects adult intimate relationships, such as emotionally focused couples therapy developed by Susan Johnson (Johnson & Cortois, 2009) or couples research done by Nasim and Nadan (2013). These researchers indicate that couple relationships can be a place of healing.

Limitations

While this study offers supporting and new evidence of the importance of the caregiver relationships for individuals' experiences of childhood abuse, there are a few limitations. The scales used asked about physical and sexual abuse, but not for other types of abuse such as emotional abuse or neglect. Emotional abuse and neglect have also been shown to have an effect on the well-being of children (Flemming et al., 1999; Siegal, 2001).

The method of data collection was also different from many other studies, which did have some possible negative effects. As the data is collected as part of an assessment, it is not anonymous, which could make participants answer questions differently if they were

anonymous. The therapist also asked the questions out loud to the clients, which could affect the answer given by the client.

Another limitation is the possibility that some of the assessments are related. All adult members in a family that come to the clinic are asked to take part in the assessment process. The assessments are still done individually, but if another member of the same family completes an assessment, or a partner of another person completes an assessment, the two assessments are not independent of one another. Another limitation is that each individual in a given family may not complete the assessment at the beginning of therapy. Individuals may come into therapy later than the first session of therapy. For example, if an individual comes to therapy, and then decides to bring their partner, their partner fills out the assessment at the point that they are brought into the therapeutic process. This is a limitation because one individual is already in therapy, which could impact their partner and cause shifts to their assessments.

Another limitation to this research may be that primary caregivers are not the only adults that can help children and adolescents to cope and to learn regulation skills. Children and adults can learn how to cope from other important adult figures in their life, as well as through other interventions such as therapy. This study did not take into account other important adults that could have helped children learn to regulate that were not considered primary caregivers by the participant.

Another important element that needs to be taken into consideration is the way that relationship satisfaction was assessed. It did not give guidelines for “primary caregiver” to the participant, nor was more information gathered on who was included as primary caregivers, which could have an effect. For example, someone may report their mother as a primary caregiver with whom the individual had a very unsatisfactory relationship, however, the

individual did not live with their mother for a majority of their childhood. This would factor into the actual influence that this person had on their abilities to regulate, or become even more dysregulated.

Furthermore, interventions can take place throughout the lifespan that can help a person learn to better regulate themselves. For example, in our sample, 67% of our sample had experienced therapy at a previous point in their life.

Another consideration in this research is that participants are viewed as individuals. However, as shown by research mentioned several times in this study, one partner may have an effect on the other partner. For example, if one individual experienced abuse as a child, and had a bad relationship with their caregiver, this has been shown to affect how a person will enter into a relationship (Colman & Widom, 2004). The individual's perception of the relationship may differ from their partner, and as it has been shown their experience of the other person may be different. As we have seen in children, their view of interactions maybe more neutral or negative than their non-abused peers (Hasket & Kisner, 1999). This can carry into adulthood and to intimate partner relationships as well. If on partner is more likely to view events that occur in their relationship as negative or neutral, this will then affect other events between the couple, such as their communication. If due to past experiences and relationships, an individual has more difficulty coping in stressful situations, this will affect their relationship. Specifically for this study, an individual who reports no childhood trauma, may report a higher degree of current relationship conflict because of the effect of the trauma that their partner experienced.

Finally, scales used in this assessment have not been validated. This can be a shortcoming, as well as useful in the therapeutic setting. For research, it can make it more difficult to compare to other research, and can be unclear if the questions measure what they are

intended to measure. On the other hand, the questions are few and direct, and can be asked by any therapist.

Future Directions

Research

Many questions are left to answer, and new questions have developed from administration of this study. Is would be important moving forward to better understand caregiver relationships and what is important to survivors. Males and females indicated that they had different satisfaction overall with primary caregivers, and it would be helpful to better understand if males and females need different things from caregivers to be satisfied, or is it possible that females and male abuse victims are treated differently by caregivers. Future research could help to clarify what is important from caregivers to survivors of abuse and domestic violence, if this differs by gender of child, and what is most important for healing and coping to receive from caregivers. This information would be important to understand to know the best intervention tactics for children who have (or are) experiencing abuse and domestic violence. Also, this study did not take into account other supportive adults in a child's life. Coping skills and emotional support does not only come from primary caregivers, but can also come from coaches, teachers, family friends and extended family (Farley & Kim-Spoon, 2014). Can other supportive adults serve as a protective factor to children, which can then influence adult intimate relationships? It would also be helpful to better understand if gender of the primary caregiver affected the relationship, or if having both parents in the home versus the father or the mother affected the satisfaction with the primary caregivers.

For adults, it would important to further explore the role that other supportive adults serve. If children can be supported by other caring adults, is it possible for the same healing

process to occur with people who have reached adulthood, but still have difficulty in intimate relationships? If adult relationships can be beneficial, what is the most important part of the relationship to aid in the healing process, and how does this affect couple relationships?

In this study, partners were not connected in any way. However, an individual that is part of a couple is going to have an effect on the other person, as well as the way in which the relationship functions. Trauma is not only the burden of the person who experiences it, but becomes a piece of the dynamic of relationships that this person enters, and thus affects the other person. It would be beneficial to further explore this concept, and be able to look at couples and see how trauma influenced the relationship as a whole, even if one of the partners did not experience trauma.

Clinical Implications

This study supports, as well as sheds new light, on the importance of caregivers for children who are survivors of abuse and domestic violence. This study indicates that caregivers are important factor in the coping process of abuse and domestic violence. In clinical settings, this translates to the importance of the interventions chosen to be used with children. This shows that relationships that are viewed by the children as satisfactory could aid in adult relationships of these same children. When children are known to have experienced domestic violence and physical abuse, it is important to help build a supportive relationship with a primary caregiver that can assist the child to continue to be able to emotionally regulate. Often in therapeutic settings, children are separated from their parents, and treated individually. This may help to build a supportive relationship with the therapist, however, this research indicates the primary caregivers are extremely important. If the child is removed from their environment and taught to regulate, the skills will be more difficult to generalize, and are more likely to be lost overtime if

the primary adult figure is not included in the therapeutic experience. As Perry (2007) discusses in his book, "The boy who was raised as a dog," children will spend a small amount of time with a therapist, and tenfold that amount of time in their home environment. One hour of therapy a week cannot change, undo, or make-up for what occurs in a child's home.

Primary caregivers may also be victims of trauma as well, which can also impacts their abilities to regulate themselves as has been shown by continued adult conflict in this study, as well as difficulty in relationships as adults in several other studies (Cherlin et all., 2004; Widom & Colman, 2004), as well as several studies that indicate intergenerational transmission of trauma (Ehrensaft, 2003; Trickett, 2011). This is incredibly important when thinking of including parents in therapy with children. Mothers who were hostile towards their children, also indicated that their children were emotionally disregulated (Morris et al., 2002). This may make it more difficult for children to have a satisfactory relationship with their primary caregivers because the caregiver has a difficult time regulating their own emotions. As children who experience abuse are more likely to act out (Hasket et al., 1991), it can be more difficult for parents to continue to regulate themselves, and in turn regulate their children. Therapeutically, it is important to understand the parent's trauma history to use best practices in helping them to emotionally regulate themselves, in order to support children learning to emotionally regulate themselves.

This study also indicates the importance of continued support by a primary adult figure in a child's life following abuse or domestic violence. This study indicated that half of the perpetrators of physical abuse or parental figures, and majority of the domestic violence occurred between primary caregivers. However, this study indicates that these caregivers could still have good relationships with their children, and that they relationships impacted the abilities of the children to have less conflict in their own relationships later in life. This situation is difficult to

decipher for clinicians how to best understand the most important factor for the child in this situation if their caregiver is violent in the household, yet their continued relationship has been shown be an important protective factor.

Another consideration for the clinician is other adult supports for a child that may continue to experience stress. This could be other family members, family friends, community supports (i.e. boys and girls club). It is important be culturally competent when working with a family to best understand what other adult supports are acceptable and most useful to the child under the umbrella of cultural understanding.

As indicated, over 80% of the population in this sample reported childhood abuse or domestic violence. This is over three times that experienced in the general population. Many studies have shown the long term effect of trauma (Daigneault, 2009; Heim, 2000; Mullen, 1996 Weiss, et al., 1999), which makes it incredibly important to be aware of the possibly of childhood trauma for clients, and to be able to be trauma informed on the best practices in working with clients who have experienced trauma. Furthermore, this study indicates the importance of relationship. As adults, individuals still have relationships with friends, parents, other family members, as well as romantic relationships. Adults may not have the same opportunity to have healing, regulatory relationships, but being able to help adults find healthy relationships that can help to be regulatory could have the same effect that relationships children have with positive caregivers.

Conclusion

The results of this study indicated that childhood abuse and domestic violence and primary caregiver relationships are both important on adult relationships conflict. Specifically, those with a history of reported abuse and domestic violence in their childhood had statistically significant correlations between the satisfaction with their primary caregivers and conflict within

their adult relationships. This highlights how critical relationships can be when a child experiences this type of trauma in how they later negotiate their adult romantic relationships. Cherlin et al., (2004) showed that adult females who experienced childhood abuse are less likely to have a network of friends and family support. Working with clients who have a history of abuse may be more susceptible to a lack of support, where support has been shown to be extremely beneficial to those who have had these experiences. Also, when working with children who have experienced childhood abuse and domestic violence, including and working with parental support is extremely important. This study is another indicator of the importance of helping to foster healthy and supportive relationships for clients with a history of trauma can be.

Appendix A

Question regarding relationship Conflict:

34: Using the scale below, rate how often the following areas are problems in your relationship:

1= N/A 1= Never a problem 2= Very seldom a problem 3= sometimes a problem 4= often a problem 5= very often a problem

34a. Financial matters
34b. Ways of dealing with children
34c. Leisure activities
34d. Emotional intimacy
34f. Sexual issues
34g. Partners/in-laws
34h. Spiritual matters
34i. Communication
34j. Decision making
34k. Commitment,
34l. Values
34m. Housecleaning
34m. Gender issues/roles
34o. Violence
34p. Drugs/alcohol

Question regarding abuse:

45a. While you were growing up, how often did conflicts which led to physical acts like kicking, hitting hard with fists, beatings, or hitting with objects happen to you?

Answers: Very often, fairly often, sometimes, hardly ever, never

45b. While you were growing up, how often did conflicts which led to physical acts like kicking, hitting hard with fists, beatings, or hitting with objects happen to other children in your home?

Answers: Very often, fairly often, sometimes, hardly ever, never

47.How often did physical violence occur between your primary caretakers while you were growing up?

Answers: Very often, fairly often, sometimes, hardly ever, never

48a. How often did sexual abuse (being touched in inappropriate places, or being forced or coerced into performing sex acts) happen to you while you grew up?

Answers: Very often, fairly often, sometimes, hardly ever, never

48b. How often did sexual abuse (being touched in inappropriate places, or being forced or coerced into performing sex acts) happen to other children in your home while you grew up?

Answers: Very often, fairly often, sometimes, hardly ever, never

Questions regarding relationship satisfaction

36a. While growing up, how satisfied were you with your relationship with your ___ (Participant inserts each primary caregiver in the blank, and repeats 36a and b between 1 and 4 times depending on number of caregiver).

Answer: Very Satisfied, Satisfied, Neutral, Dissatisfied, Very Dissatisfied, N/A

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Education

Master of Science Marriage and Family Therapy — Graduation Date: May 2015
Syracuse University, Syracuse, NY — GPA: 4.0

Bachelor of Science Psychology — Graduation Date: May 2011
Colorado State University, Fort Collins, CO — GPA 3.57
Study Abroad: Tasmania Spring 2010

Research

The Effects of Relationship Satisfaction with Primary Caregivers on Adult Relationship Conflict in Survivors of Childhood Abuse (2015). Masters Thesis

Trott, C. D**.**, Canetto, S. S., Thomas, J., Wynstra, C., & Stoops, T. (April, 2011). Career plans of atmospheric sciences graduate students: Does gender matter? Poster presented at the Rocky Mountain Psychological Association Conference, Salt Lake City, UT.

Stoops, T., Thomas, J., Canetto, S. S., Trott, C. D**.**, & Wyntsra, C. (August, 2011). Plans for children of women and men in STEM. Poster presented at the American Psychological Association Conference, Washington D.C.

Therapy Experience

Vera House – Graduate Therapist Intern — May 2014- May 2015

- Therapy with children, adults and families who have experienced domestic violence and sexual assault
- Work with families to establish safety within the family and living environment
- Process experiences in age and developmentally appropriate manner

Upstate Hospital – Graduate Therapist Intern — October 2014- May 2015
Pediatric Cancer Center and Blood Disorders

- Meet and access families for needs and stressors related to diagnosis
- Treat patients and families for issues related to illness or change within the family

Couple and Family Therapy – Graduate Student Therapist January 2014- January 2015

- Assess clients on present and past symptoms and experience in order to establish a treatment plan
- Create treatment and goal plan with client/s
- Treat families, individuals, couples and children on issues presented
- Establish safe and attuned relationship to process and use interventions to work towards goals set by the client/s

Work Experience

Catholic Charities, Goals for Success September 2014- May 2015
Skill builder

- Work with youth 7-18 to establish skills to better improve functioning in their homes, schools and other environments
- Work with families to establish goals
- Use art, sports, worksheets, and peers to practice skills in real work settings

Syracuse University- *Health and Wellness Promotion* August 2013- May 2014

- Responsible for promoting health and wellness issues to students, in part by establishing a coordinated approach across the divisions of Student Affairs
- Implemented a new peer education program starting this semester for Be Wise
- Conducted and documented research regarding SHAC, alcohol prevention, and insurance in evidence-based articles and currently practiced initiatives at other Universities
- Responsible for the evaluation of Orange After Dark and Mindful Eating Course
- Served as a member on the Safety Committee and Drug and Other Drug Committee

Conferences and Accomplishments

Internal Family Systems – March 2014

Trauma Resilience Model, I and II- October/November 2014

Motivational Interviewing Conference- February 2014

Campus Step Up - Spring 2009

- Engage with students from across campus on a retreat to better understand race, gender, class, religion and diversity and how we experience cycles of oppression

Shades of Promise - Fall 2008

- Worked with students from a historically Black University regarding issues of race and personal identity