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AN EXAMINATION OF THE IMPACTS OF CHILDHOOD TRAUMA ON HEALTHY INTIMATE RELATIONSHIPS IN COLLEGE-AGED AFRICAN AMERICANS

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AN EXAMINATION OF THE IMPACTS OF CHILDHOOD TRAUMA ON HEALTHY INTIMATE RELATIONSHIPS IN COLLEGE-AGED AFRICAN AMERICANS

By

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To the children that needed a healthy love and

to the adults navigating their concept of love.

Naku penda

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ABSTRACT

For African Americans, the dynamics of relationships are rooted in childhood experiences of unconditional love, restraint, and respect. These experiences help individuals form their understanding of how relationships function. Experiencing healthy relationships has an enduring impact on social development and interpersonal relationships. However, regarding studies on childhood trauma and intimate relationships, there is insufficient literature that includes African American samples as the primary foci of the research. Due to gaps in extant literature, the present study aims to explore whether experiences of healthy intimate relationship in African Americans are associated with childhood trauma (neglect, emotional, sexual, and physical abuse). Using the concept of *Adverse Childhood Experiences (ACEs;* Felitti & Anda, 1998), the present study examined the extent to which trauma experienced in childhood serves as a predictor of healthy intimate relationship experiences, using a novel measure, the *Healthy Intimate Relationship Assessment (HIRA*; Shepard, 2019). Psychometric properties regarding the HIRA were explored to determine factor loadings and reliability. The study measured whether gender or counseling moderated the relationship between ACEs and healthy relationship factors as well. Findings suggest that 1) higher reported ACEs scores were associated with lower HIRA scores on the trust, honesty, and communication subscales, 2) participants that endorsed higher ACEs abuse and neglect clusters scores reported experiencing less trusting, honest, and communicative intimate relationships as outlined in the HIRA measure, and 3) gender and counseling experience did not attenuate the association between ACEs and HIRA scores. Implications of adverse childhood experiences on experiences in adult intimate relationships are discussed as well as future directions to consider when exploring similar research.

An Examination of the Impacts of Childhood Trauma on Healthy Intimate Relationships in College-Aged African Americans

CHAPTER I

INTRODUCTION

Various researchers have studied childhood trauma (Esteves et al., 2017; Gaskin-Wasson et al., 2017; Kuhl & Boyraz, 2016; Miskiewicz et al., 2016) and romantic relationships (Debnam et al., 2014; Kogan et al., 2013). However, concerning studies on childhood trauma and intimate relationships, there is insufficient literature that includes African American samples as the primary foci of the research. Studies that include participants of African descent, trauma, and relationships are scarce and inadequate in comparison to their Caucasian counterparts. A proper examination among African Americans must occur to determine if adverse childhood experiences negatively impact critical components of healthy intimate relationships in adulthood. Race is a significant indicator of the likelihood for a child to experience trauma and adverse experiences. When comparing race as a predictor of adverse experiences, African American children were 45 percent more likely to experience traumatic experiences compared to their Caucasian counterparts (Jimenez et al., 2016). Individuals exposed to adverse events during childhood are at-risk of experiencing negative impacts to their social, biological, and physical development (Crandall et al., 2020; Harris et al., 2017; Oh et al., 2018). African American mothers exposed to childhood abuse (i.e., ACEs abuse cluster) have the potential to internalize and later, during adulthood, externalize negative behaviors (i.e., displays of aggression towards their children and spouses; Esteves et al., 2017). The cycle of trauma may continue to persist trans-generationally (Esteves et al., 2017) and impact the quality of intimate relationships (Allen

& Mitchell, 2015) in marginalized communities if researchers do not bring the problem to the forefront through research, activism, and intervention.

Historically, ACEs were used to measure biophysiological health outcomes in majority White adult samples (Felitti et al., 1998). As such, an investigation of healthy relationships is necessary for an integrity-based approach to understanding relationship experiences in African American college-aged adult samples. The present study seeks to objectively measure adverse experiences occurring in childhood through the ACEs framework and understand pertinent components of healthy relationships (trust, honesty, and good communication) using Debnam et al.'s (2014) seminal qualitative conceptualization of healthy relationships in African Americans. The study aims to resolve a disconnect that exists regarding research on ACEs, race, and ramifications of childhood adverse experiences on intimate relationship experiences, unveiling the factors impacted by childhood adversity in an African American college aged sample. Moreover, and consistent with a counseling psychological perspective, the present study may have implications for culturally-responsive prevention and/or intervention.

Definition of Terms

In the context of the present study, *intimate or romantic relationships* are defined as a committed emotional and physical companionship commonly between two people. Still, they can include several individuals depending on the nature of the relationship (i.e., polyamorous and open relationships). The meaningfulness of intimate relationships is dependent upon the individuals involved. Debnam et al. (2014) examined the conceptualization of healthy romantic relationships. The characteristics identified were based on the Centers for Disease Control and Prevention's (CDC; 2010) list of beneficial characteristics for a healthy relationship. Beneficial characteristics included but were not limited to respect, trust, secure communication, honesty,

and freedom from violence and abuse. With respect to trauma, according to Houry and Mercy (2019), *adverse childhood experiences* are defined as potentially traumatic events that occur in childhood (0-17 years). Exemplars of adverse experiences include physical, emotional, and sexual abuse; neglect; experiencing communal violence; witnessing a death; having a parent with a mental health disorder; parental instability; and having a parent who misused substances. The CDC (2019) and Arias et al. (2008) offered the following definitions 1) *physical abuse* (the use of intentional physical action that can injure a child), 2) *emotional abuse* (actions harming a child's emotional well-being), 3) *sexual abuse* (the act of sexual activity with a child under 18 years old), 4) *neglect* (a caregiver's failure to provide to a child with sustenance, housing, and other commodities needed to meet their basic needs), and 5) *household dysfunction* (circumstances negatively impacting persons in the home; pp. 11-19).

CHAPTER II

REVIEW OF LITERATURE

Adverse Experiences and Trauma

Adverse Childhood Experiences

Attempts to understand and conceptualize the short and long-term effects of childhood trauma are not novel tasks (McCauley et al., 1997; Springer at al., 2003). In 1995, Felitti et al. noted that no study to that point in time observed potential childhood trauma's effects on health outcomes. As a result, Felitti and colleagues, in conjunction with the Centers for Disease Control and Prevention (CDC), Emory University, and Kaiser Permanente sought to explore the role of abuse, neglect, and household challenges during childhood to health outcomes in adults. Individuals were mailed a survey assessing childhood abuse, neglect, and household dysfunction. Felitti and colleagues (1998) developed a questionnaire instrument that measured ACEs using existing questionnaires to compile a comprehensive instrument to measure the three major adverse experience clusters in the sample. The clusters included questions about physical abuse, sexual abuse, emotional neglect community violence, and exposure to mental impairment in the home. The questions were designed to measure adverse experiences until the legal age of adulthood in California (18 years-old).

Researchers noted that ACEs impacted a plethora of health outcomes including hypertension, cardiovascular disease, and stroke as well as increased the risk for health risk factors such as obesity, smoking, and suicide attempts (Felitti et al., 1998; Dube et al., 2001; Marie-Mitchell et al., 2016). These long-term physical health risks and outcomes can impact individuals' psychological function and increase the chance for developing depression (Anda et al., 2002; Chapman et al., 2004), anxiety (Sachs-Ericsson et al., 2007), and substance use

disorders (Anda et al., 2002). Though Felitti and Anda (1998) intended to examine the link between adverse experiences and health outcomes primarily, further research noted that ACEs affect other areas of daily functioning (Beilharz et al., 2020). Vioth et al. (2020) and Hammet et al. (2020) discussed the abuse ACE cluster and its effects on romantic relationships. Hammet et al. (2020) noted that childhood abuse was a predictor of intimate partner violence, and the violent behaviors negatively impacted individual's perception of their relationships. Researchers have also posited that children exposed to abuse and parental violence are more likely to display similar aggressive behaviors in their intimate relationships (Gaskin-Wasson et al., 2017; Hammet et al., 2020). Other scholars note that childhood sexual abuse contributes to the perpetration of sexual abuse in adulthood (Vioth et al., 2020). Likewise, Esteves et al. (2017) noted similar findings that mothers who experienced physical abuse during their childhood went on to externalize aggressive behaviors traditionally seen in physical abuse such as corporally punishing their children through spanking. If left untreated, this cycle of abused to abuser may contribute to continuance of ACEs across generations (Esteves et al., 2017).

Importance of Studying ACEs Among African Americans

There is documentation that individuals with different ethnic-racial backgrounds are at risk of experiencing adverse events during childhood (Harris et al., 2017; Jimenez et al. 2016; Macguire et al., 2019; Oh et al., 2018). For example, Maguire and Colleagues (2019) findings suggest that Caucasian children had a decreased chance of being exposed to any adverse experiences (59.1%) while African American children only had a 36% chance of not being exposed to any adverse experiences. Following an examination of specific ACEs, African American children were exposed to more traumatic events than Caucasian and Latinx children in all adverse experiences with the exception of living with someone who misused substances and

living with someone who was mentally ill. African American children were more likely to experience abuse, violence, and household dysfunction compared to other racial groups.

Furthermore, Maguire et al.'s (2019) research draws attention to the plausibility that African Americans have an increased chance to inherit adverse experiences from their environment and family systems. Within household dysfunction, African American children were approximately twice as likely to experience the death of a parent or have had an incarcerated parent. The loss of a parent, whether legal or physical, can impact a child's life trajectory (Dawson et al., 2013). The high rates of parental loss in the lives of African American children spotlights the greater impact of systemic and institutional discrimination and racism on this community of people. African Americans have been the target of the injustices of oppression for decades, including New York's Stop and Frisk practice which racially profiled African Americans, created redlining policies which allowed for the refusal of loans to individuals because they live in a "poor" neighborhood, and denied individuals the right to livable wages based on their inability to access adequate education. The injustices as mentioned earlier are not an exhaustive list, rather a glimpse into the lived realities which perpetuate adverse experiences faced by African Americans. Given what is known about the rates of ACEs in African American communities, it is crucial to investigate other factors of daily functioning that may be impacted by adverse events including individuals' intimate relationships.

Impact of ACEs on Intimate Relationships

Historical Focus on Unhealthy Relationships

The extant literature is vast regarding the role of ACEs on intimate partner violence (Cascio et al., 2020; Goodman et al., 2020; Voith et al., 2020); however, limited research has examined the role of ACEs on healthy intimate relationships in adult samples. Similar to Voithe

et al. (2020) findings that childhood physical abuse and sexual abuse were predictors for perpetration of sexual and physical violence in men. Most literature to date has examined a singular aspect of relationships that was impacted by ACEs - violence. It is pertinent to acknowledge and discuss that the ways that relationships are conceptualized has been from a Eurocentric, pathological perspective and that this study takes an Africentric, normative functioning approach. The conceptual understanding of relationships in the African American community are rooted in childhood experiences of unconditional love, restraint, and respect (Nobles et al., 1987). These experiences help individuals form their understanding of how relationships function. Operating from the African World View (AWV), intergenerational relationships (e.g., caregiver and child) are the foundation in which future platonic and intimate relationships are predicated (Kambon, 1998). When African Americans do not function from the AWV, they become misoriented, resulting in identifying with a culture outside of their own, consequently experience dissonance. This cognitive dissonance is a result of internalized beliefs and ideas that do not further the progress of the AWV. Subsequently, a portion of trauma experienced in African Americans occurs due to caregivers adopting and subscribing to the European World View of chaos and dysfunction; thus, atypical actions and behaviors arise. Multigenerational impacts of maternal physical abuse may contribute to the possible inheritance of generational abuse and contribute to maternal mood symptoms and children's exposure to traumatic events in early life (Esteves et al., 2017). There is a propensity for experiences of childhood trauma and ACEs to persist into adulthood; thus, continuing the cycle of abuse from victim to perpetuator. Esteves and colleagues (2017) studied a sample of African American mothers and their children to determine if there was a link between mothers' experiences of

abuse and behaviors that those mothers endorse as ways to corporally punishment and discipline their children (parenting styles).

In an attempt to further comprehend the influence of childhood trauma in African Americans, Gaskin-Wasson et al. (2017) examined experienced childhood emotional abuse, attachment, and hopelessness in women. In women that endorsed higher levels of hopelessness, childhood emotional abuse was a significant factor impacting their ability to establish and maintain healthy relationship as adults (Gaskin-Wasson et al., 2017). This finding perpetuated the notion that childhood emotional abuse can limit one's ability to identify positive and healthy ideas of self and others; hence impacting their ability to accurately identify intimate partners to establish healthy intimate relationships with and distorting their views of themselves. Additional findings indicated that for some participants, child physical abuse had a multigenerational impact, such that the transgenerational inheritance of physical abuse and internalized behaviors influenced an individual to misunderstand intimate relationships. This would suggest that encounters with physical abuse negatively impacts individual's experiences in intimate relationships. While scholars have begun to analyze the focal point of unhealthy relationships in the literature (Kambon, 1998; Gaskin-Wasson et al., 2017; Cascio et al., 2020; Goodman et al., 2020; Voith et al., 2020), attention should be given to the components that compromise healthy intimate relationships.

Trust

Experiencing healthy intimate relationships exemplifies successful social development within individuals. Some individuals consider the focal point of a relationship to be rooted in trust. To oppose, mistrust can be the catalyst for relationship instability, dysfunction, and difficulties between persons involved (Miller & Rempel, 2004). For some, past trauma

negatively impacts an individual's ability to develop the necessary skills to create and establish healthy intimate relationships (Esteves et al., 2017; Gaskin-Wasson et al., 2017). Exposure to trauma may reduce one's ability to trust and decrease the ability to form social support networks with others. This reduced ability is particularly evident when victims know the perpetrator. Individuals traumatized by members of their family, friend groups, or community have the potential to distrust persons around them, which predisposes them to unsuccessful social development. As such, mistrust in relationships may manifest as the ramifications of childhood trauma. Kuhl and Boyraz (2016) sought to identify mindfulness and general trust as significant factors contributing to an increased sense of social support. Social support proved to help college students' adjustment with school, social, and personal challenges. The skills commonly drawn upon to socially support peers and receive social support (trust and mindfulness) are not learned as quickly in individuals with a history of experienced trauma (Kuhl & Boyraz, 2016).

Kuhl and Boyraz (2016) identified mindfulness and general trust as primary factors that led to a greater sense of social support. Researchers found mindfulness to positively associate with overall relationship satisfaction and increased levels of empathy for self and others. In contrast, individuals with a history of trauma may endorse more hesitancy and reluctancy to trust friends and family and detach themselves from others. Lacking social support may contribute to less trusting intimate relationships, Individuals with experiences of trauma are likely to disregard trusting people and primarily focus their attention on the awareness of themselves only (Kuhl & Boyraz, 2016; Wachs & Cordova, 2007). Kuhl and Boyraz's (2016) findings justify the assumption that trauma influences some individual's experiences with trust, such that some persons with a history of trauma experience unique challenges in their intimate relationships. Individuals who experienced trauma had a diminished perception of social support from others.

Given these findings, it will be beneficial for college students to with a history of trauma to develop skills like trust to better regulate their emotions more effectively, navigate socially supportive networks, and establish healthy intimate relationships.

A caveat of the Kuhl and Boyraz (2016) study lays in the demographics of the sample. This study primarily collected data from Caucasian students which hinders researchers from drawing conclusions about factors that vary by race or culture (e.g., types of traumas experienced, resilience to trauma, and cultural differences of social support). There are cultural differences in African Americans that account for some behaviors, beliefs, and overall attitudes towards experienced trauma (Kogan et al., 2013). As an example, someone who has experienced constant racial discrimination from outside races is more likely to have internalizing behaviors such as mistrust and depressive symptoms (Anderson et al., 2013; Seaton et al., 2014). It should be noted that the development of trust can also vary as individuals mature and undertake new roles in their relationships (e.g., child and caregiver, platonic friendships, and intimate relationships). Said another way, the mechanisms of trust in child and caregiver relationships differ from trust in intimate relationships, in that a child trusts their caregiver to provide for, protect, and nurture them. In intimate relationships, all the parties involved have a mutual trust not to harm each other and not practice infidelity outside of the relationship. While the underlying value of trust is evident among numerous relationships, the role and meaning of trust varies (Miller & Rempel, 2004).

Honesty

Congruent with trust, honesty is a hallmark of a healthy relationships. Despite the significant overlaps in trust and honesty as components of healthy intimate relationships, it is important to distinguish honesty from trust. According to Merriam-Webster's dictionary trust is

the "assured reliance on the character, ability, strength, or truth of someone or something" while honesty is the "adherence to the facts" ("Trust" & 'Honesty", 2003). In the context of relationships, trust is the action of being truthful and honesty is the belief that someone is being honest. Notwithstanding that these concepts are not mutually exclusive such that someone can believe their partner is being honest based on a false truth, when considered together, they are the strongest predictors of a healthy intimate relationship (Debnam et al., 2014; Royer et al., 2009).

Developing social skills to navigate intimate relationships appropriately begins during adolescence. (Royer et al., 2009; Xia et al., 2017). Children learn social norms through parental engagement in early life, later shifting to peer-to-peer social interactions (i.e., friendships) to base their behaviors and morals (Cushman et al., 2017; Haidt, 2001). With this in mind, adolescents begin establishing friendships and intimate relationships based on values normed by their social groups. These intimate relationships have the ability to impact various facets of adolescent development including social interactions, problem-solving skills, self-esteem, and identity. Beyond that, adolescents are ultimately internalizing the behaviors and dynamics displayed in their intimate relationships as normal aspects of "healthy" relationships (Debnam et al., 2014). Despite being developmentally normal, adolescents have the potential to internalize unhealthy behaviors in the relationships including, but not limited to partner violence, jealousy, gaslighting, and ineffective communication. Debnam and colleagues' (2014) sought to understand the conceptualization of healthy intimate relationship in African American high school-aged girls and examine the disconnect, if any, between existing standards and African American adolescents' discourse about healthy relationships.

During the qualitative interviews, the three components of healthy intimate relationships identified most often in the sample were trust (91%), good communication (82%), and honesty

(79%). Researchers noted honesty as a fundamental component needed to establish and maintain a healthy relationship successfully. Debnam et al. (2014) suggest a complex link between honesty and trust- though the concepts are often used interchangeably, they are different; however, they complement and build upon each other. Through qualitative coding, honesty was a value that they developed during childhood, persisted into adolescence, and manifested in intimate relationships as loyalty and practicing monogamy in relationships. The practice of honesty in relationships is vital for the longevity and overall health of a relationship (Debnam et al., 2014); in spite of that, the ways in which honesty is communicated are seldomly mentioned. Adolescents in the previously mentioned study wanted their partner to be honest with them regardless of the delivery, but extant literature suggests that "honest but hurtful" messages may negatively impact intimate relationship dynamics (Zhang, 2009; Zhang & Stafford, 2009). Good communication is the conduit for trust and honesty in relationships; it is imperative to consider each of these factors when considering individuals' experiences in their current intimate relationships.

Communication

Dialogue, conversation, and discourse between partners is central to the function of intimate relationships. Findings in extant literature suggest that communication in a relationship is a salient factor in conflict resolution (Young et al., 2015; Zhang & Stafford, 2009). While commonly experienced in real-world interactions between partners, researchers have overlooked differences in communication expectations in intimate relationships. There is an abundance of research examining the associations between communication styles and dating violence in teens (Bonache et al., 2017), hurtful messages and relationships (Vangelisti & Young, 2000; Zhang, 2009; Zhang & Stafford, 2009), as well as conflict resolution and relationship stability (Morrison

& Schrodt, 2017); still, gaps in research exist thus a need to investigate the ramifications of childhood adverse experiences on communication and other components of healthy in an adult sample.

Albeit mentioned, participants in Debnam and colleagues (2014) study conceptualized good communication as openness, transparency, the ability to confide in one's partner, as well as the ability to engage in open dialogue about the meaning of their relationship. Individuals value open communication relationships because it is closely related to their ability to trust and believe their partner(s) is being honest. Scholars examined the perception of hurtful communication in relationships (Theiss et al. 2009; Zhang & Stafford, 2009). Researchers found that honest but hurtful messages as well as frequently poorly communicated messages were perceived as intentional and did not enhance the recipient's view of themselves or the relationship. Across numerous studies, the samples were comprised of mostly Caucasian individuals making it difficult to generalize the findings to other racial groups including African Americans (Theiss et al. 2009; Zhang & Stafford, 2009; Morrison & Schrodt, 2017). Given the intricate importance of communication in intimate relationships, it is crucial to understand the role of communication to healthy relationships in African Americans adults.

Potential Factors Impacting ACEs and Intimate Relationships

Gender

Given potential gender differences, it is important to investigate the differences in how men and women assess components of their current intimate relationships. Scholars have noted the long-standing differences in how boys and girls are socialized by society and the roles they are expected to assume in familial and intimate relationships. Girls are expected to be dutiful, obedient, and responsible while boys are tasked with being self-reliant and orienting their

behavior to achieve excellence (Barry, Bacon, & Child, 1957; Bem 1981). Stereotypes held by society provide an arbitrary justification for the socialization, rearing, and treatment of children based on gender. Extant literature suggests that experiences of trauma differ between the binary genders (Kerig & Ford, 2014; Miskiewics et al., 2016). Miskiewicz et al. (2016) analyzed gender differences in men and women who experienced childhood trauma and ACE abuse clusters (sexual, physical, and emotional) as well as how individuals with experiences of childhood trauma adjusted to intimate relationships. Abuse proved to impact an individual's views of the world negatively and resulted in individuals not being emotionally present in adult intimate relationships. Additionally, researchers examined the impact of violence that persists into adulthood. These impacts include the likelihood of individuals to display aggressive behaviors, sexual dysfunction, and a lack of interpersonal skills.

Miskiewicz and colleagues (2016) indicated that men report more avoidant behaviors than women; conversely, women were more likely to report more anxious behaviors than men. There were no statistically significant gender differences in neither emotional abuse, emotional neglect, nor physical neglect; however, levels of physical and sexual abuse differed across gender. On average, women in the study experienced higher levels of sexual abuse than their male counterparts. Men reported more experiences of physical abuse (punching, hitting, slapping). In contrast to Kogan et al.'s (2013) finding that men reported higher relationship satisfaction, Miskiewicz et al. (2016) revealed relationship adjustment and overall satisfaction as consistent across genders. Both men and women who experienced childhood abuse had low levels of relational adjustment and overall relationship satisfaction. The findings suggest a link between abuse (ACEs), relational adjustment, and overall relationship satisfaction; however, the

sample was limited in that it only included Caucasian clinical participants as opposed to a more inclusive and representative population from the community (Miskiewicz et al., 2016).

Further, when researchers (Kogan et al., 2013) assessed parental factors, cumulative community stress, relational schemas, and healthy romantic relationship levels, findings indicated men were "more often satisfied" in their intimate relationships when compared to women. Researchers measured relationship satisfaction based on happiness, lack of verbal abuse, and absence of violence. These gender differences also indicate the extent to which community stressors impacted participants' relationship-based actions such as displays of intimacy and affection towards one's partner. The lack of diversity in the racial and ethnic demographics of the sample reduces the generalizability of the study findings. It emphasizes the need for further research to be conducted that seeks to examine differences with respect to race, trauma, and relationships.

Counseling

In addition to race and gender, another relevant factor to consider is individuals' participation in counseling as a factor moderating the association between ACEs and healthy intimate relationship assessment. For African Americans, there is an increased likelihood of experiencing one or more ACE before their ascension into adulthood (Maguire et al., 2019). Adverse experiences have the propensity to evoke symptoms similar to post-traumatic stress disorder by increasing the exposure to toxic (negative) stress thus causing individuals to become hypervigilant, experience a startled response, and frequently be in a state of anxiety (Kalmakis et al., 2020). Scholars investigated the role of counseling, therapy, and resilience following ACEs (Craig et al., 2020; Tranter et al., 2020). Tranter and colleagues (2020) found that treating the trauma following an adverse experience increased individuals' emotional resiliency and overall

mental health. This work suggests that someone who has endorsed one or more ACEs can combat the deleterious effects of trauma by engaging in therapeutic intervention. Liddon et al. (2017) noted the significant differences in help-seeking behaviors between genders. Men were more reluctant to seek help from mental health professionals, while women were most likely to seek help for psychological dysfunction. Further research is needed to determine whether counseling and gender moderate the relationship between childhood adverse experience and healthy intimate relationships in an African American sample.

The Current Study

The present study aims to examine African American participants to establish a connection between childhood trauma and healthy intimate relationships and determine if levels of childhood trauma predict experiences in intimate relationships gauged by a novel, researcher-developed relationship assessment. An individual with a history of trauma can internalize these experiences, and subsequent negative behaviors can externalize within their intimate relationship(s). Few samples in the extant literature consider African American populations; additionally, there is no literature highlighting African American college-aged adults. The present study will work to strengthen the shortcomings of previous research in the field. The research questions that the present study intends to answer are: 1) In what ways does childhood trauma (i.e., ACEs) relate to healthy intimate relationship values assessed? 2) To what extent does gender moderate the association between ACEs and healthy intimate relationship values? and 3) Does participation in counseling strengthen the association between ACEs and healthy intimate relationship experiences? I hypothesized that (1) higher reported ACEs scores would be associated with lower *Healthy Intimate Relationship Assessment* (*HIRA*; Shepard, 2019) scores on the trust, honesty, and good communication subscales, (2) gender would moderate the

relationship between ACEs scores and HIRA scores, and (3) participation in counseling would weaken the association between ACEs and HIRA scores. As an exploratory aim, the present study examined whether gender and counseling interacted to moderate the relationship between ACEs and HIRA scores. Lastly, given the novelty of the HIRA scale, factor analyses were conducted to determine whether the a priori factor loadings were consistent.

CHAPTER III

METHOD

Participants

Participants in this study included 341 Florida Agricultural and Mechanical University (Florida A&M University) students and 159 Bethune-Cookman University (B-CU) students (total N = 500). Inclusion criteria for the present study included identifying as African/African American/Black and being at least 18-years old at the time of survey completion. All participants in the study were currently enrolled at their respective university. The study included approximately 15% males (N = 76) and 85% females (N = 424), participants ranging from 18-35 years old (M_{age} = 20.52). Students in participating courses (e.g., Introduction to Psychology, Developmental Psychology, Black Psychology, Introduction to Food Sciences, Principles of Food Manufacturing, and Pre-Teacher Education courses) were assessed using convenience sampling. Participants' classification varied; however, 32.8% of the participants reported being sophomores (N = 165). Approximately 30% of participants endorsed counseling participation, while 69% had not received any counseling services. All participants in the study were volunteers.

Procedure

The Institutional Review Board (IRB) at Florida A&M University and B-CU granted full approval of the present study in the Fall semester of 2019 (see Appendix A). All procedures were conducted in accordance with the ethical standards of the institution's IRB. Participants were recruited with the assistance of faculty members within the Department of Psychology, Education, and Food Science at Florida A&M University as well as the Department of Education and Psychology at B-CU. Available professors within the Department of Psychology, the College of Education, and the College of Food Sciences at Florida A&M University as well as the Department of Education and Psychology at B-CU were asked to distribute a link for the study survey to their undergraduate and graduate students. The survey was administered via the internet through a third-party website (i.e., Qualtrics, Provo, UT). An informed consent document was displayed on the first screen in the online survey. Participants were unable to advance through the survey unless they agreed to and read the terms of the digital consent form. Each participant was ensured confidentiality. To decrease the chances of priming and carryover effects, survey questions were presented in a randomized order. Some participants completed the ACEs questionnaire first, followed by the HIRA, while other participants completed the HIRA, then the ACE questionnaire. The participants filled out the online survey, which contained questions about experienced childhood trauma, and their endorsement of trust, honesty, and good communication in intimate relationships based on their relationship experiences. At the discretion of the faculty at the university, extra credit was provided to students who participated in the study.

Measures

Demographic data

The demographic questionnaire allowed for the collection of self-reported information on participants' gender, age, race, ethnicity, university affiliation, current major, previous major, classification, past GPA, academic course load, participation in counseling (coded using dummy coding; 0=no, yes=1), scholarship status, loans, parental financial support, personal income, and employment status (see Appendix B). Dummy coding was used to score scholarship status, loans, parental financial support, employment status (0=no, 1=yes), gender (0=female, .5= other, 1=male), and race (0=White, .5=other, 1=Black). The classification demographic was scored as follows: 1= freshmen, 2= sophomore, 3= junior, 4= senior, 5= other). Numeric values were assigned based on endorsed ethnicity (See Appendix C for all ethnic categories).

Childhood Trauma

Participants completed the Adverse Childhood Experiences (ACE) Questionnaire (Felitti et al., 1998; see Appendix D) online. The ACE Questionnaire was adapted from the epidemiological study of the Kaiser Permanente health-care group in California between 1995 to 1997 (Felitti et al., 1998). This questionnaire contains 10 items measuring subtypes of maltreatment, (abuse, maltreatment, and neglect), parental dysfunction (parental separation, divorce, parental incarceration, and witnessing domestic violence), and other risk factors like living with someone in the house with a mental illness. Existing research on ACEs use among Black samples is limited as it focused on the long-term effects on health outcomes (Hicks et al., 2021).

Healthy Intimate Relationships

The Healthy Intimate Relationship Assessment (HIRA) (Shepard, 2019; Appendix E) was specifically developed for this study. 25 items were developed and considered for subsequent factor analyses. Items in this measure addressed the most important attributes of a healthy relationship: trust, communication, and honesty (Debnam et al., 2014). The items exist on a 5-point Likert-scale with responses ranging from "never" to "always." Four items were reversed such that lower scores are more favorable to understanding components of healthy intimate relationships (e.g., "*I find it difficult to share things with my partner(s)*" was scored as "Never"=5 and "Always"=1). Higher scores indicate stronger abilities to engage in healthy intimate relationships, and lower scores indicate weaker ability to engage in healthy intimate relationships (e.g., "*I trust my partner(s) to not physically hurt me*." "*I can be open to my partner(s) about my most intimate secrets*.")

Data Analytic Plan

Power Analysis

Researchers in the current study hypothesized that higher scores on childhood adverse experiences would predict weaker healthy intimate relationship understanding in the present sample. Although no studies to-date have examined ACEs and intimate relationships in a college adult African American sample, previous studies have investigated various factors impacted by ACEs (Felitti et al., 1998; Anda et al., 2002; Hammett et al., 2020) as well as components of healthy relationships in adolescents (Debnam et al., 2014). Given there are no prior studies that examined factors in the present study synergistically, the investigator conservatively estimated a medium effect size of .15 based on Cohen's (1988) proposal of effect size and completed a priori power analysis using G*Power software (Faul, Erdfelder, Buchner, & Lang, 2009). The

minimum number of participants required (n = 105) would be sufficient to detect an effect (power ≥ 0.80 alpha ≤ 0.0125) based on ACEs clusters, HIRA, and subscales on the HIRA.

Preliminary Analyses

Due to the dearth of measurements quantifying healthy intimate relationship understanding in African Americans, the present study developed a novel assessment to evaluate participant's ability to understand components of healthy intimate relationships. To account for the recently developed assessment, exploratory and confirmatory factor analyses were utilized to evaluate psychometric properties for the HIRA and subscales.

Primary Analyses

The data collection used in the present study utilized a multitude of analyses to examine the impacts of ACEs, gender, and counseling on components of healthy intimate relationships (trust, honesty, and good communication).The broad purpose of this study was to test multiple moderation models to understand the potential ramifications of childhood adverse experiences on trust, honesty, and good communication as conceptualization by Debnam et al. (2014) and CDC's (2010) study of healthy intimate relationships. Additionally, in the present study the two hypothesized moderators were analyzed to determine whether they interacted with one another in a way that might explain the relationship between ACEs and healthy intimate relationships. Therefore, the researcher proposed three moderation models to be tested. First, the direct relationship between ACEs and HIRA scores was examined using correlational analysis. Second, gender was added to the model as a candidate moderator in the relationship between ACEs and HIRA scores. Counseling was also added to the regression model as a potential moderator between ACEs and HIRA scores. Lastly, a three-way interaction, including gender and counseling, was entered to assess their joint impact on the relationship between ACEs and HIRA score in the present sample. The proposed models were conducted using the PROCESS Macro

version 3.4 using IBM SPSS Statistics (Hayes, 2017; Version 27), Models 1 and 3. In each of the moderation analyses, university affiliation was added as a covariate.

CHAPTER IV

Results

Exploratory Factor Analyses

To understand the factor structure of the novel HIRA measure, I first conducted an exploratory factor analysis (EFA) as a means of choosing the appropriate number of factors and items. To do so, the larger sample was randomly split into two subsamples: the exploratory factor analytic subsample consisted of 250 participants from a split sample of participants from B-CU and FAMU (7.14 subject to item ratio), which is considered reasonable for EFA (see Osborne et al., 2008). Numerous steps were taken to assess whether factor analysis was appropriate. First, I employed Bartlett's test of sphericity to examine redundancy between variables, which was statistically significant for the HIRA measurement ($p < .001$). Small p-values suggests that data reduction (i.e., factor analysis) is appropriate. Second, I used the Kaiser–Meyer–Olkin test to measure sampling adequacy, which indicated values of .901 for overall HIRA (see Table 1). Using the criteria of Tabachnick and Fidell (2001), values greater than .60 are required for factor analysis.

Given these recommendations, I next conducted an EFA using weighted least squares mean and variance adjusted estimation (WLSMV) in MPlus version 8 (Muthén & Muthén, 2017). Weighted least squares mean and variance was used rather than Maximum Likelihood estimation, given that Likert-style items such as those in the HIRA are often better categorized as ordered categorical (Brown, 2014). Given the assumption of inter-factor correlations, an Oblique

Geomin rotation was employed in which one-, two-, three-, and four-factor solutions were estimated for the HIRA.

HIRA

The one-, two-, three-, and four-factor solutions demonstrated various model fits with the four-factor being a good fit for the model: one-factor: χ^2 (210) = 7821.570, p < .000, RMSEA = .230, CFI = .668 TLI = .631, and SRMR = .163 (poor fit); two-factor: χ^2 (210) = 7821.570, p < .000, RMSEA = .115, CFI = .925, TLI = .907, and SRMR = .081 (poor fit); three-factor: χ^2 (210) = 7821.570, p < .000, RMSEA = .086, CFI = .963, TLI = .948, and SRMR = .049 (adequate fit); four-factor: χ^2 (210) = 7821.570, p < .000, RMSEA = .054, CFI = .987, TLI = .980, and SRMR = .031 (good fit). The four-factor solution suggested that 7 items loaded onto factor one, 6 items loaded onto factor two, 4 items loaded onto factor three, and 5 items loaded onto factor four. Lastly, the communalities were all above .3 (see Table 2), confirming that each item shared some common variance with other items on the scale. Notably, four items (*"I trust my partner(s) to be friends with people who find them attractive" (*item #10), "*I trust my partner(s)*" (item #17), "*My partner(s) keeps secrets from me*" (item #19), and "*My partner(s) does suspicious things behind my back*" (item #21) were removed from further analyses due to loading onto two factors (item #19 loaded onto factor 3 (-0.60) and factor 4 (-0.53) and item #21 loaded onto factors 3 and 4 (-0.735 and -0.56 respectively)) or factor loadings below 0.5 (item #10, 0.43; item #17, 0.46) . The researchers examined the four proposed factors to make conceptual sense of the items and identified a theoretical basis for the proposed structure. As a result, the four-factor solution was carried forward for Confirmatory Factor Analysis (CFA).

Confirmatory Factor Analysis

HIRA

The cross-validation sample (n = 250) was used to test the fit of the four-factor solution in the CFA. Exploring the model results revealed that item #4 on factor three ("*I have disagreements with my partner(s)*") did not allow the solution to converge (due to lack of response diversity) and was consequently removed from further analyses. The model was then re-run with item #4 on factor 3 removed. Notably, the four-factor solution showed adequate fit, χ^2 (190) = 10331.294, p < .000, RMSEA = .066, CFI = .982, and TLI = .979. Removal of item #4 from factor three maintained model fit, χ^2 (323) = 624.28, p < .00, RMSEA = .07, CFI = .97, and TLI = .96. Given the theoretical grounds, the authors decided to retain the four-factor, 20-item measure for HIRA including four subscales: trust, honesty, self-focused communication, and partner-focused communication. Each subscale had statements that addressed components of participants intimate relationships, either current or past. The trust subscale included seven items designed to measure participants' assessment of trustworthiness in their relationship. The five statements in the honesty subscale addressed aspects of honesty, fidelity, and faithfulness. The last two subscales focused on perceptions on communication, in that, the third subscale had three items which measured self-focused communication (i.e., "I" statements) while the fourth subscale containing five items was concerned with communication conveyed by the participants' partner(s). Notably, this measure showed overall good reliability (α = .90), and good reliability on subsequent subscales (trust, α = .87; honesty, α = .89; self-focused communication, α = .76; and partner-focused communication, α = .85; see Table 3).

Preliminary Analyses

Before conducting any formal analyses, diagnostics of the discrete predictor variable (ACEs) was performed to identify outliers and other influential points. The data collected in the present study were handled to ensure normality and linearity in the data. The data were assessed for duplicate cases, out-of-range values, univariate outliers (absolute standardized scores greater than 3.29, $p < .001$), multivariate outliers (observations with Mahalanobis distance χ^2 (3) > 16.27, $p < .001$), skewness, Kurtosis, and missing data (N=36). Secondary responses in duplicate cases were deleted thus retaining primary responses only (N=30). Values that were out-of-range were deleted from primary analyses (N=3). Skewness and kurtosis were within the acceptable ±1.5 range for ACEs total (1.03 skewness, .339 kurtosis), ACEs household dysfunction cluster (.89 skewness, .23 kurtosis), ACEs neglect cluster (1.50 skewness, 1.17 kurtosis), and ACEs abuse (1.05 skewness, -.20 kurtosis). Based on these results, assumptions of univariate and multivariate normality, linearity and normally distributed errors using both statistical and visual inspection were acceptable and within normal range.

Descriptive statistics were run to examine demographics of participants in the study (see Table 4). Similar to Felitti et al. (1998), ACEs scores were calculated by adding together the number of adverse events participants reported experiencing during their childhood. ACEs totals ranged from 0-9 (M = 2.36, SD = 2.15), indicating that the presence of adverse and traumatic events experienced by participants occurred in varying levels (see Table 4). From the total sample, 88 participants endorsed 0 ACE score, 149 participants endorsed 1 ACE score, 81 participants endorsed 2 ACEs scores, 50 participants endorsed 3 ACEs scores, 41 participants endorsed 4 ACEs scores, 42 participants endorsed 5 ACEs scores, 19 participants endorsed 6 ACEs scores, 16 participants endorsed 7 ACEs scores, 9 participants endorsed 8 ACEs scores,

and 5 participants endorsed 9 ACEs scores (see Table 5). Among these individual ACEs scores, 207 participants endorsed ACEs in the abuse cluster, 142 participants endorsed ACEs in the neglect cluster, and 367 participants endorsed ACEs in the household dysfunction cluster.

Healthy Intimate Relationship Assessment (HIRA) scores ranged from 45-100 (M = 78.63, SD = 12.63). The scores from the four subscales within the HIRA, trust, honesty, self-focused communication, and partner-focused communication ranged as participants responded to the questions. Trust scores ranged from 16-35 (M = 29.77, SD = 5.04), honesty scores ranged from 5-25 (M = 18.75, SD = 4.50), self-focused communication scores ranged from 5-15 (M = 10.07, SD = 3.75), and partner-focused communication from 8-25 (M = 20.03, SD = 4.03; see Table 4).

Primary Analyses

To address the first research question, a bivariate correlation analysis was conducted using IBM SPSS Statistics (Version 27) to assess whether endorsement of more ACEs was associated with lower overall scores for relationship assessment (i.e., total HIRA scores and subsequent subscales). The findings suggest an inverse relationship between HIRA scores and ACEs scores (rs (498) = -.16, $p < .001$; see Table 5). When examining ACEs clusters, the ACEs neglect cluster was negatively associated with total HIRA scores (rs (498) = -.20, $p < .001$) as well as the trust (rs (498) = -.21, $p < .001$), honesty (rs (498) = -.15, $p < .001$), and partner-focused communication subscales (rs (498) = -.19, $p < .001$). The ACEs abuse cluster was negatively associated with trust (rs (498) = -.18, $p < .001$), honesty (rs (498) = -.10, $p = .02$), self-focused communication (rs (498) = -.13, $p = .003$), partner-focused communication (rs (498) = -.17, $p < .001$), and overall HIRA totals (rs (498) = -.19, $p < .001$). With respect to the HIRA subscales, trust (rs (498) = -.14, $p = .002$), self-focused communication (rs (498) = -.14,

p = .002), and partner-focused communication (rs (498) = -.16, p < .001), were all significantly negatively associated with ACEs total scores. Although not included in the primary analyses, participation in counseling was associated with ACEs clusters (childhood household dysfunction, p = .004; childhood neglect, p = .004; abuse, p < .001; see Table 6).

Impact of Gender on the Association Between ACEs and HIRA

To answer the second question a moderation analysis was conducted using PROCESS Macro Model 1 (Hayes, 2013). The overall model was significant, R^2 = .05, F(4, 495) = 6.69, p < .001. Although there was a significant main effect for ACEs total, b = -.73, p = .01, there was no significant effect of gender. Furthermore, the interaction between ACEs and gender was not significant, b = -.77, t = -1.08, p = .28, 95% CI [-2.18, .64]. Of note, there was a significant main effect of university affiliation on HIRA scores, b = -4.16, t = 3.5, p = .001, 95% CI [-6.5, -1.81].

Impact of Counseling on the Association Between ACEs and HIRA

To answer the third research question, moderation analyses evaluated the hypothesized influence of counseling participation on the association between ACEs and HIRA totals in the present study. The overall model was significant, R^2= .05, F(4, 493) = 7.06, p < 001. Although there was a significant main effect for ACEs total b = -.82, p = .01, there was no significant main effect of counseling. Furthermore, the interaction between ACEs and counseling was not significant b = .24, t = .42, p = .67, 95% CI [-.87, 1.35]. Again, university affiliation was significantly associated with HIRA scores, b= -4.06, t = 3.4, p = .001, 95% CI [-6.4, -1.72].

Joint Impact of Gender and Counseling on the Association Between ACEs and HIRA

Finally, a Model 3 moderation analysis was conducted to examine the interaction between counseling and gender on the association between ACEs and HIRA totals. The overall model was significant, R^2= .06, F(8, 489) = 3.91, p < .001. There was not a significant main

effect for ACEs total b = -.59, p = .10, nor significant main effects for counseling, gender, or the interactions between ACEs and either of these variables. Furthermore, the interaction between ACEs, counseling, and gender was not significant, b = 2.18, t = .95, p = .34, 95% CI [-2.32, 6.67].

Discussion

Individuals who experience childhood trauma have the potential to undergo impaired psychological, emotional, and relational health. The current study sought to explore these potential interrelationships by examining the impact of adverse childhood experiences on experiences in healthy intimate relationships among African American college students, as well as the potential role that gender and participation in counseling would have on this relationship. In addition, this study provided a novel assessment tool for measuring healthy intimate relationship. In the sections that follow, I briefly describe the psychometric properties of this measure, followed by a detailed discussion of the research questions this work sought to address.

The Establishment of the Healthy Intimate Relationship Assessment

In order to explore our principal question, I first had to validate the novel measure Healthy Intimate Relationship Assessment (HIRA). The development of the HIRA was based on Debnam et al.'s (2014) research which explored the conceptualization of relationship understanding in Black teenage girls. Debnam and colleagues' (2014) work found several major themes across qualitative interviews conducted within their sample. Notably, there were three major themes that all participants in their study described as core components of healthy relationship: trust, honesty, and communication. As such, items in the measure were created to address the previously mentioned components. The original HIRA measure included 25 items that were intended to assess the three major themes that emerged from Debnam et al.'s (2014)

work. Both EFA and CFA were utilized to assess the psychometrics of the measure. Following the factor analyses, five items from the original measure were removed due to inadequate loading, and a fourth dimension (four-factor solution) was found to be a better fit for the overall model. This fourth dimension revealed that there were two components being assessed in the communication subscale: self-focused and partner-focused communication. The subscales make a clear distinction between the communication expectations of one's partner(s) in a relationship (partner-focused) and the participations perception of their own communication in an intimate relationship. This finding provided insight that my prior conceptualization of communication in intimate relationships was too broad. The final HIRA measure used for analyses in the present study retained 20-items with four factors.

The Connection between Adverse Childhood Experiences and Healthy Intimate Relationship Values

My first primary question was to explore the ways in which childhood trauma (i.e., ACEs) related to healthy intimate relationship values. Based on the findings, my hypothesis that experiences of childhood and assessment of healthy intimates were associated was supported. This finding strengthened previous studies that explored the impact of ACEs, specifically the abuse cluster, and intimate relationships (Esteves et al., 2017; Gaskin-Wasson et al., 2017; Hammet et al., 2020; Vioth et al., 2020). Existing studies have noted an association between experiences of childhood physical abuse and perpetration of abuse in adult intimate relationships (Esteves et al., 2017; Gaskin-Wasson et al., 2017; Hammet et al., 2020). The present study does not explicitly measure the externalization of the aforementioned behavior, however items from the HIRA do assess participants' experiences of intimate partner(s) violence (i.e., trusting their partner(s) not to physically harm them.) This is crucial when considering those

participants that experienced childhood abuse to ensure that they are not continuing to engage in abuse relationships as adults.

Notably, among the ACEs clusters, household dysfunction was the only ACEs cluster not significantly associated with any subscales of the HIRA (or the overall HIRA). When considering the items in this subscale, it is important to note that none of the questions are directly involving the participants; instead, the questions ask about occurrences and events that may have occurred in the home and are then assumed to have residually impacted the participant. Understanding the adverse events that a participant experienced as a child are salient for the present study, the indirect effects of household dysfunction do not correlate strongly with the significant association between abuse, neglect, and healthy intimate relationship involvement as an adult.

While the present study did not examine attachment styles, given the findings presented in other studies (Kisiel et al., 2014; Miskiewics et al., 2016), one might opine a connection between lower ACEs and higher HIRA values to denote a possible association with what is typically deemed as a secure attachment style. Interpersonal trauma manifests as both internalizing and externalizing behaviors in adolescents. Manifestations include insecure attachment, as well as a disorganized attachment in which the adolescent impacted and expressed ambivalent behavior towards the caregiver (Lyons-Ruth, 1996). Individuals with insecure attachment styles endorsed poor relationship satisfaction and experiencing unhealthy relationships (Miskiewics et al., 2016). Individuals that endorse ACEs and trauma in conjunction with insecure or disorganized attachment and poor social support are predicted to have poorer ability to establish healthy intimate relationships (Kisiel et al., 2014). The findings of the present study bring awareness to how African Americans internalize trauma; specifically, the stressors

experienced during childhood, as assessed by the ACEs questionnaire (i.e., neglect, abuse, household dysfunction, etc.). In alignment with the work of Criss et al. (2009), the present study findings suggest a moderating variable (e.g., resiliency or post-traumatic growth) that was not assessed may account for higher levels of relationship understanding.

Another salient point to consider is the perceived effects of trauma that individuals experience. The experience of trauma compared to the perceived impacts of trauma differs based on individuals' coping styles and post traumatic growth following adverse events (Esteves et al., 2017; Gaskin-Wasson et al., 2017; Weiss et al., 2012). Participants in the present study may have developed healthy coping skills as a means to deal with experienced trauma. Individuals that experience interpersonal trauma may be aware of the adverse experiences but do not have an understanding of the ramifications said trauma yields on their development. Similar to findings in the extant literature, the effects of suppressed trauma continue to manifest in behaviors (i.e., aggression) displayed in unhealthy intimate relationships (Esteves et al., 2017).

Gender and Counseling as Moderators in the Relationship Between of ACEs and Healthy Intimate Relationship Qualities

I was also interested in whether gender or having ever attended counseling moderated the association between ACEs and HIRA totals. Contrary to my expectations, neither gender nor counseling participation moderated the association between ACEs and HIRA totals. With regard to gender, there are mixed findings that suggest there are not gender differences in the assessment of intimate relationships, however, there are differences in endorsement of ACEs (Kogan et al., 2013; Miskiewicz et al., 2016). Kogan et al. (2013) found that participant gender was not a significant predictor when examining the health of intimate relationships. Miskiewicz and colleagues (2016) found that men reported more severe instances of physical abuse. Due to

the gender distribution, the present study had a large ratio of women-identifying participants compared to men-identifying which impacted the gender analyses which would have allowed for the examination of abuse cluster differences.

Concerning counseling, it can be hypothesized that while experience with therapy does not attenuate the relationship between ACEs and HIRA scores, experiencing childhood trauma may increase the likelihood of participating in counseling to mitigate the effects of trauma (Tranter et al., 2020). Of note, the present study found that despite the lack of counseling as a moderator, counseling was associated with ACEs clusters. Moreover, although counseling participation did not moderate the association between ACEs and HIRA totals, there may be extraneous variables (e.g., resiliency, perceptions of trauma, age(s) that trauma(s) occurred, non-Western methods healing practices) that were not measured in the present study that contributed to lack of significance in the moderation analysis. An alternative explanation may also be that individuals that experienced childhood trauma were currently participating in counseling services following a past unhealthy intimate relationship. This explanation is limited to speculation because data on when, how long, and how frequently counseling services were received was not collected in the present study.

Of note, there was not support for double moderation: the intersection of gender and counseling did not emerge as a significant predictor in the ACEs and HIRA association. Given that gender and counseling did not moderate the association between ACEs and HIRA totals when considered separately, it is common to see similar non-significance when entered into a model simultaneously. Gender differences were noted in extant literature when examining the likelihood to seek treatment when experiencing mental health difficulties (Liddon et al. 2018). When examining men-identifying individuals and women-identifying individuals, men were less

likely to seek resources for treatment to relieve their psychological problems. When examining gender differences and counseling participation in the present study, there was a significance difference between men and women's endorsement of counseling experience, in that gender and counseling are connected, and women reported participating in counseling more than men.

Implications

Clinicians and mental health professionals are urged to use information about client's experiences with childhood adversity to inform case conceptualization, treatment planning, and intervention practices. Subsequently, clinicians and mental health professionals are advised to use caution when interpreting the presentation and manifestations of childhood adversity in adult intimate relationships. Extraneous factors may convolute whether abuse, neglect, or household dysfunction are directly attributed to reported distress in adult intimate relationships. With that, clinicians must begin using a more informed approach when collaborating with clients to develop successful treatment plans. Given the findings of the present study, childhood abuse and neglect are strong predictors of less trusting, honest, and communicative intimate relationships. Emphasizing the importance of identifying and rectifying the aforementioned childhood adversity lends itself well to psychosocial improvements in future intimate relationships. Considering the impacts of childhood adversity and trauma beyond the individual and microsystem level (as described by Brofenbrenner, 1979), clinicians, community-engaged researchers, and educators are encouraged to bring awareness to caregivers and children at-risk of experiencing abuse or neglect. Information regarding the potential ramifications of childhood adversity could be disseminated through social media campaigns sponsored by school districts, universities, and community partners. In addition to social media campaigns, school counselors and social workers can develop primary, secondary, and tertiary prevention plans to inform all

students (regardless of exposure to trauma) of the effects of adversity as well as students that have endorsed exposure to adversity.

Given that interpersonal development in African American adolescents can be disrupted as a result of trauma and adverse childhood experiences, culturally appropriate interventions designed to combat trauma are necessary. While it is pertinent to examine the impacts of childhood adverse experiences on health outcomes, researchers note that the science of the ACEs study was normed using a predominately White upper-middle-class sample (Cronholm et al., 2015). Issues of generalizability to racial-ethnic minorities and economically diverse populations persist in the literature (Merrick et al., 2017; Allen et al., 2019). Further, Felitti et al.'s (1998) seminal work overlooks the implications of community-level trauma and suggests that experiences of adversity are inherently traumatic to youth development.

Childhood trauma negatively impacts an individual's intimate relationships; therefore, reducing a child's exposure to traumatic events will subsequently increase their experiences in healthy intimate relationships as adults. Subsequently, researchers examining ACEs must continue to identify factors that influence the psychosocial well-being of Black youth following exposure to trauma in order to empower individuals impacted by trauma, educate the community about the harmful effects of trauma, and stop the cycle of abuse within the Black community.

Limitations and Future Directions

Though the present study is strong in terms of the internal reliability of the assessments employed to measure variables, the study is limited as it relates to the overall gender distribution of the sample and generalizability. With that, there was an imbalance with the number of female participants (85%) compared to the male participants (15%). The imbalance in gender (more female-identifying participants than male-identifying) may have impacted the moderation

analyses when incorporating gender in the model. It is important to note that given the increase of women-identifying individuals matriculating in academia, is not unexpected that a gender imbalance exists in an all-college sample (Baum & Goodstein, 2005; Conger & Dickson, 2017). Existing literature suggests that men more often report experiencing physical abuse compared to women, whereas women report more sexual abuse than men (Miskiewicz et al. 2016). When examining ACEs at the cluster-level (neglect, abuse, and household dysfunction), both physical and sexual abuse are analyzed together. This clustering coupled with the disproportionate gender sample did not allow for the present study to appropriately examine the endorsement of the types of abuse experienced by gender.

While the present study informed participants that participation was entirely voluntary and no identifiable information was required to be collected, students might have been compelled to be conservative with their responses to questions as a means of not triggering existing trauma within themselves. Regarding the potential conservative responses, future studies may provide participants with resources before and after collecting questionnaire responses for dealing with childhood trauma (e.g., The National Child Traumatic Stress Network website) and intimate partner violence (e.g., National Domestic Violence Hotline contact information). Participants of the present study were students of African descent that identified as African, African American, or Black attending a historically Black college/university (HBCU) in the southern region of the United States. Due to the sampling limitations, general assumptions cannot be drawn because external and environmental factors may impact Black students enrolled in Predominantly White Institutions (PWI) and Hispanic Serving Institutions (HSI) in different regions of the United States differently when compared with participants in the present study.

The aims of the present study are not rooted in generalizability; however, that may pose as a limitation to researchers focused on generalizing findings to other ethnic-racial cultures across the country (Mook, 1983). The current literature surrounding childhood trauma, healthy intimate relationships, gender, and counseling experience in an African American sample is limited. The vast majority of the previously mentioned research, come from predominantly White samples; thus, the samples attempt to generalize to the population as a whole without accurate representation for more ethnicities. Future research that investigates how each of the variables interacts and connects must consider the ethnic and cultural differences between groups.

Given the previously mentioned limitations of the study, future research examining childhood trauma and relationships, with respect to race, should consider assessing additional factors such as post-traumatic growth, attachment style, coping style, perceptions of trauma, non-Western healing practices, and perceived cultural discrimination. Future research should determine whether types of traumas reported (physical, emotional, sexual, and neglect) and the occurrence of adverse experiences between genders varied.

Conclusion

Research and literature can be strengthened in the field of psychology by broadening sample participant pools to people of various racial-ethnic backgrounds. If investigations into healthy intimate relationships, childhood trauma, and gender do not consider more under-represented ethnicities, the literature will always have significant limitations as it pertains to the overall population. Without adequate research that cuts across racial and cultural divides, especially concerning vital topics like trauma and intimate relationships, culturally-responsive treatment interventions will continue to fail these minoritized groups facing complex

interpersonal traumas. DeReef Jamison (2018) discussed the notion of a culturally-responsive treatment approach with African Americans. Treatment for trauma and adverse experiences that includes a cultural and holistic approach is more likely to yield healing for the future development of healthy intimate relationships in contrast to a standard procedure that does not involve culture. Consideration of race allows researchers to identify a theoretical framework for culturally competent intervention methods to be developed which target persons who have experiences of trauma so they can build healthy intimate relationships.

Within the African American community, when individuals are not functioning according to their cultural and community norms, maintaining and developing healthy relationships yields difficulties such as conflict, discontent, and instability (Kambon, 1998). Wilson (1985) discussed how an individual's community defines the basis for relationships, establishes relational norms, and models how relationships are to operate. Youth that witness adults in healthy intimate relationships with trust, honesty, and good communication at its core will begin normalizing, internalizing, and instilling those values in the following generation. Normalizing these values will persist and promote the continuation of healthy relationships in Black families and ultimately within the Black community as a whole. Academicians, mental health workers, and community advocates alike are urged to educate persons about the warning signs of abuse and neglect. Translation research should encourage the universal screening of ACEs in adolescents before the age of 18 in social services and other health related settings, as well as inform clinicians of the importance of healing from the past to ensure a safe and optimal future for Black youth.

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Table 1
KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.901
Bartlett's Test of Sphericity	Approx. Chi-Square	3517.312
	df	300
	Sig.	.000

Table 2

Communalities

	Initial	Extraction
I trust my partner(s) to not hurt my feelings.	1.000	.587
I trust my partner(s) to be friends with people who find them attractive.	1.000	.551
I trust my partner(s) to not physically hurt me.	1.000	.697
I can be open to my partner(s) about my most intimate secrets.	1.000	.547
I trust my partner(s) to not tell people about the things I confide in him/her/them.	1.000	.498
I trust my partner(s) to not be judgmental about the things I tell him/her/them	1.000	.668
I trust my partner(s) to transparent about the things he/she/they likes about our relationship	1.000	.659
I trust my partner(s) to not be controlling over me.	1.000	.689
I trust my partner(s).	1.000	.656
My partner does not lie to me.	1.000	.537
My partner(s) keep secrets from me.	1.000	.626
If something is bothering my partner(s), he/she/they will tell me.	1.000	.526
My partner(s) does suspicious things behind my back.	1.000	.754
I know my partner(s) would tell me the truth if he/she was being unfaithful in our relationship	1.000	.739
I know my partner(s) would tell me the truth even if it was challenging.	1.000	.701
I know my partner(s) would tell me the truth if he/she/they did something to compromise our relationship	1.000	.775
My partner is honest with me.	1.000	.661
I listen to my partner's needs.	1.000	.797
I discuss my wants/needs with my partner(s).	1.000	.774
My partner(s) listens to me.	1.000	.748
I have disagreements with my partner(s).	1.000	.698
My partner(s) and I communicate often.	1.000	.683
I find it difficult to share things with my partner(s).	1.000	.341
My partner(s) takes responsibility for his/her/their actions (i.e., admitting when he/she/they are wrong).	1.000	.612
My partner(s) communicates well with me.	1.000	.676

Extraction Method: Principal Component Analysis.

Table 3
Standardized loadings for confirmatory model of HIRA Trust, Honesty, Self-Focused Communication, and Partner-Focused Communication (N=250)

Items/Constructs	Loadings	α
Trust		.870
I trust my partner(s) to not hurt my feelings.	.52	
I trust my partner(s) to not physically hurt me.	.87	
I can be open to my partner(s) about my most intimate secrets.	.52	
I trust my partner(s) to not tell people about the things I confide in him/her/them.	.47	
I trust my partner(s) to not be judgmental about the things I tell him/her/them.	.79	
I trust my partner(s) to be transparent about the things he/she/they likes about our relationship.	.81	
I trust my partner(s) to not be controlling over me.	.93	
Honesty		.891
My partner(s) does not lie to me.	.56	
I know my partner(s) would tell me the truth if he/she/they were being unfaithful in our relationship.	.91	
I know my partner(s) would tell me the truth even if it was challenging.	.78	
I know my partner(s) would tell me the truth if he/she/they did something to compromise our relationship.	.94	
My partner(s) is honest with me.	.56	
Self-Focused Communication		.763
I listen to my partner's needs.	.95	
I discuss my wants and needs with my partner(s).	.90	
I find it difficult to share things with my partner(s).	.42	
Partner-Focused Communication		.848
If something is bothering my partner, he/she/they will tell me.	.49	
My partner(s) listens to me.	.86	
My partner(s) and I communicate often.	.74	
My partner(s) takes responsibility for his/her/their actions (i.e., admitting when he/she/they are wrong).	.74	
My partner(s) communicates well with me.	.86	

Table 4
Descriptive Statistics of Participant Demographics and Major Variables

	N	Minimum	Maximum	Mean	Std. Deviation
Age (years)	500	18	33	20.38	2.201
Gender	500	0	1	.15	.359
Weekly Hours Worked	218	0	40	23.76	10.036
Bi-weekly Income ($USD)	218	0	2000	457.59	306.608
Counseling Participation	498	0	1	.31	.462
Classification	500	1	5	2.73	1.103
GPA	500	.50	4.00	2.9852	.69351
Credit Hours Enrolled In	500	0	21	14.61	2.511
School Affiliation	500	1.00	2.00	1.3180	.46617
ACEs Total	500	.00	9.00	2.3560	2.14814
ACEs Household Dysfunction Total	500	.00	5.00	1.3260	1.19272
ACEs Neglect Total	500	.00	2.00	.3200	.53868
ACEs Abuse Total	500	.00	3.00	.7100	.96528
HIRA Total	500	45.00	100.00	78.6280	12.63221
Trust Total	500	16.00	35.00	29.7720	5.03734
Honesty Total	500	5.00	25.00	18.7480	4.50478
Self-Focused Communication Total	500	3.00	15.00	10.0740	3.74547
Partner-Focused Communication Total	500	8.00	25.00	20.0340	4.02956
Valid N (listwise)	217				

Table 5
Adverse Childhood Experiences Frequency Table

	Frequency		
ACEs Scores	Absolute	Percent	Cumulative Percent
.00	88	17.6	17.6
1.00	149	29.8	47.4
2.00	81	16.2	63.6
3.00	50	10.0	73.6
4.00	41	8.2	81.8
5.00	42	8.4	90.2
6.00	19	3.8	94.0
7.00	16	3.2	97.2
8.00	9	1.8	99.0
9.00	5	1.0	100.0

Table 6

Bivariate Correlations of Demographic and Major Variables

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.
1. ACEs Total	-										
2. ACEs Household Dysfunction Total	.819**	-									
3. ACEs Neglect Total	.650**	.369**	-								
4. ACEs Abuse Total	.766**	.361**	.496**	-							
5. HIRA Total	-.162**	-.053	-.202**	-.185**	-						
6. Trust Total	-.135**	-.017	-.207**	-.180**	.836**	-					
7. Honesty Total	-.086	-.005	-.150**	-.104*	.799**	.582**	-				
8. Self-focused Communication Total	-.138**	-.101*	-.064	-.131**	.481**	.222**	.108*	-			
9. Partner-focused Communication Total	-.156**	-.059	-.189**	-.165**	.831**	.703**	.648**	.159**	-		
10. Gender	-.096*	-.063	-.057	-.080	-.020	-.086	.039	-.013	-.014	-	
11. Counseling Participation	.201**	.139**	.130**	.166**	-.114*	-.139**	-.007	-.071	-.111*	-.125**	-

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

*. Correlation is significant at the 0.05 level (2-tailed).

APPENDICES
APPENDIX A: IRB APPROVAL LETTERS

Florida Agricultural and Mechanical University

Tallahassee, Florida 32307-3200

Excellence With Caring

DIVISION OF RESEARCH
OFFICE OF ANIMAL WELFARE AND RESEARCH INTEGRITY

TELEPHONE: (850) 412-5246
FAX: (850) 412-5012

DATE:	July 17, 2019
TO:	Novell Tani, Phd
FROM:	Florida Agricultural and Mechanical University IRB
PROJECT TITLE:	[1451070-2] The Impact of Childhood Trauma on Healthy Intimate Relationships in College-Aged African Americans at a Southern University
REFERENCE #:	055-19
SUBMISSION TYPE:	Amendment/Modification
IRB CHAIR:	ANGELA THORNTON

Thank you for your submission of Amendment/Modification materials for this project. The Florida Agricultural and Mechanical University IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Administrative Review based on applicable federal regulations.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others (UPIRSOs) and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

This project has been determined to be a MINIMAL RISK project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for

this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of July 17, 2020.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact the IRB Office at 850-412-5246 or IRB@famu.edu. Please include your project title and reference number in all correspondence with this committee.
X5tyxwfgxxwdxwdsxwdscxwdscexdscexdsexdsdsd
-+Florida A&M University has an Assurance on file with the Office of Human Research Protection. Assurance No.: FWA00005391.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Florida Agricultural and Mechanical University IRB's records.

BETHUNE–COOKMAN UNIVERSITY

Founded in 1904 by Dr. Mary McLeod Bethune E. La Brent Chrite, University President

INSTITUTIONAL REVIEW BOARD

DATE: October 17, 2019

TO: Broquelynn Shepard
Graduate Student: Psychology
School of Graduate Studies and Research Florida
Agricultural and Mechanical University

FROM: Bethune-Cookman University Institutional Review Board

TITLE: **The Impact of Childhood Trauma on Healthy Intimate Relationships in College-Aged African Americans at a Southern University**

Dear Ms. Shepard,

This letter is to notify you that your research project entitled: "**The Impact of Childhood Trauma on Healthy Intimate Relationships in College-Aged African Americans at a Southern University**" hasbeen approved by the BCU-IRB via expedited review on October 17, 2019. This approval is valid untilOctober 17, 2020. This project should be conducted in full accordance with all applicable sections of the IRB Guidelines; and the IRB should be notified immediately of any proposed changes that may affectthe status of your research project.

Please report any unanticipated problems involving risks to the participants or others to the IRB. For projects which continue beyond one year from the starting date, the IRB Committee must be contacted and informed in order to continue review.

If you have any questions, please contact me at (386) 481-2445 or bcuirb@cookman.edu

Sincerely,

Richard A. Buckelew

Richard Buckelew, Ph.D.

Chair, Institutional Review Board

FWA OHRP No.: FWA 00022680
IRB Registration: 00009916 #1

APPENDIX B: INFORMED CONSENT
CONSENT FOR INVESTIGATIVE PROCEDURES FLORIDA A&M UNIVERSITY TALLAHASSEE, FL 32301

A research project entitled, "The Impact of Childhood Trauma on Healthy Intimate Relationships in College-Aged African Americans at a Southern University" is being conducted within the Department of Psychology at Florida Agricultural and Mechanical University. Dr. Novell Tani, principal investigator and Broquelynn Shepard, co-principal investigator, are conducting the study.

You will be asked to participate in a survey that examines if you experienced childhood trauma and assessing your understanding of healthy intimate relationships as an adult. In particular, we are interested in whether childhood trauma is internalized and expressed through an unclear understanding of healthy intimate relationships.

The benefit to you for participating in this study is that you will receive experimental credit and/or extra credit to be applied to your final course grade if you are currently enrolled an introductory psychology course. However, extra credit may be assigned at the discretion of the course instructor. No other form of compensation will be made available for participation in this study.

The entire survey should take you approximately 15-30 minutes to complete; during which time, your participation is entirely voluntary. Your name will not be requested on the survey; and you will be kept anonymous during all phases of this study. Incidents of abuse experienced while under the age of 18 may have to be reported if you decide to use identifiable information (i.e., RattlerID). If you decide to opt out of providing identifiable information your answer will remain anonymous for research purposes.

If you are uncomfortable completing this survey, you may stop at any time without it affecting services or ongoing care that you may receive from Florida A&M University.

If you would like further information, please contact Broquelynn Shepard via email at broquelynn1.shepard@famu.edu or Dr. Novell Tani via email at novell.tani@famu.edu. You may also call Dr. Angela Thornton, Florida A&M University Institutional Review Board, Room 308H SRC, Tallahassee, FL 32307-3800, office phone number 850-412-5246 between 9:00 a.m. and 5:00 p.m., Monday through Friday if you would like to discuss this study with someone other than the investigators. Additionally, if you require counseling services, you may contact the FAMU Office of Counseling Center at 636 Gamble Street, Tallahassee, FL 32307, office number 850-599-3145.

YOU ARE MAKING A DECISION WHETHER OR NOT TO PARTICIPATE. PROCEEDING WITH THE SURVEY INDICATED THAT YOU HAVE DECIDED TO PARTICIPATE HAVING READ THE INFORMATION PROVIDED ABOVE.

APPENDIX C: DEMOGRAPHIC SCALE

At the time I am completing this survey, I AM 18 YEARS OF AGE, OR OLDER.

 Yes
 No

I am currently a student at Florida A&M University.

 Yes
 No

Are you using a cell phone/smartphone to complete this survey?

 Yes
 No

How old are you? Age in Years

What is your Gender?

 Male
 Female
 If other, please specify 

Which RACIAL group do you most identify with? [You will be asked "What is your Race?" several times.]

 Black
 White
 Hispanic/Latino
 Asian

 Native American

 If other, please specify 

What is your Ethnicity or Ethnic Background?

- African (Continental)
- Black, African-American
- Afro-Caribbean; Jamaican
- Afro-Caribbean; Trinidadian
- Afro-Caribbean; Antiguan and Barbudan
- Afro-Caribbean; Bahamian
- Afro-Caribbean; Barbadian
- Afro-Caribbean; Haitian
- Afro-Caribbean; Grenadian
- Afro-Caribbean; Guyanese
- Afro-Caribbean; Kittian and Nevisian
- Afro-Caribbean; Saint Lucian
- Afro-Caribbean; Surinamese
- Afro-Caribbean; Vincentians
- Afro-Caribbean; Australian
- Afro-Caribbean; West Indian American
- Afro-Latino; Cuban
- Afro-Latino; Costa Rican
- Afro-Latino; Dominican
- Afro-Latino; Guatemalan
- Afro-Latino; Honduran
- Afro-Latino; Puerto Rican
- Afro-Latino; Panamanian
- Afro-Latino; Nicaraguan
- Afro-Latino; Brazilian
- Afro-Latino; Mexican
- Afro-Latino; Uruguayan
- Afro-Latino; Venezuelan
- Afro-Latino; Peruvian
- Afro-Latino; Paraguayan
- Afro-Latino; Ecuadorian
- Afro-Latino; Colombian
- Afro-Latino; Chileans
- Afro-Latino; Nicaraguan

- Afro-Asian
- Other

Are you currently employed?

 Yes
 No

How many hours a week do you work?

What is your average bi-weekly incomes? (EVERY 2 WEEKS)?

Do your parents support you financially?

On average, how much money do your parents provide you with bi-weekly (EVERY 2 WEEKS)?

Do you receive any other financial aid and or loans?

 Yes
 No

Do you receive scholarships or fellowships?

 Yes
 No

Have you received counseling services before (from campus or an outside provider)?

 Yes
 No

What is your year/classification in school?

- Freshmen, 1st semester
- Freshmen, 2nd semester
- Sophomore, 1st semester
- Sophomore, 2nd semester
- Junior, 1st semester
- Junior, 2nd semester
- Senior, 1st semester
- Senior, 2nd semester
- Graduate Student
- Professional
- Other

What is (are) your current major(s)?

- Agribusiness
- Agronomy
- Animal Science
- Biological and Agricultural System Engineering
- Entomology
- Food Science
- Forestry and Natural Resources Conservation
- Veterinary Technology
- Elementary Education
- Mathematics Education
- Music Education
- Physical Education
- Physics Education
- Pre-Kindergarten/Primary Education
- Social Science Teacher Education
- Technology Education
- Chemical and Biomedical Engineering
- Civil and Environmental Engineering
- Industrial and Manufacturing Engineering
- Computer and Electrical Engineering
- Mechanical Engineering
- Biology (Pre-Professional/Molecular-Cell)
- Chemistry (ACS/Biochemistry/Pre-Medicine/Dentistry)
- Computer Information Systems
- Mathematics (Mathematical Sciences/Traditional/Actuarial Sciences)

- Computer Science
- Physics (General/Applied)
- African-American Studies
- Criminal Justice
- English
- Fine Arts
- History
- Music
- Philosophy & Religion
- Political Science
- Psychology
- Social Work
- Sociology
- Arts in Theatre
- Cardiopulmonary Sciences
- Health Care Management
- Health Information Management
- Health Sciences
- Architecture
- Architectural Studies
- Construction Engineering Technology
- Electronic Engineering Technology
- Accounting
- Business Administration
- Business Administration with a Program Major in Facilities Management
- Economics with Minor in Business
- Environmental Sciences
- Graphic Design
- Journalism
- Public Relations
- Nursing
- Undecided

What was (were) your past major(s)?

- Agribusiness
- Agronomy
- Animal Science
- Biological and Agricultural System Engineering
- Entomology
- Food Science

- Forestry and Natural Resources Conservation
- Veterinary Technology
- Elementary Education
- Mathematics Education
- Music Education
- Physical Education
- Physics Education
- Pre-Kindergarten/Primary Education
- Social Science Teacher Education
- Technology Education
- Chemical and Biomedical Engineering
- Civil and Environmental Engineering
- Industrial and Manufacturing Engineering
- Computer and Electrical Engineering
- Mechanical Engineering
- Biology (Pre-Professional/Molecular-Cell)
- Chemistry (ACS/Biochemistry/Pre-Medicine/Dentistry)
- Computer Information Systems
- Mathematics (Mathematical Sciences/Traditional/Actuarial Sciences)
- Computer Science
- Physics (General/Applied)
- African-American Studies
- Criminal Justice
- English
- Fine Arts
- History
- Music
- Philosophy & Religion
- Political Science
- Psychology
- Social Work
- Sociology
- Arts in Theatre
- Cardiopulmonary Sciences
- Health Care Management
- Health Information Management
- Health Sciences
- Architecture
- Architectural Studies
- Construction Engineering Technology

- Electronic Engineering Technology
- Accounting
- Business Administration
- Business Administration with a Program Major in Facilities Management
- Economics with Minor in Business
- Environmental Sciences
- Graphic Design
- Journalism
- Public Relations
- Nursing
- Undecided

What is your current GPA?

What was your GPA last semester?
*Final High School GPA if you are a first semester freshman

How many credit hours are you currently enrolled in?

APPENDIX D: Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE score

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

1. Did a parent or other adult in the household often …

Swear at you, insult you, put you down, or humiliate you?

or

Act in a way that made you afraid that you might be physically hurt?

Yes No If yes enter 1 _____

2. Did a parent or other adult in the household often …

Push, grab, slap, or throw something at you?

or

Ever hit you so hard that you had marks or were injured?

Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you ever…

Touch or fondle you or have you touch their body in a sexual way?

or

Try to or actually have oral, anal, or vaginal sex with you?

Yes No If yes enter 1 _____

4. Did you often feel that …

No one in your family loved you or thought you were important or special?

or

Your family didn't look out for each other, feel close to each other, or support each other?

Yes No If yes enter 1 _____

5. Did you often feel that …

You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

or

Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes No If yes enter 1 _____

6. Were your parents ever separated or divorced?

Yes No If yes enter 1 _____

7. Was your mother or stepmother:

Often pushed, grabbed, slapped, or had something thrown at her?

or

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

or

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

Yes No If yes enter 1 _____

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

Yes No If yes enter 1 _____

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

Yes No If yes enter 1 _____

10. Did a household member go to prison?

Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Scoring Key:

Total number of ACEs		
Total items	Minimum score	Maximum score
10	0	10

Appendix E: Healthy Intimate Relationship Assessment (HIRA)

Statements will correspond with a Likert-Scale ranging from Never, Almost Never, Sometimes, Almost Always, and Always. Item 3 in self-focused communication was scored in reverse. Lower scores on the previously mentioned item were more favorable to assessing participant's current (or past) intimate relationships. Normal scoring will be used for all other questions. Higher scores indicate stronger abilities to assess healthy intimate relationships and lower scores indicate weaker abilities to assess healthy intimate relationships based on relationships that participants engaged in.

Trust

1) I trust my partner(s) to not hurt my feelings.
2) I trust my partner(s) to not physically hurt me.
3) I can be open to my partner(s) about my most intimate secrets.
4) I trust my partner(s) to not tell people about the things I confide in him/her/them.
5) I trust my partner(s) to not be judgmental about the things I tell him/her/them.
6) I trust my partner(s) to be transparent about the things he/she/they likes about our relationship.
7) I trust my partner(s) to not be controlling over me.

Honesty

1) My partner(s) does not lie to me.
2) I know my partner(s) would tell me the truth if he/she/they were being unfaithful in our relationship.
3) I know my partner(s) would tell me the truth even if it was challenging.
4) I know my partner(s) would tell me the truth if he/she/they did something to compromise our relationship.
5) My partner(s) is honest with me.

Self-focused communication

1) I listen to my partner's needs.
2) I discuss my wants and needs with my partner(s).
3) I find it difficult to share things with my partner(s).

Partner-focused communication

1) My partner(s) listens to me.
2) If something is bothering my partner, he/she/they will tell me.
3) My partner(s) and I communicate often.
4) My partner(s) takes responsibility for his/her/their actions (i.e., admitting when he/she/they are wrong).
5) My partner(s) communicates well with me.

Scoring Key:

Total number of HIRA scores			
	Number of items	Minimum possible score	Maximum possible score
Trust	7	7	35
Honesty	5	5	25
Self-focused communication	3	3	15
Partner-focused communication	5	5	25
Total HIRA	20	20	100