

Spring 2014

## Childhood Trauma, Self-Esteem, and Helping Behaviors: Does History of Trauma Predict Helping?

Adriana B. Joseph

Follow this and additional works at: <https://digitalcommons.georgiasouthern.edu/etd>



Part of the [Clinical Psychology Commons](#)

---

### **Recommended Citation**

Joseph, Adriana B., "Childhood Trauma, Self-Esteem, and Helping Behaviors: Does History of Trauma Predict Helping?" (2014). *Electronic Theses and Dissertations*. 1130.  
<https://digitalcommons.georgiasouthern.edu/etd/1130>

This thesis (open access) is brought to you for free and open access by the Graduate Studies, Jack N. Averitt College of at Digital Commons@Georgia Southern. It has been accepted for inclusion in Electronic Theses and Dissertations by an authorized administrator of Digital Commons@Georgia Southern. For more information, please contact [digitalcommons@georgiasouthern.edu](mailto:digitalcommons@georgiasouthern.edu).

CHILDHOOD TRAUMA, SELF-ESTEEM, AND HELPING BEHAVIORS: DOES HISTORY  
OF TRAUMA PREDICT HELPING?

by

ADRIANA B. JOSEPH

(Under the direction of C. Thresa Yancey)

ABSTRACT

There is insufficient evidence from the available research to fully determine the relationship between self-esteem and helping behaviors. Specifically, some findings indicate that those with lower self-esteem are less likely to help others than those with higher self-esteem (Michelin, Wilson, & Messe, 1975), while others show the opposite trend (Briggs, Landry, & Wood, 2007). Individuals with a history of childhood trauma are more likely to report low self-esteem than those with no history of childhood trauma (Valerio & Lepper, 2009); also, those with a history of trauma are more likely to help others (Frazier, Greer, Gabrielsen, Tennen, Park, & Tomlich, 2012). Based on the available literature, it is difficult to predict 1. whether someone with low self-esteem will help others more than someone with higher self-esteem, and 2. whether the lower self-esteem reported by those with a history of childhood trauma is related to the likelihood of helping behaviors. The current study investigated these gaps in the literature regarding self-esteem, childhood trauma, and helping behaviors. Participants completed questionnaires on self-esteem and history of trauma experiences and provided demographic information. Additionally, to evaluate current helping behaviors, participants were given the opportunity to further assist the researchers with several tasks. Number of helping tasks completed as well as self-esteem scores were the dependent variables. The results revealed that individuals who report a history of trauma were more likely to endorse lower self-esteem, but

were also more likely to engage in helping behaviors than individuals with no history of trauma. Additionally, the results revealed no evidence of self-esteem mediating the relationship between trauma history and helping behaviors.

INDEX WORDS: childhood trauma, self-esteem, helping behaviors

CHILDHOOD TRAUMA, SELF-ESTEEM, AND HELPING BEHAVIORS: DOES HISTORY  
OF TRAUMA PREDICT HELPING?

by

ADRIANA B. JOSEPH

B.S., Georgia Southern University, 2012

A Thesis Submitted to the Graduate Faculty of Georgia Southern University in Partial  
Fulfillment of the Requirements for the Degree

MASTER OF SCIENCE

STATESBORO, GEORGIA

2014

© 2014

ADRIANA B. JOSEPH

All Rights Reserved

CHILDHOOD TRAUMA, SELF-ESTEEM, AND HELPING BEHAVIORS: DOES HISTORY  
OF TRAUMA PREDICT HELPING?

by

ADRIANA B. JOSEPH

Major Professor: C. Thresa Yancey  
Committee: Karen Z. Naufel  
Jeff Klibert

Electronic Version Approved:  
May 2014

## DEDICATION

I would like to dedicate this book to my friends, family, and colleagues who encouraged me to continue my search for knowledge. Your support means more than you know, and I am truly blessed to have you all in my life.

## ACKNOWLEDGEMENTS

I would first like to thank Dr. Thresa Yancey for her continued guidance and support throughout the years. Without your humor and positive attitude, I would not have made it as far as I did. Thank you for always encouraging me to achieve my goals, and for providing me with advice in my times of need. I would also like to thank Dr. Karen Naufel. The research skills you have taught throughout the years have always stuck with me, and I have enjoyed being one of your many eager pupils. Finally, I would like to thank Dr. Jeff Klibert. Your feedback was very much valued during this process, and I appreciate you always opening your door to me. Again, thank you all for all your support, without each of you, this book may have not come to fruition.



## TABLE OF CONTENTS

ACKNOWLEDGMENTS .....	7
LIST OF TABLES .....	10
CHAPTER	
1 INTRODUCTION .....	11
Purpose of Study .....	11
2 CHILDHOOD TRAUMA, SELF-ESTEEM, AND HELPING BEHAVIORS: DOES HISTORY OF TRAUMA PREDICT HELPING? .....	13
Trauma and Helping Behaviors .....	14
Trauma and Self-Esteem.....	16
Self Esteem and Helping Behaviors .....	19
3 METHOD .....	21
Participants.....	21
Procedure .....	22
Measures/Materials .....	23
Computation of Scores.....	25
4 RESULTS .....	26
Preliminary Results.....	26
Primary Results.....	26
5 DISCUSSION .....	28
Strengths and Limitations .....	31
Conclusions and Future Research.....	32
REFERENCES.....	34

APPENDICES .....	39
Appendix A: Informed Consent.....	39
Appendix B: Assessment of Previous Traumatic Events (APTE) .....	41
Appendix C: Helping Tasks.....	49
Appendix D: Demographics .....	53
Appendix E: Debriefing .....	54

## LIST OF TABLES

Table 1: Means and standard deviations of trauma score, self-esteem score, and helping scores.....	55
Table 2: Demographic statistics.....	56
Table 3: Correlations among trauma, self-esteem, and helping scores.....	57

## CHAPTER 1

### INTRODUCTION

It is estimated from community samples that more than two-thirds of children report experiencing a traumatic event prior to age 16 (Greca et al., 2008). Additionally, individuals who have experienced a trauma are more likely to exhibit impaired social functioning and symptoms of PTSD than individuals who have not experienced a traumatic event (Greca et al., 2008). The current study focused on the long term impact of childhood trauma on individuals' self-esteem and helping behaviors. The researchers defined childhood trauma as any personal traumatic experience that occurred before the age of 18, including sexual abuse (CSA), sexual assault, neglect, witnessing domestic violence, and physical abuse.

#### **Purpose of Study**

It is known that trauma survivors may report lower self-esteem; however, it is unclear if they are likely to engage in helping behaviors in social settings (Valerio & Lepper, 2009). The present research provides more information on the relationships among history of trauma, self-esteem, and helping behaviors. Because self-esteem and helping behaviors are important in maintaining relationships, it is essential to understand how trauma is related to both variables. The objective of the current study was to determine the relationship between traumatic experiences and helping behaviors, as well as the relationship among traumatic experiences, helping behaviors, and self-esteem.

Specifically, the following were hypothesized: 1) there is a positive relationship between reports of previous trauma and helping behaviors. It is expected that those participants with more incidents of trauma will be more likely to engage in helping behaviors; 2) there will be a negative relationship between reports of previous trauma and self-esteem. Specifically, the

researchers expect more incidents of trauma to be associated with a lower score on a measure of self-esteem; 3) self-esteem will mediate the relationship between helping behaviors and trauma history due to the established link among the variables.

## CHAPTER 2

### **CHILDHOOD TRAUMA, SELF-ESTEEM, AND HELPING BEHAVIORS: DOES HISTORY OF TRAUMA PREDICT HELPING?**

Research indicates that those who are victims of childhood trauma are more likely to exhibit low self-esteem, have higher residual stress, and utilize more avoidant coping mechanisms (e.g., withdrawal, criticism of oneself) than those with no history of childhood trauma (Bryant-Davis, 2005; Finkelhor, 2009; Fortier, DiLillo, Messman-Moore, Peugh, DeNardi, & Gaffey, 2009). Fortier and colleagues (2009) suggested that such avoidant coping mechanisms can be healthy strategies immediately following a trauma, but detrimental for long-term functioning. For instance, lower self-esteem has been observed in survivors of childhood trauma in comparison to individuals with no childhood trauma (Finkelhor, 2009). Interestingly, those who have low self-esteem may engage in helping behaviors to regain self-esteem (Bizman, Yinon, Ronco, & Shachar, 1980). While a relationship between negative coping strategies and functioning in later life in those with childhood trauma has been established, positive coping strategies, such as activism have also been found in survivors of childhood trauma. Bryant-Davis (2005) evaluated African-American women who survived childhood violence and their use of different coping strategies (e.g., therapy, introspection, humor). The researcher found that in addition to community support and spirituality, survivors engaged in activism as a way of coping with their trauma. This notion of engaging positively with one's environment following a significant adversity is a phenomenon known as posttraumatic growth (Tedeschi & Calhoun, 2004). This phenomenon does not simply involve short-lasting coping, but instills confidence within the individual to maintain the positive transformation after experiencing adversity.

## **Trauma and Helping Behaviors**

Although traumatic events are correlated with negative social functioning, recent research explores the relationship between trauma exposure and frequency of helping behaviors (Frazier et al., 2012). Findings suggest that the more traumatic events an individual experienced, the *more* likely one would report engaging in helping behaviors. Similarly, those who experienced recent traumatic events indicated more daily occurrences of helping. Frazier et al. (2012) suggest that individuals who experienced trauma were more likely to report engaging in helping behaviors because of the association between prosocial behaviors and greater well-being. The importance of these findings is that trauma survivors' interpersonal skills are negatively associated with a history of trauma, yet they engage in more helping behaviors. More research regarding trauma exposure and helping behaviors is necessary because often the expectation is that negative events will predict antisocial behavior or isolation, neither of which results in helping behaviors (Davis, Petretic-Jackson, & Ting, 2001).

To strengthen the extent to which self-report reflects actual behavior, Prochazka and Vaculik (2011) combined self-report with observation in real situations to further understand helping behaviors. The self-report included questions regarding various forms of prosocial behavior, such as aiding another individual with a simple task, donating to a charity, or volunteering for a charity. Upon completion of the questionnaire, participants were escorted out of the room by the experimenter. To observe prosocial behavior in this study, the experimenter went through a series of acts (i.e., dropping the testing room key, struggling to unlock the door, announcing aloud that he/she grabbed the wrong room key) which gave the participant three opportunities to help. The researchers allowed participants sufficient time to react in the situation, and found that self-report of prosocial behaviors significantly predicted engagement in

prosocial behaviors. Although Prochazka and Vaculik found a positive correlation between self-reported behaviors and observed behaviors, there was a possible priming effect. Self-reported and observed behaviors can increase the external validity, or generalizability, of a study's design, but it is best when both self-reported and observed behaviors are measured, even when self-reports of prosocial behaviors are related to the self.

To provide further support that individuals with a history of trauma, sexual abuse, or both are more likely to help than those with no history of either trauma or sexual abuse, Stidham et al. (2012) suggest that survivors of sexual violence engaged in altruism as a way of coping. Altruism was defined as “thoughts or behaviors aimed at helping others, expressions of understanding or compassion for others, and feelings of concern for the welfare of others as a result of having experienced sexual violence,” (Stidham et al., 2012, p. 148). Participants were interviewed regarding their traumatic experiences, and the researchers deemed it necessary to include categories regarding altruism after many participants freely reported engaging in altruistic acts. The categories of altruism were identified by the researchers (in order of importance) as follows: protecting children, participating in the study, being understanding, thinking about helping, choosing a helping profession, providing guidance or advice about avoiding or healing from abuse, becoming involved in advocacy organizations, taking actions to stop perpetrators, and speaking out publicly on violence and abuse (Stidham et al.). It appears that, although survivors of trauma, sexual abuse, or both are more likely to exhibit lower self-esteem than those with no history of trauma, survivors are more likely to engage in helping behaviors than those with no history of trauma to prevent others from being victimized (Stidham et al., 2012; Valerio & Lepper, 2009).



## **Trauma and Self Esteem**

Nelson Goff, Crow, Reisbig, and Hamilton (2007) suggest that people who have experienced a traumatic event report lower self-esteem and less relationship satisfaction than those who have not experienced a traumatic event. Prosocial behaviors, or behaviors intended to benefit others, are important in the development and maintenance of interpersonal relationships, and the reciprocity of these relationships is mediated by expressed gratitude (Bartlett & DeSteno, 2006). Bartlett and DeSteno suggest that gratitude, a positive emotion, increases the likelihood of helping behaviors. In contrast, individuals who have experienced traumatic events report having greater negative emotion, which is associated with relationship and life dissatisfaction (Nelson Goff et al., 2007). When individuals experience traumatic events, they may have difficulty developing and maintaining healthy relationships.

In addition, individuals who have experienced trauma have reported less satisfaction in intimate and peer relationships due to difficulties trusting others, increased likelihood of depressive symptoms, and lower self-esteem (Nelson Goff et al., 2007). When developing relationships, self-esteem and the ability to trust others are important. When there are negative emotions associated with social experiences, it is more difficult to maintain interpersonal relationships (Bartlett & DeSteno, 2006).

To provide further research support regarding the negative association with past experiences on self-esteem, Nelson Goff and colleagues (2007) sought to determine the impact of Posttraumatic Stress Disorder (PTSD) on relationship functioning in soldiers. Soldiers who exhibited higher levels of individual trauma symptoms and their unaffected partners, those with no military background, reported lower relationship satisfaction than individuals with less severe symptoms of PTSD (Nelson Goff et al., 2007). These results suggest that trauma relates to

individuals' interpersonal skills such as communication, reciprocation of feelings, and the desire to help others. Additionally, soldiers had difficulty being emotionally available to their significant others, further supporting the theory that trauma is not individually experienced. Through their emotional unavailability, soldiers neglected to communicate their feelings to their partners, causing the impact of their traumatic experiences to also impact the lives of their partners (Nelson Goff et al.). Communication is important when developing and maintaining relationships, and trauma is negatively associated with levels of trust and self-esteem, which are vital to communication. The importance of these findings is that traumatic past experiences are associated negatively with interpersonal functioning, which is essential in establishing self-esteem. Specifically, when individuals have experienced traumatic events, such as childhood trauma, they report having difficulty trusting others and having impaired self-esteem (Finkelhor, 2009; Valerio & Lepper, 2009).

To understand the association between feelings of relationship status and past traumatic experiences more, Kallstrom-Fuqua, Weston, and Marshall (2004) examined the mediating relationships of feelings of stigmatization and powerlessness in women who experienced child sexual abuse. The experimenters expected the severity of CSA to negatively relate to individuals' psychological distress as well as other symptoms of PTSD. The researchers measured the severity of the sexual abuse (use of physical force, use of a weapon, number of perpetrators), powerlessness (fatalism or feelings of hopelessness, perceived mastery or the extent to which life chances were perceived as under the victim's control), and stigmatization (feelings of guilt and shame). Stigmatization and powerlessness were mediators of the association between past child sexual abuse and current social relationship status. The more severe the sexual abuse, the more individuals felt betrayed, powerless, and stigmatized, thus causing more psychological distress

(Valerio & Lepper, 2009). These maladaptive feelings can hinder individuals' pursuit of caring relationships.

Sahin, Timur, Ergin, Taspinar, Balkaya, and Cubukcu (2010) sought to determine 1. the type of violence to which women were exposed during childhood and adulthood and 2. the relationship the self-esteem of married Turkish women and their exposure to domestic violence. Sahin and colleagues found a negative relationship between scores on the Rosenberg Self-Esteem Scale (RSES) and scores on subscales of the Childhood Trauma Questionnaire (i.e., emotional abuse, emotional neglect, physical abuse, and sexual abuse; Bernstein et al., 2003). Specifically, women with more childhood trauma were more likely to report lower self-esteem than women with less childhood trauma. The relationship between self-esteem and childhood trauma suggests that, due to negative past experiences, women continue to feel victimized years after the abuse. Although feelings of victimization are not readily apparent to the individual, this can have a negative association with interpersonal functioning. Additionally, victims of childhood trauma report having difficulty trusting others and inhibited relationship functioning (Nelson Goff et al., 2007; Valerio & Lepper, 2009).

Similarly, Muller and Lemieux (2000) suggested that a negative view of the self was a significant risk factor associated with psychopathology in survivors of child abuse. Specifically, participants with a history of childhood abuse were assessed on social support, attachment styles, behavioral and emotional problems, anxiety, depression, self-esteem, PTSD, history of maltreatment, and intelligence. Negative view of self was found to be the highest predictor of psychopathology, suggesting that childhood trauma and development of esteem are negatively associated (Muller & Lemieux, 2000). Low self-esteem is commonly associated with fewer

instances of helping others, but the literature also indicates low self-esteem can produce an increase in helping behaviors (Stidham, Draucker, Martsof, & Mullen, 2012).

### **Self-Esteem and Helping Behaviors**

In order to demonstrate that personality characteristics influence helping behaviors, Micheline, Wilson, and Messe (1975) selected two of Maslow's motives to characterize individuals. Those characterized as safety-oriented are dependent on others, anxious, mistrustful, and low on self-esteem. In contrast, individuals characterized as esteem-oriented are dominant, competent in social interactions, achievement-oriented, and high on self-esteem. Micheline, Wilson, and Messe predicted that those who were safety-oriented would be less likely to engage in helping behaviors than those who were esteem-oriented. The researchers tested the hypothesis by placing individuals in a situation where helping was expected after independently measuring whether participants were safety-oriented or esteem-oriented. Specifically, a woman carrying books and papers mentioned that she was lost upon arrival to the test room. When she quickly turned to leave, she spilled her papers and books near the doorway. All participants witnessed the incident, and the researchers found that participants were less likely to help in the safety-oriented group compared to those in the esteem-oriented group. These results suggest that individuals with lower self-esteem are less likely to help than those with higher self-esteem.

To further understand the relationship between self-esteem and helping behaviors, Briggs, Landry, and Wood (2007) predicted that individuals with lower self-esteem would be less likely to volunteer than those with higher self-esteem. Questionnaires were administered by mail to teenagers who received brochures from an international relief organization promoting a fundraising opportunity which included fasting for 30 hours. The questionnaires were given to some participants before the fast, some after the fast, and to some who did not wish to participate

in the fast. The questionnaires measured self-esteem and attitudes regarding the organization. Briggs, Landry, and Wood found that those with lower self-esteem were more likely to participate in the fast than those with higher self-esteem. This finding appears to conflict with previous literature suggesting greater likelihood of helping behaviors in those individuals with higher versus lower self-esteem (Michelini et al., 1975).

Similarly, Lee and Shrum (2012) suggested that individuals gain esteem from social interactions with others, and esteem is hindered when individuals are explicitly rejected. In contrast, when individuals are ignored, they do not immediately express feelings of rejection, but rather express feelings of powerlessness. While one can actively assert control when rejected by a group, one cannot provide control when being ignored (Lee & Shrum, 2012). Specifically, when rejected, one has to be acknowledged by the group, whereas when one is ignored, one is not acknowledged by the group and not given the chance to assert control. The researchers suggest that individuals were less likely to report a preference to help after receiving a self-esteem boost in the rejection condition in comparison to those who were ignored. This suggests that when rejected, esteem is threatened and individuals are less likely to engage in helping behaviors (Lee & Shrum, 2012).

## CHAPTER 3

### METHOD

#### Participants

For sufficient power, the researchers collected data from 149 participants (Cohen, 1992). This was to ensure that we had enough participants who have and have not experienced childhood trauma for comparison, given approximately 37% of Americans report a history of childhood trauma (Briere & Elliott, 2002). The current sample included 40 men, 108 women, and one with an unidentified gender, with a mean age of 19.77 ( $SD = 3.20$ ). Ninety (60.4%) participants classified their ethnicity as white, 50 (33.6%) as African American, 4 (2.7%) as bi/multi-racial, 3 (2%) as Hispanic, 1 (0.7%) as Asian and 1 (0.7%) as Native American. For current year in school, 61 (40.9%) classified as a freshman, 54 (36.2%) as a sophomore, 22 (14.8%) as a junior, and 12 (8.1 %) as a senior. Participants were recruited through SONA, an organizational system that allows participants to sign up for research studies via the internet. The SONA system is owned and operated by the GSU Psychology Department which requires all Introduction to Psychology (PSYC 1101) students to participate in research activities. Research activities can include participating in a research study or another assignment developed by the course instructor. In addition, students in other psychology courses may be given the opportunity to participate in research activities for extra credit. The SONA system presents students with a brief abstract stating the purpose and nature of each study available for participation. Students then sign up for the studies that are available and interesting to them. All participants were 18 years or older. Also, participants were enrolled in a psychology course. There were no other limits to inclusion for participation in this study.

## **Procedure**

Participants who volunteered to participate completed all study activities via the Internet. Once interested students reached the website, they read the informed consent page (see Appendix A). The informed consent detailed the purpose, nature, risks, benefits, confidentiality, administrators' contact information, and ethical parameters of participating in this study. Considering the study was web-based, the researchers did not have the opportunity for participants to sign their name – to verify their consent to voluntarily participate in this study. Instead, if after reading the informed consent participants wished to participate in the study, they chose to give consent by clicking on a yes/no question to indicate desire to voluntarily participate in the survey. After consenting to participate in the study, participants were directed to a page that informed them about when and how credit for participation was granted. The participant was then directed to the survey.

The survey consisted of the Assessment of Previous Traumatic Events (see Appendix B), the Rosenberg Self-Esteem Scale (Rosenberg, 1965), helping tasks (see Appendix D) and 10 demographic questions (see Appendix E). To evaluate helping behaviors, participants were given the opportunity to further assist the researchers after completion of the surveys. If participants declined to further assist, they were directed to the debriefing page (see Appendix F). If participants agreed to further assist, they were directed to the first of three helping tasks. The first was a graphic that participants clicked to increase a charitable donation to the Prevent Child Abuse America campaign (<http://www.preventchildabuse.org/index.php>). The second helping task was a word search within an article. Once participants completed the task, the researchers donated to the aforementioned organization. The researchers ensured that these donation promises were kept at the end of data collection. The final helping task contained a passage

followed by three comprehensive questions. This passage was designed to be of minimal interest so that a participant was reading and answering only to help the researcher (Appendix D). Upon completion of the study, participants were directed to the debriefing page. If participants decided to discontinue before the end of the survey they were automatically directed to the final page of the survey for debriefing. The administrator had no role in the collection of data to reduce experimenter bias. The administrator only answered questions concerning the purpose and nature of the study to those students who were interested in taking the survey. To assist participants who might experience distress after the study, the researchers provided a list of low cost health services and a suicide hotline number in the debriefing (see Appendix F).

### **Measures/Materials**

**Assessment of Previous Traumatic Events.** Participants completed an 18-item questionnaire designed to assess previous traumas experienced. If participants reported a history of a specific trauma, they were directed to answer follow up questions regarding that trauma (e.g., age of traumatic event, disclosure of traumatic event; see Appendix B). This questionnaire was designed by the researchers to gain a self-report of experience of several traumatic events. The researchers designed the questionnaire to encompass different kinds of traumatic experiences that were not specified or elaborated on in previous measures. Additionally, participants were asked how much they were harmed emotionally and physically for the endorsed events for the current sample. For this study, participants reported histories of CSA, sexual assault, neglect, witnessing domestic violence, and physical abuse.

**Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965).** Participants completed a 10-item questionnaire evaluating both positive and negative feelings about individual self-esteem. All items were answered using a 4-point Likert scale, including the responses: Strongly Agree (4



points), Agree (3 points), Disagree (2 points), and Strongly Disagree (1 point). A higher score indicated that an individual has higher self-esteem. Previous research supports the validity and reliability of this scale. Specifically, the RSES has moderate convergent validity with two personality traits on the Big Five Inventory, neuroticism and extraversion, with a Pearson's coefficient of  $-.54$  and  $.36$ , respectively (Benet-Martinez & John, 1998; Schmitt & Allik, 2005). The RSES also has relatively high test-retest reliability, Cronbach's alpha of  $.88$  (Robins, Hendin, & Trzesniewski, 2001).

**Helping Tasks.** Three helping tasks were included to ensure that participants had a variety of tasks in which to participate (see Appendix C). The first was a cartoon picture of three children holding a banner that displays "You Can Prevent Child Abuse" ([https://www.azdes.gov/child\\_abuse\\_prevention\\_councils/](https://www.azdes.gov/child_abuse_prevention_councils/)). Participants clicked for 30 seconds to increase a charitable donation of \$10.00 for every 5,000 clicks to the Prevent Child Abuse America campaign (<http://www.preventchildabuse.org/index.php>). The second helping task was a fact sheet that contained the word "child" a total of 9 times within the clickable graphic (<http://www.cdc.gov/violenceprevention/pdf/cm-data-sheet--2013.pdf>). Participants were told to find the word, and for every 10 participants who completed the task within the allotted time (120 seconds), the researchers would donate \$5.00 to the aforementioned organization. The final helping task contained a passage titled "The Guttman Scales," followed by three comprehensive questions (Nunnally & Bernstein, 1994). The passage was designed to be of minimal interest so that a participant was reading and answering only to help the researcher. Each question allowed the participant to provide a text entry response. To assess the interest in the passage, a manipulation check was conducted.

**Demographics Questionnaire.** Participants completed a 10-item questionnaire to evaluate current demographic information (e.g., age, gender, current year in school) (see Appendix E).

### **Computation of Scores**

**Trauma Scores.** To calculate the trauma scores, the researchers scored a no for each question as 0 points and a yes as 1 point. This yields a range of 0 to 18 for the trauma score.

**Self-Esteem Scores.** To calculate the self-esteem scores, the researchers scored the responses as follows: Strongly Agree (4 points), Agree (3 points), Disagree (2 points), and Strongly Disagree (1 point). Questions 2, 5, 6, 8, and 9 were reverse scored. This yields a range of 10 to 50 for the self-esteem score, with higher scores indicating greater self-esteem (Rosenberg, 1965).

**Helping Scores.** To calculate the helping scores, if a participant attempted to complete the helping tasks, each individual task was scored as one point. If the helping tasks were not completed, the participant's helping score was calculated as a zero. One point was calculated if one of the three helping tasks was completed. Two points were calculated if two of the three helping tasks were completed. Three points were calculated if all three helping tasks were completed. This yields a range of 0-3 for the helping score.

## CHAPTER 4

### RESULTS

#### Preliminary Analyses

To explore gender differences, a one-way between groups ANOVA was conducted and revealed that, overall, men and women did not differ significantly when reporting trauma history or self-esteem,  $F(1, 146) = 0.39, p > 0.05$  and  $F(1, 146) = 3.82, p > 0.05$ , respectively. They also did not differ significantly in number of helping tasks completed,  $F(1, 146) = 1.87, p > 0.05$ . Mean scores and standard deviations for the overall sample are included in Table 1.

#### Primary Analyses

The current sample revealed that of the 149 participants, 65 (43.6%) reported experiencing at least one traumatic event (see Table 2). A Pearson's correlation coefficient was conducted to determine if the frequency of trauma history was associated with helping behaviors. Pearson's correlation coefficient determined that there was a significant positive correlation between trauma history and helping behaviors,  $r(149) = 0.23, p < 0.01$ . Specifically, a higher trauma score was associated with a higher helping score. A Pearson's correlation was also conducted to determine if the frequency of trauma history was associated with self-esteem. There was a significant negative correlation between trauma history and self-esteem,  $r(149) = -0.29, p < 0.01$ . Specifically, a higher trauma score was associated with a lower self-esteem score (see Table 3).

Additionally, a series of regression analyses, as proposed by Baron and Kenny (1986), were conducted to determine whether or not self-esteem would mediate the relationship between instances of traumatic experiences and helping behaviors. Baron and Kenny suggested a four-step procedure to determine if mediation is occurring among the variables:

1. Regress frequency of helping behaviors (Y) onto trauma history (X) to establish a relationship between X and Y (path c).
2. Regress self-esteem scores (mediator) onto trauma history to establish a relationship between the mediator and X (path a).
3. Regress frequency of helping behaviors onto self-esteem scores and trauma history to establish a relationship between the mediator and Y (path b).
4. Regress frequency of helping behaviors onto trauma history while controlling for self-esteem to establish the association among the two predictors (X and mediator) and Y (Baron & Kenny, 1986).

In the first step of the regression model (path c), helping behaviors predicted 5.4% of the variance in trauma history scores,  $F(1,147) = 8.33, p < 0.01$ . In the second step of the regression model (path a), self-esteem scores predicted 6.7% of the variance in trauma history scores,  $F(1,147) = 10.51, p < 0.01$ . In the third step of the regression model (path b), self-esteem scores predicted 5.5% of the variance in helping scores revealing no evidence of mediation,  $F(1,147) = 4.22, p > 0.05$ . Because the model requires significance at the previous step to move on to the following step, the researchers concluded the analyses at path b (Baron & Kenny, 1986).

## CHAPTER 5

### DISCUSSION

Understanding the long term impact of traumatic experiences is crucial to understanding how past experiences can shape present behaviors. Previous research has suggested that individuals who have experienced a trauma are more likely to exhibit symptoms of PTSD and impaired social functioning than individuals who have not experienced a traumatic event (Greca et al., 2008). Research also indicates that those who are victims of childhood trauma are more likely to exhibit low self-esteem, have higher residual stress, and utilize more avoidant coping mechanisms (e.g., withdrawal, criticism of oneself) than those with no history of childhood trauma (Bryant-Davis, 2005; Finkelhor, 2009; Fortier et al., 2009). Lower self-esteem has been observed in survivors of childhood trauma in comparison to individuals with no childhood trauma (Finkelhor, 2009). The purpose of the current study was to determine the relationship between traumatic experiences and helping behaviors, as well as the relationship among traumatic experiences, helping behaviors, and self-esteem.

The current study provides support for the first hypothesis that a positive relationship exists between reports of previous trauma and helping behaviors. Of the 149 participants, 99 (66%) participated in the helping tasks. Seventy-four percent of those who reported a history of trauma (compared to 61% of those with no history of trauma) completed at least one of the helping tasks. We found that a higher trauma score was associated with a higher helping score. Activism in the form of a brief survey may be a small act of altruistic kindness, which may be used by participants as a positive coping strategy as suggested by Bryant-Davis (2005). Also, the findings fit the theory of posttraumatic growth (Tedeschi & Calhoun, 2004). In the current sample, individuals who reported experiencing traumatic events also participated in the helping

tasks. In comparison to the posttraumatic growth theory, our model found that higher instances of trauma (negative experiences) were associated with higher instances of helping (a positive outcome). As suggested by Tedeschi and Calhoun (2004), posttraumatic growth is an unconscious process utilized to find a way of coping with trauma rather than searching for meaning of the trauma (e.g., Why did this happen to me?).

While we cannot infer the reasons behind individuals' willingness to participate in the helping behaviors, our research provides evidence of an association between negative past experiences and a positive outcome. Helping is described as a positive coping strategy by Bryant-Davis (2005), and one suggests that individuals who have experienced trauma would be likely to engage in helping as a positive coping strategy. To further compare our model to the theory of posttraumatic growth, Tedeschi and Calhoun (2004) also state that individuals do not simply return to their normal state after experiencing trauma, but instead sustain improvement that can be deeply meaningful. Seeking out ways to help others can provide improvement in one's life, especially if the individual was not interested in helping others prior to the trauma. Even if the individual engaged in helping behaviors prior to a traumatic event, it is particularly beneficial to engage in helping behaviors to achieve positive psychological health.

The current study also provides support for the second hypothesis that there was a negative relationship between reports of previous trauma and self-esteem. Consistent with the findings of Briere and Elliott (2003), we found that a higher trauma score was moderately associated with a lower self-esteem score. This finding supports previous research in the area. This relationship should be further explored by observing a different measure of psychological health. Although we found self-esteem to be associated with trauma history, recent studies suggest that self-compassion is a more accurate measure of psychological health than self-esteem

(Neff, 2003). Self-compassion involves being touched by and open to one's own suffering, not disconnecting from it to alleviate one's suffering (Neff, 2003). In addition, other related variables such as self-concept and self-awareness should be further investigated to provide a better understanding of the relationship between trauma history and helping behaviors.

The final hypothesis, that self-esteem would mediate the relationship between helping behaviors and traumatic past experiences, was not supported. According to Bizman and colleagues (1980), helping may be a way to regain self-esteem and may explain greater helping behaviors by those with a history of trauma, but in the current study, there was no evidence of a mediating relationship between helping behaviors and self-esteem. Because we did not observe any significant indirect effects, we suggest observing the effects of a moderator variable between traumatic experiences and helping behaviors. Future research should focus on when the relationship between trauma history and helping behaviors exists instead of the indirect effects of an additional variable. We suggest researchers evaluate extraversion, optimism, openness to experiences, and resiliency to determine when individuals with a history of trauma exhibit helping behaviors. These variables are discussed by Tedeschi and Calhoun (2004) as possible personality characteristics that increase posttraumatic growth. One asserts that the evaluation of these variables as moderators could strengthen the interesting relationship found between history of trauma and helping behaviors.

The findings provide preliminary support for the position that trauma may not always lead to isolation, self-blame, or substance abuse (Fortier et al., 2009). The current study suggests that trauma history is associated with engaging in helping, but also associated with low self-esteem. Despite this contradiction, individuals with a history of trauma should be aware that their experiences can result in posttraumatic growth. In this instance, donating to a child abuse

prevention charity could increase affected individuals' self-esteem. While we cannot infer that posttraumatic growth was why individuals with a history trauma completed the helping measures more often than those without a history of trauma, we can provide a foundation for more research regarding positive outcomes following a traumatic experience. This research can also be helpful in determining possible interventions for those with a history of trauma. In fact, recent research suggests that helping is a positive coping strategy following traumatic events (Bryant-Davis, 2005).

### **Strengths and Limitations**

Because correlational analyses were conducted, we cannot infer a causal relationship among the variables. One strength of utilizing correlational data was that we were able to observe an association among the variables without actually manipulating trauma history. Experimenter bias and demand characteristics were also minimized due to the collection of data via the internet. Another strength of the current study was that the study design gave participants a chance to engage in a variety of helping tasks to suit their interests. Additionally, the inclusion of a previously validated self-esteem measure increases the study's construct validity.

The researchers realize that the current study is not without limitations. We were interested in whether or not history of trauma was associated with helping behaviors. The helping measures in the current study were not counterbalanced, thus affecting the internal validity. The helping tasks were also measured in a restrictive range (from 0-3), possibly affecting the accuracy of the helping scores. Introducing more helping tasks with a less restrictive range can increase the study's internal validity. Manipulation checks should also be conducted to measure participants' willingness to help to further explain why individuals helped and to examine a possible link to the theory of posttraumatic growth. Additionally, self-reports



were utilized, and while there is research suggesting a positive correlation between self-reported behaviors and observed behaviors, social desirability may have had an effect on the current results (Prochazka & Vaculik, 2011). Specifically, due to the nature of the study, participants may have been more likely to evaluate their responses and change them to fit societal expectations (Holtgraves, 2004). External validity is threatened in our design as participants were recruited from a website used by psychology students which was not accessible to other populations. Finally, statistical validity was threatened such that we did not detect strong effects among the variables, and the researchers suggest increasing power by examining these associations with a larger sample of participants.

### **Conclusions and Future Research**

In summary, the current study provides evidence that there is an association between helping behaviors and history of trauma specifically that those who reported more total prior traumatic events were more likely to engage in a greater number of helping behaviors. It is important to study this association to determine effective coping strategies for individuals who have experienced trauma. Knowing that those who have a history of trauma may experience posttraumatic growth or other positive outcomes following helping others can be used in treatment for people who experience trauma. If engaging in helping behaviors can decrease negative outcomes or increase self-esteem or other positive attributes, those who conduct therapy with victims of trauma can encourage clients to engage in volunteerism or other helping behaviors as a way to increase psychological health. We have already suggested that posttraumatic growth is a possible explanation for this association, but we cannot accurately assume this is the case for all individuals. For future research, we suggest further exploration regarding helping behaviors as a result of posttraumatic growth or a positive coping strategy.

Perhaps researchers should focus on the process utilized during posttraumatic growth, specifically what variables affect the relationship between negative past experiences and positive outcomes. For example, psychological distress, extraversion, optimism, openness to experiences, resiliency, and vulnerability could be evaluated as moderator variables for the relationship between trauma history and helping behaviors. Future studies should also provide helping tasks that can more accurately measure the extent participants were willing to help to compute a more precise helping score. Perhaps future research can also utilize the clickable tasks in the current study and measure the number of clicks as a dependent variable. We also suggest placing participants in an environment where helping behaviors can be observed by the researchers.

## REFERENCES

- Baron, R. M., & Kenny, D. A (1986). The moderator–mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology*, *51*(6), 1173-1182. doi: 10.1037/0022-3514.51.6.1173
- Bartlett, M. Y., & DeSteno, D. (2006). Gratitude and prosocial behavior: Helping when it costs you. *Psychological Science*, *17*(4), 319-25. doi: 10.1037/a0017883
- Benet-Martínez, V., & John, O. P. (1998). Los Cinco Grandes across cultures and ethnic groups: Multitrait-multimethod analyses of the Big Five in Spanish and English. *Journal Of Personality And Social Psychology*, *75*(3), 729-750. doi:10.1037/0022-3514.75.3.729
- Bernstein, D. P., Stein, J. A., Newcomb, M. D., Walker, E., Pogge, D., Ahluvalia, T., . . . Zule, W. (2003). Development and validation of a brief screening version of the Childhood Trauma Questionnaire. *Child Abuse & Neglect*, *27*(2), 169-190. doi:10.1016/S0145-2134(02)00541-0
- Bizman, A., Yinon, Y., Ronco, B., & Shachar, T. (1980). Regaining self-esteem through helping behavior. *Journal of Psychology: Interdisciplinary and Applied*, *105*(2), 203-209.
- Briere, J., & Elliott, D. M. (2003). Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Child Abuse & Neglect*, *27*(10), 1205-1222. doi:10.1016/j.chiabu.2003.09.008
- Briggs, E., Landry, T., & Wood, C. (2007). Beyond just being there: An examination of the impact of attitudes, materialism, and self-esteem on the quality of helping behavior in youth volunteers. *Journal of Nonprofit & Public Sector Marketing*, *18*(2), 27-45. doi:10.1300/J054v18n02\_02

Bryant-Davis, T. (2005). Coping strategies of African American adult survivors of childhood violence. *Professional Psychology: Research and Practice*, 36(4), 409-414.

doi:10.1037/0735-7028.36.4.409

Child Maltreatment fact sheet, (September 19, 2013). Retrieved December 3, 2013 from

<http://www.cdc.gov/violenceprevention/pdf/cm-data-sheet--2013.pdf>.

Child Maltreatment logo, (2013). Retrieved December 3, 2013 from

[https://www.azdes.gov/child\\_abuse\\_prevention\\_councils/](https://www.azdes.gov/child_abuse_prevention_councils/).

Cohen, J. (1992). A power primer. *Psychological Bulletin*, 112, 155–159. doi: 10.1037/0033-2909.112.1.155.

Davis, J., Petretic-Jackson, P. A., & Ting, L. (2001). Intimacy dysfunction and trauma symptomatology: Long-term correlates of different types of child abuse. *Journal of Traumatic Stress*, 14 (1), 63-79. doi: 0894-9867/01/0100-0063\$19.50/1

doi: 10.1037/0894-9867.14.1.63

Finkelhor, D. (2009). The prevention of childhood sexual abuse. *The Future of Children*, 19(2), 169-194. doi:10.1353/foc.0.0035

Fortier, M. A., DiLillo, D., Messman-Moore, T. L., Peugh, J., DeNardi, K. A., & Gaffey, K. J. (2009). Severity of child sexual abuse and revictimization: The mediating role of coping and trauma symptoms. *Psychology Of Women Quarterly*, 33(3), 308-320.

doi:10.1111/j.1471-6402.2009.01503.x

Frazier, P., Greer, C., Gabrielsen, S., Tennen, H., Park, C., & Tomich, P. (2012). The relation between trauma exposure and prosocial behavior. *Psychological Trauma: Theory, Research, Practice, and Policy*, 5(3). doi:10.1037/a0027255

doi:10.1037/a0027255

- Greca, A., Boyd, B., Jaycox, L., Kassam-Addams, N., Mannarino, A., Silverman, W., Tuma, F., Wong, M. (2008). Children and Trauma: Update for Mental Health Professionals. Retrieved February 20, 2014 from <http://www.apa.org/pi/families/resources/children-trauma-update.aspx>.
- Holtgraves, T. (2004). Social desirability and self-reports: Testing models of socially desirable responding. *Personality and Social Psychology Bulletin*, 30, 161–172. doi: 10.1177/0146167203259930
- Kallstrom-Fuqua, A. C., Weston, R., & Marshall, L. L. (2004). Childhood and adolescent sexual abuse of community women: Mediated effects on psychological distress and social relationships. *Journal of Consulting and Clinical Psychology*, 72(6), 980-992. doi: 10.1037/0022-006X.72.6.980
- Lee, J., & Shrum, L. J. (2012). Conspicuous consumption versus charitable behavior in response to social exclusion: A differential needs explanation. *Journal of Consumer Research*, 39(3), 530-544. doi:10.1086/664039
- McKeever, V. M., & Huff, M. E. (2003). A diathesis-stress model of posttraumatic stress disorder: Ecological, biological, and residual stress pathways. *Review of General Psychology*, 7(3), 237-250. doi:10.1037/1089-2680.7.3.237
- Micheline, R. L., Wilson, J. P., & Messe, L. A. (1975). The influence of psychological needs on helping behavior. *Journal of Psychology: Interdisciplinary and Applied*, 91(2), 253-258. doi:10.1080/00223980.1975.9923950
- Muller, R. T., & Lemieux, K. E. (2000). Social support, attachment, and psychopathology in high risk formerly maltreated adults. *Child Abuse & Neglect*, 24(7), 883-900. doi:10.1016/S0145-2134(00)00150-2

- Neff, Kristin. (2003). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity*, 2, 85-101. doi: 10.1080/15298860390129863
- Nelson Goff, B. S., Crow, J. R., Reisbig, M. J., & Hamilton, S. (2007). The impact of individual trauma symptoms of deployed soldiers on relationship satisfaction. *Journal of Family Psychology*, 21(3), 344-353. doi: 10.1037/0893-3200.21.3.344
- Nunnally, J., & Bernstein, I. (1994). *Psychometric Theory*. (3rd ed.). New York: McGraw-Hill.
- Prochazka, J., & Vaculík, M. (2011). The relationship between prosocial behavior and the expectation of prosocial behavior. *Studia Psychologica*, 53(4), 363-372.
- Robins, R. W., Hendin, H. M., & Trzesniewski, K. H. (2001). Measuring global self-esteem: Construct validation of a single-item measure and the Rosenberg Self-Esteem Scale. *Personality And Social Psychology Bulletin*, 27(2), 151-161.  
doi:10.1177/0146167201272002
- Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press.
- Rushton, J. P., Chrisjohn, R. D., & Fekken, G. C. (1981). The altruistic personality and the self-report altruism scale. *Personality and Individual Differences*, 2, 293-302. doi: 10.1016/0191-8869(81)90084-2
- Sahin, N., Timur, S., Ergin, A., Taspinar, A., Balkaya, N., & Cubukcu, S. (2010). Childhood trauma, type of marriage and self-esteem as correlates of domestic violence in married women in Turkey. *Journal of Family Violence*, 25(7), 661-668. doi:10.1007/s10896-010-9325-5

- Schmitt, D. P., & Allik, J. (2005). Simultaneous administration of the Rosenberg Self-Esteem Scale in 53 nations: Exploring the universal and culture-specific features of global self-esteem. *Journal of Personality and Social Psychology*, 89(4), 623-642.  
doi:10.1037/0022-3514.89.4.623
- Tedeschi, R. G., & Calhoun, L. G. (2004). Target article: 'Posttraumatic growth: Conceptual foundations and empirical evidence'. *Psychological Inquiry*, 15(1), 1-18.  
doi:10.1207/s15327965pli1501\_01
- Stidham, A., Draucker, C. B., Martsolf, D. S., & Mullen, L. (2012). Altruism in survivors of sexual violence: The typology of helping others. *Journal of the American Psychiatric Nurses Association*, 18(3), 146-155. doi:10.1177/1078390312440595
- Valerio, P., & Lepper, G. (2009). Sorrow, shame, and self-esteem: Perception of self and others in groups for women survivors of child sexual abuse. *Psychoanalytic Psychotherapy*, 23(2), 136-153. doi:10.1080/02668730902920405

**GEORGIA SOUTHERN UNIVERSITY**

---

**DEPARTMENT OF PSYCHOLOGY**

---

**INFORMED CONSENT**

Childhood Experiences and Self-Esteem

This study is being conducted by Adriana Joseph and Dr. C. Thresa Yancey. Adriana Joseph is a graduate student in the experimental psychology program and Dr. Yancey is an associate professor in the Psychology Department at Georgia Southern University.

**Purpose of the Study:** The purpose of this research is to gain a better understanding of the long term effects of childhood experiences on individuals' self-esteem.

**Procedures to be followed:** Participation in this research will include completing surveys.

**Discomforts and Risks:** Completing this survey should be no more uncomfortable than everyday life.

**Benefits:**

- a. The benefits to participants include a better understanding of how research is conducted in psychology.
- b. The benefits to society include a better understanding of how past experiences affect individuals' self-esteem.

**Duration/Time required from the participant:** Participation in this study will take no longer than 50 minutes.

**Statement of Confidentiality:** This study is completely anonymous. Your identity will be protected to the fullest extent of the law. Your name will only be used to provide you with credit for participating in the study. The researchers will not be able to attach your responses to any identifiable features of your person. Also, we will only report that you participated to your professor through the SONA system – all of your information is confidential and no one will know what your answers to the questionnaires are. Your professors will not be allowed access to any of your responses. Moreover, all of your information will be held in a safe and secure environment. All data will be stored on a password protected data file and only the researchers will have access to the data. All data will be kept for five years. Your information will be combined with information from other people taking part in the study. When we write up the study to share it with other researchers, we will write about this combined information. Your responses will not be identified in these written materials. Finally, because data will be collected through the internet there are always some risks concerning security. However, we have taken stringent steps to ensure that all of your responses will be collected and maintained through the most secure means possible.

**Right to Ask Questions:** Participants have the right to ask questions and have those questions answered. If you have questions about this study, please contact the researcher named above or the researcher's faculty advisor, whose contact information is located at the end of the informed consent. For questions concerning your rights as a research participant, contact Georgia Southern University Office of Research Services and Sponsored Programs at 912-478-0843 or email at [IRB@georgiasouthern.edu](mailto:IRB@georgiasouthern.edu).



## Appendix A

**Compensation:** You will receive research participation credit for participating in this study. Participation in this research study is worth one research credit. Equivalent alternative research participation opportunities will be available for those who elect not to participate. Please see your course instructor for alternative research participation opportunities.

**Voluntary Participation:** Please know that your participation in this research is completely voluntary, and as such, you have the right to withdraw at anytime without prejudice, penalty, or loss of benefits to which you are otherwise entitled. You may choose to not answer any item without penalty. Additionally, students may receive the same credit as research participation by opting for an alternative, indicated by each individual Introduction to Psychology instructor.

**Penalty:** There is no penalty for deciding not to participate in the study; if you decide to stop participation at any point, you will be entitled to the compensation of credit.

You must be 18 years of age or older to consent to participate in this research study. If you consent to participate in this research study and to the terms above, please indicate by selecting the “I give my consent freely” button below.

Please print off a copy of this consent form to keep for your records. This project has been reviewed and approved by the Georgia Southern Institutional Review Board under tracking number H14086.

Principal Investigator: Adriana Joseph, 229-506-0500, [aj01193@georgiasouthern.edu](mailto:aj01193@georgiasouthern.edu)

Co-Investigator: C. Thresa Yancey, Ph.D., Associate Professor, 912-478-5704, [tyancey@georgiasouthern.edu](mailto:tyancey@georgiasouthern.edu)

### **Title of Project: Childhood Experiences and Self-Esteem**

Since we cannot obtain your signature to verify that you are voluntarily providing our consent to participate, it is important that we obtain your consent through another means. By clicking the “I give my consent freely” button below, you are acknowledging that you have read and understood the instructions and limitations to participating in this research. Moreover, you are indicating that you would like to participate in this study as a volunteer. If you do not wish to take this survey or are hesitant about participating, cancel out of the survey and then please email the primary investigator to discuss any concerns you may have.

**I have read and understand the purpose, instructions, and limitations to participating in this study.**

**I give my consent freely to participate as a volunteer in this study.**



Appendix B

3. As a child, were you placed in foster care, put up for adoption, or placed in an orphanage?

YES NO

Please rate how emotionally harmed you were by this/these (incidents). None, Little, Some, A Lot

Age: \_\_\_\_\_

Placement: \_\_\_\_\_

4. Have you ever been slapped or hit in a way that left marks or bruises?

YES NO

Please rate how emotionally harmed you were by this/these (incidents). None, Little, Some, A Lot

How old were you the first time?: \_\_\_\_\_

Number of times: \_\_\_\_\_

Who did this to you?: \_\_\_\_\_

Any injury (broken bone, bruises, scratches, etc.): \_\_\_\_\_

Did you tell someone at the time? YES NO

Who?

If not, have you ever told anyone? YES NO

Were the police or child protective services involved? YES NO

5. Have you ever been thrown, punched, or kicked?

YES NO

Please rate how emotionally harmed you were by this/these (incidents). None, Little, Some, A Lot

Please rate how physically harmed you were by these (incidents). None, Little, Some, A Lot

How old were you the first time?: \_\_\_\_\_

Number of times: \_\_\_\_\_

Who did this to you?: \_\_\_\_\_

Any injury (broken bone, bruises, scratches, etc.): \_\_\_\_\_

Did you tell someone at the time? YES NO

Who?

If not, have you ever told anyone? YES NO

Were the police or child protective services involved? YES NO

Appendix B

6. Have you ever been tied up or locked in a closet or other place?

YES NO

Please rate how emotionally harmed you were by this/these (incidents). None, Little, Some, A Lot

Please rate how physically harmed you were by these (incidents). None, Little, Some, A Lot

How old were you the first time?: \_\_\_\_\_

Number of times: \_\_\_\_\_

Who locked you up?: \_\_\_\_\_

Any injury (broken bone, bruises, scratches, etc.): \_\_\_\_\_

Did you tell someone at the time? YES NO

Who?

If not, have you ever told anyone? YES NO

Were the police or child protective services involved? YES NO

7. Have you ever been burned on purpose with a cigarette, hot water, or something else?

YES NO

Please rate how emotionally harmed you were by this/these (incidents). None, Little, Some, A Lot

Please rate how physically harmed you were by these (incidents). None, Little, Some, A Lot

How old were you the first time?: \_\_\_\_\_

Number of times: \_\_\_\_\_

Who burned you?: \_\_\_\_\_

Any injury (broken bone, bruises, scratches, etc.): \_\_\_\_\_

Did you tell someone at the time? YES NO

Who?

If not, have you ever told anyone? YES NO

Were the police or child protective services involved? YES NO



Appendix B

10. Have you ever been forced to participate in a violent act (such as a beating, sexual assault)?

YES NO

Please rate how emotionally harmed you were by this/these (incidents). None, Little, Some, A Lot

Please rate how physically harmed you were by these (incidents). None, Little, Some, A Lot

How old were you the first time?: \_\_\_\_\_

Number of times: \_\_\_\_\_

Who forced you? \_\_\_\_\_

What was the violent act? \_\_\_\_\_

Did you tell someone at the time? YES NO

Who?

If not, have you ever told anyone? YES NO

Were the police or child protective services involved? YES NO

11. Has anyone ever made you have intercourse, oral, or anal sex against your will?

YES NO

Please rate how emotionally harmed you were by this/these (incidents). None, Little, Some, A Lot

Please rate how physically harmed you were by these (incidents). None, Little, Some, A Lot

How old were you the first time?: \_\_\_\_\_

Number of times: \_\_\_\_\_

Who forced you? \_\_\_\_\_

Did you tell someone at the time? YES NO

Who?

If not, have you ever told anyone? YES NO

Were the police or child protective services involved? YES NO



Appendix B

14. Has anyone ever touched private parts of your body or made you touch theirs through other means (coercion, pressure, or because you were young)?

YES NO

Please rate how emotionally harmed you were by this/these (incidents). None, Little, Some, A Lot

Please rate how physically harmed you were by these (incidents). None, Little, Some, A Lot

How old were you the first time?: \_\_\_\_\_

Number of times: \_\_\_\_\_

Who did this to you? \_\_\_\_\_

Did you tell someone at the time? YES NO

Who?

If not, have you ever told anyone? YES NO

Were the police or child protective services involved? YES NO

15. Other than the incidents mentioned above, have there been any situations in which another person tried to force you to have unwanted sexual contact?

YES NO

Please rate how emotionally harmed you were by this/these (incidents). None, Little, Some, A Lot

Please rate how physically harmed you were by these (incidents). None, Little, Some, A Lot

How old were you the first time?: \_\_\_\_\_

Number of times: \_\_\_\_\_

Who did this to you? \_\_\_\_\_

Did you tell someone at the time? YES NO

Who?

If not, have you ever told anyone? YES NO

Were the police or child protective services involved? YES NO



Appendix B

16. Have you ever been in any other situation in which you were seriously injured or suffered physical damage?

YES      NO

Please rate how emotionally harmed you were by this/these (incidents). None, Little, Some, A Lot

Please rate how physically harmed you were by these (incidents).      None, Little, Some, A Lot

Age: \_\_\_\_\_

Please describe? \_\_\_\_\_

17. Have you ever been in any other situation in which you feared you might be killed or seriously injured?

YES      NO

Please rate how emotionally harmed you were by this/these (incidents). None, Little, Some, A Lot

Please rate how physically harmed you were by these (incidents).      None, Little, Some, A Lot

Age: \_\_\_\_\_

Please describe? \_\_\_\_\_

18. Have you experienced any other situation that was not already asked about which was extraordinarily stressful?

YES      NO

Please rate how emotionally harmed you were by this/these (incidents). None, Little, Some, A Lot

Please rate how physically harmed you were by these (incidents).      None, Little, Some, A Lot

Age: \_\_\_\_\_

Please describe? \_\_\_\_\_

Appendix C:  
Helping Tasks

Appendix C:  
Helping Tasks

**Title: Guttman Scales**

Citation: Nunnally, J., & Bernstein, I. (1994). *Psychometric Theory*. (3rd ed.). New York: McGraw-Hill.

Guttman scales are developed by administering items to a group and then attempting to arrange the responses so that they form the required triangular pattern (see Torgerson, 1958). The data will form a “solid staircase” or alpha responses, and the height of each step will be proportional to the number of people at each level of the attribute. The term “scalogram analysis” describes methods of developing Guttman scales.

Unfortunately, it is very unlikely that the initial set of items will produce a triangular pattern. It is therefore necessary to (1) discard some items and (2) find the best possible ordering among the remaining items. The reproducibility of score patterns is of primary concern regarding the latter issue. If a triangular pattern is obtained, knowing the number of alpha responses allows one to reproduce *all* of an individual’s responses. The percentage of people whose patterns are thus reproduced is a basic statistic in scalogram analysis (Nunnally and Bernstein, 1994).

Questions:

- 1) How are Guttman scales developed?
- 2) What kind of pattern is formed when responding on a Guttman scale?
- 3) Through the pattern, what is one able to deduce while relying on this sort of scale?

Appendix C:  
Helping Tasks

Child Maltreatment Image for Clicking



## Child Maltreatment

### Facts at a Glance

2013

#### Child Maltreatment

- In 2011, U.S. state and local **child** protective services (CPS) received an estimated 3.7 million referrals of children being abused or neglected.<sup>1</sup>
  - CPS estimated that 681,000 children (9.1 per 1,000) were victims of maltreatment.
  - Of the **child** victims, 79% were victims of neglect; 18% of physical abuse; 9% of sexual abuse; and 10% were victims of other types of maltreatment including threatened abuse, parent's drug/alcohol abuse, or lack of supervision.
- CPS reports of **child** maltreatment may underestimate the true occurrence. Non-CPS studies estimate that 1 in 7 U.S. children experience some form of **child** maltreatment in their lifetimes.<sup>2,4</sup>
- Between 1990 and 2010, CPS-reported rates of sexual violence declined 62%, physical abuse declined 56%, and neglect declined 10%.<sup>5</sup>
- The total lifetime economic burden resulting from new cases of fatal and nonfatal **child** maltreatment in the United States is approximately \$124 billion.<sup>6</sup>

#### Deaths from Child Maltreatment

- In 2011, an estimated 1,750 children died from **child** maltreatment (rate of 2.1 per 100,000 children).<sup>1</sup>
- Of the children who died from maltreatment in 2011, 71% experienced neglect either exclusively or in combination with another form of maltreatment and 48% percent experienced physical abuse either exclusively or in combination with another form of maltreatment.<sup>1</sup>
- Of **child** maltreatment fatalities in 2011, 81.6% occurred among children younger than age 4; 9.5% among 4-7 year-olds; 4.6% among 8-11 year-olds; 2.2% among 12-15 year-olds; and 1.4% among 16-17 year-olds.<sup>1</sup>
- The fatality rate for boys was 2.5 per 100,000 and for girls was 1.7 per 100,000.<sup>1</sup>
- The 2011 rates of death per 100,000 children was 3.9 for African Americans, 2.6 for American Indian/Alaska Natives, 1.9 for Hispanics, 1.6 for non-Hispanic Whites, 1.2 for Pacific Islanders and 0.4 for Asians.<sup>1</sup>

#### Characteristics of Victims

- In 2011, 35% of victims were younger than 3 years, with children younger than 1 year having the highest rate of victimization (21.2 per 1,000 children).<sup>1</sup>
- The rates of victimization in 2011 were 8.7 per 1,000 children for boys and 9.6 per 1,000 children for girls.<sup>1</sup>
- The 2011 rates of victimization per 1,000 children were 14.3 for African Americans, 11.4 for American Indian/Alaska Natives, 8.5 for Pacific Islanders, 8.6 for Hispanics, 7.9 for non-Hispanic Whites, and 1.7 for Asians.<sup>1</sup>
- Approximately three quarters of victims in 2011 had no prior victimization for each year from 2007-2011.<sup>1</sup>

#### Characteristics of Perpetrators

- Most victims in 2011 were maltreated by a parent (80.8%). Other perpetrators included relatives other than parents (5.9%), unmarried partners of parents (4.4%), and other unrelated adults (2.9%).<sup>1</sup>
- In 2011, fewer than 6% of perpetrators were aged  $\leq$  19 years; 36.4% were aged 20-29 years; 32.3% were aged 30-39 years; 15.9% were aged 40-49 years; and 5.0% were aged 50-59 years.<sup>1</sup>
- Two-fifths (45.1%) of perpetrators in 2011 were men, and 53.6% were women.<sup>1</sup>

#### References

1. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2012). Child Maltreatment 2011. Available from <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>.
2. Finkelhor D, Turner H, Ormrod R, Hamby SL. Violence, abuse, and crime exposure in a national sample of children and youth. *Pediatrics* 2009; 124:1411-1423.
3. Theodore AD, Chang JJ, Bunyan DK, Hunter WM, Bangdewala SI, Agans R. Epidemiologic features of the physical and sexual maltreatment of children in the Carolinas. *Pediatrics* 2005; 115: e331-e337.
4. Finkelhor D, Ormrod H, Turner H, Hamby S. The victimization of children and youth: a comprehensive national survey. *Child Maltreatment* 2005; 10: 5-25.
5. Finkelhor D, Jones L, Shattuck A. Updated Trends in Child Maltreatment, 2010. Durham, NH: Crimes against Children Research Center, 2011. Available from [www.unh.edu/ccrc/pdf/CV203\\_Updated%20trends%202010%20FINAL\\_12-19-11.pdf](http://www.unh.edu/ccrc/pdf/CV203_Updated%20trends%202010%20FINAL_12-19-11.pdf).
6. Fang X, Brown DS, Florence CS, Mercy JA. The economic burden of child maltreatment in the United States and implications for prevention. *Child Abuse and Neglect* 2012; 36:156-165.



Appendix D

**Demographics Questionnaire**

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Gender:

- Male  Female  Other

Race:

- White  African American  Hispanic  Asian  Pacific Islander  
 Native American  Bi/Multi Racial: \_\_\_\_\_

Current Marital Status:

- Single, Not dating  In exclusive relationship, Not married  Married  
 Partnership/Civil Union  Divorced  Widowed  Other: \_\_\_\_\_

Sexual Orientation:

- Heterosexual  Homosexual (Lesbian/Gay)  Bi-Sexual  Undecided

Occupation Status:

- Full Time  Stay-at-Home Parent/Caregiver  Part Time  
 Unemployed  Student  Retired

If you are a student, what is your current major? \_\_\_\_\_

Current year in school?

- Freshman  Sophomore  Junior  
 Senior  Post baccalaureate  Graduate student

How would you best describe the area in which you were raised? (lived prior to 18 years of age)

- Urban/Large City  Suburban  Small city/Small town  Rural

## Appendix E

### Debriefing

Thank you for your participation.

The purpose of this study was to gain a better understanding of the impact of childhood experiences on self-esteem. If you feel you have experienced any discomfort in answering any of these questions, here are some free to low cost health services that will help relieve discomfort:

Georgia Southern University's Counseling Center: 912-478-5541

National Mental Health Association: 1-800-969-6642

National Suicide Hotline: 1-800-784-2443

Table 1

*Means and standard deviations of trauma score, self-esteem score, and helping scores*

---

<i>Variable</i>	<i>Mean</i>	<i>Standard Deviation</i>
Trauma Score	0.98	1.63
Self-Esteem Score	38.68	6.79
Helping Score	1.79	1.38

---



Table 2

*Demographic statistics*

Characteristic	N=149		
Age			
<i>M</i>	19.77		
<i>SD</i>	3.20		
		n	%
Gender			
Male		40	26.8
Female		108	72.5
Ethnicity			
African American		50	33.6
White		90	60.4
Bi/Multi-Racial		4	2.7
Hispanic		3	2.0
Asian		1	0.7
Native American		1	0.7
Current Year in School			
Freshman		61	40.9
Sophomore		54	36.2
Junior		22	14.8
Senior		12	8.1
History of Trauma			
Yes		65	43.6
No		84	56.4

Table 3

*Correlations among trauma, self-esteem, and helping scores*

Variable	<i>Trauma Score</i>	<i>Self-Esteem Score</i>	<i>Helping Score</i>
Trauma Score	--	--	--
Self-Esteem Score	-0.26**	--	--
Helping Score	0.23*	-0.03	--

\*  $p < .05$

\*\*  $p < .01$