



Theses and Dissertations

2007-09-12

Disclosure of Abuse as a Moderating Variable for Internalized Shame in Adult Survivors of Childhood Sexual Abuse

Ami Mariko Hood Frost
Brigham Young University - Provo

Follow this and additional works at: <https://scholarsarchive.byu.edu/etd>



Part of the [Family, Life Course, and Society Commons](#)

BYU ScholarsArchive Citation

Frost, Ami Mariko Hood, "Disclosure of Abuse as a Moderating Variable for Internalized Shame in Adult Survivors of Childhood Sexual Abuse" (2007). *Theses and Dissertations*. 1191.
<https://scholarsarchive.byu.edu/etd/1191>

This Thesis is brought to you for free and open access by BYU ScholarsArchive. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of BYU ScholarsArchive. For more information, please contact scholarsarchive@byu.edu, ellen_amatangelo@byu.edu.

DISCLOSURE OF ABUSE AS A MODERATING VARIABLE FOR
INTERNALIZED SHAME IN ADULT SURVIVORS OF
CHILDHOOD SEXUAL ABUSE

by

Ami Mariko Hood Frost

A thesis submitted to the faculty of

Brigham Young University

in partial fulfillment of the requirements for the degree of

Master of Science

Marriage and Family Therapy Program

School of Family Life

Brigham Young University

August 2007

Copyright © 2007 Ami Mariko Hood Frost

All Rights Reserved

BRIGHAM YOUNG UNIVERSITY

GRADUATE COMMITTEE APPROVAL

of a thesis submitted by

Ami Mariko Hood Frost

This thesis has been read by each member of the following graduate committee and by majority vote has been found to be satisfactory.

Date

Leslie L. Feinauer, Chair

Date

James M. Harper

Date

Mark H. Butler

BRIGHAM YOUNG UNIVERSITY

As chair of the candidate's graduate committee, I have read the thesis of Ami Mariko Hood Frost in its final form and have found that (1) its format, citations, and bibliographical style are consistent and acceptable and fulfill university and department style requirements; (2) its illustrative materials including figures, tables, and charts are in place; and (3) the final manuscript is satisfactory to the graduate committee and is ready for submission to the university library.

Date

Leslie L. Feinauer
Chair, Graduate Committee

Accepted for the Department

Date

Robert F. Stahmann
Graduate Coordinator

Accepted for the College

Date

Elaine Walton
Associate Dean;
College of Family, Home, and Social Sciences

ABSTRACT

DISCLOSURE OF ABUSE AS A MODERATING VARIABLE FOR INTERNALIZED SHAME IN ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE

Ami Mariko Hood Frost

Marriage and Family Therapy Program

School of Family Life

Master of Science

Although previous research has established a correlation between childhood sexual abuse and internalized shame in adult survivors, very little research has been done to examine how disclosure affects that correlation. An adult female sample of survivors of childhood sexual abuse (N=467) were surveyed to determine a possible moderating effect of disclosure on internalized shame. It was predicted that 1) severity of abuse would be a significant predictor of internalized shame; 2) disclosure would be a significant predictor of internalized shame; and 3) disclosure would moderate the relationship between severity of abuse and internalized shame. Through structural

equation modeling using AMOS, results indicated a statistically significant positive relationship between severity and internalized shame as well as a statistically significant negative relationship between disclosure and internalized shame. However, when examining the possible moderating effect of disclosure on the relationship between severity and internalized shame, disclosure was found to have had no effect. Possible explanations for these results are given, and future research is discussed. Implications for clinical practice are included.

ACKNOWLEDGEMENTS

Completing this thesis marks the end of a personally enlarging journey that I consider myself privileged to have experienced. I hope that it also marks the beginning of other fruitful, enriching pursuits.

I wish to offer my gratitude and respect to the survivors of sexual abuse who participated in this study and offered a piece of their lives in order to further research and understanding. I never cease to be amazed and inspired by the strength and resilience they and countless other survivors exhibit each day.

I would like to acknowledge my chair, Leslie L. Feinauer, for her guidance, encouragement, advice, and advocacy when I needed her most. She has been an incredible mentor and example of the kind of therapist and person I would like to be. I also wish to acknowledge all of my committee members, Leslie L. Feinauer, James M. Harper, and Mark H. Butler for their time, effort, and input to help make this paper possible.

Further, I would like to offer appreciation to my parents, Kent and Hiromi Hood, for their encouragement as I completed this challenging program, and to my siblings, Kenta, Rika, Kenji, and Mika for being there for me to talk to when I needed to not think about school for a while. I would also like to thank my extended family, in-laws, and the many friends I have made along the way for their support and presence in my life.

I owe particular thanks to my husband, Joel, for his unending encouragement, excitement, and sacrifice as I have weathered the ups and downs of this program. He has been there for me every step of the way and never wavered in his love, faith, and devotion for me. I am fortunate to have him as my companion, and I will strive to offer him the same kind of support that he has so freely given me.

Finally, I would like to acknowledge my soon-to-be born child, who has been with me through the most difficult moments and to whom I will now gladly devote my full attention. We're happy you'll be here soon.

TABLE OF CONTENTS

CHAPTER ONE 1

 Introduction..... 1

 Operational Definition of Terms 3

CHAPTER TWO..... 4

 Review of Literature 4

 Effects of Disclosure of Sexual Abuse on Current Functioning..... 4

 Abuse Factors that Affect Disclosure and Symptomology..... 8

 Severity 8

 Traumagenic Dynamics..... 8

 Internalized Shame 9

 Summary of the Review of Literature..... 12

 Significance of Study 13

 Statement of Purpose 13

 Hypotheses 14

 Figure 1 15

 Figure 2..... 15

 Figure 3..... 16

CHAPTER THREE 17

 Methods..... 17

 Procedures..... 17

Participants.....	18
Demographics	18
Table 1.....	19
Subject Inclusion Criteria.....	20
Instruments	20
Internalized Shame Scale (ISS).....	20
Trauma Symptom Checklist 33 (TSC-33).....	21
Severity of Abuse Scale (SAS)	22
Traumatic Experience Self-Report.....	22
Disclosure Questionnaire.....	23
Figure 4.....	23
Design and Statistical Analysis.....	24
CHAPTER FOUR	25
Results	25
Severity of Abuse as a Predictor of Internalized Shame (Model 1).....	25
Figure 5.....	25
Experience of Disclosure as a Predictor of Internalized Shame (Model 2) ...	26
Figure 6.....	26
Severity of Abuse and Experience of Disclosure as Predictors of Internalized Shame (Model 3).....	26
Figure 7.....	28
CHAPTER FIVE	29
Discussion	29

Findings Consistent with Previous Research.....	29
Disclosure as a Moderating Variable.....	30
Implications for Clinical Practice	32
Strengths and Limitations	33
Conclusion	34
REFERENCES.....	36
APPENDICES.....	44
Appendix A	44
Appendix B.....	46
Appendix C.....	48

LIST OF FIGURES

1. Conceptual Model with Severity of Abuse Predicting Internalized Shame (Model 1)	15
2. Conceptual Model with Experience of Disclosure Predicting Internalized Shame (Model 2)	15
3. Conceptual Model with Severity of Abuse and Experience of Disclosure as Predictors of Internalized Shame (Model 3).....	16
4. Measurement Model for Experience of Disclosure	23
5. Standardized Coefficients for Model 1	25
6. Standardized Coefficients for Model 2	26
7. Standardized Coefficients for Model 3	28

LIST OF TABLES

1. Demographic Characteristics of the Sample 19

CHAPTER ONE

Introduction

Despite a growing interest from both scholarly and public domains, childhood sexual abuse (CSA) remains a significant problem in the United States. Herman (1981) estimates that about one-fifth to one-third of women have been sexually abused. More recent studies estimate the prevalence to be between one in twelve and one in four women (e.g., Finkelhor, Ormrod, Turner, & Hamby, 2005; Finkelhor, Hotaling, Lewis, & Smith, 1990). Though some studies assert that incidence of sexual abuse in the United States is declining (Jones & Finkelhor, 2003), the aftermath of the trauma experienced by CSA survivors remains. The devastating effects of the repercussions of CSA are evident by the percentage of CSA survivors in clinical populations. Estimates of the percentage of females in clinical populations who report a history of sexual abuse range from 35% to 75% (Briere & Zaidi, 1989).

Feinauer (1989) defines CSA as involving children in sexual activities that they do not truly understand and to which they do not fully consent. Such acts against children, whether explicitly coercive or not, have proven to be harrowing for most survivors. Long-term effects include posttraumatic stress disorder (PTSD); depression; substance abuse; eating disorders; low self-esteem; dissociation; interpersonal problems, including trust and sexual issues; and feelings of guilt and shame (e.g., Zlotnick, Zakriski, Shea, & Costello, 1996). More specifically, internalized shame has been identified as a common effect of CSA and leads to negative perceptions of self, relationships, and life. These negative perceptions

can then in turn result in or exacerbate other psychological symptoms to which CSA survivors were already vulnerable.

Shame has often been identified as having a mediating effect on the psychopathology following CSA. Stuewig (2005) found that shame-proneness in maltreated adolescents was associated with greater incidences of depression. Other research has shown that many other symptoms of emotional distress, including anxiety and dissociation, are highly associated with the mediating variable of shame (Whiffen & MacIntosh, 2005). Shame has also been found to have a moderating effect between internal attributions of abuse and PTSD symptoms (Feiring, Taska, & Chen, 2002). Thus, identifying moderators of shame in survivors of sexual abuse could potentially lead to significant attenuation of the negative symptoms associated with CSA.

Research shows that disclosing difficult experiences can moderate poor mental health (Bootzin, 1997; Pennebaker & Francis, 1996). Further, disclosing traumatic experiences may result in fewer symptoms that are normally associated with the sequelae of trauma (Ruggiero et al., 2004; Sauzier, 1989). In addition to moderating more observable symptoms such as depression and substance abuse, disclosure can be useful in assuaging the more abstract symptoms of helplessness, somatization, and poor self-esteem (Bradley & Follingstad, 2001). It is therefore a reasonable progression from the previous research to examine the possibility of disclosure moderating shame.

The purpose of this study is to assess the potential moderating effect that disclosing childhood sexual abuse has on shame. According to recent research, it appears that disclosure can have both negative and positive effects on shame in CSA survivors. This

study therefore seeks to identify what factors influence whether disclosure improves or exacerbates shame, taking into account severity of abuse, whether the victim was believed when she disclosed, and whether she would do so again given the chance to choose. Furthermore, this study will identify whether the correlation between disclosure and moderation of shame or disclosure and increase of shame is significantly different, therefore distinguishing if the potential for good outweighs the potential for harm.

Operational Definition of Terms

Child Sexual Abuse (CSA). For the purposes of this study, child sexual abuse was defined as involving children in sexual activities that they do not truly understand and to which they do not fully consent (Feinauer, 1989).

Severity of Abuse. Severity of abuse distinguishes between the different types of sexual acts that were committed by the perpetrator, ranging from sexual comments to sexual intercourse. This study utilized three measures of severity. The Trauma Symptom Checklist 33 (Briere & Runtz, 1989) assessed the prevalence of negative symptoms in the survivor, assuming greater severity leads to more symptoms. The Severity of Abuse Scale (Wilkin, 1992) assesses severity in three categories: noncontact abuse, contact abuse, and intercourse. Finally, participants were asked to rate on a five-point Likert scale how traumatic their abuse experience was for them.

Internalized Shame. Internalized shame was defined in this study as chronic and persistent negative evaluation of self (Feinauer, Hilton, & Callahan, 2003, p. 66). Shame was measured using the Internalized Shame Scale (Cook, 1991).

CHAPTER TWO

Review of Literature

The following review of literature will discuss current research on the variables associated with the present study, including disclosure, abuse severity, and shame. The dynamics of disclosing childhood sexual abuse (CSA) will be examined, along with the effect that disclosure has on survivors, considering the factor of if the survivor was believed. Finkelhor and Browne's (1986) traumagenic dynamics will also be discussed as they relate to internalized shame. Moreover, this review will examine internalized shame as a symptom of CSA and will review the current findings on how disclosure of CSA affects shame.

Effects of Disclosure of Sexual Abuse on Current Functioning

The concept of disclosure seems to be an intuitive one, yet a significant amount of variability exists within it. Although it typically means "the act of telling," some definitions may include reporting abuse to persons of authority. Further, disclosure is usually separated into three categories: purposeful, accidental, and elicited. Nevertheless, some researchers have identified more numerous categories, including behavioral and indirect verbal attempts, disclosures intentionally withheld, and disclosures triggered by recovered memories (Alaggia, 2004). For the purposes of this present study, the more typical definition of disclosure will be used.

Research indicates that "emotional suppression, denial, detachment, self-blame, and self-isolation, may result in more impaired functioning than coping involving disclosure

and support-seeking behavior,” (Rosenthal, Hall, Palm, Batten, & Follette, 2005, p. 29). Ruggiero, et al, (2004) examined the effects of disclosure of childhood rape on mental health outcome using a national sample of women, specifically looking at the timeliness of disclosure and to whom they disclosed. Researchers randomly contacted women from four areas of the United States, interviewed them by telephone, and then contacted them again one year later. Assessments used included the Incident Classification Interview (Kilpatrick, Saunders, Amick-McMullan, & Best, 1989) and specific questions regarding characteristics of the rape and disclosure.

Of the sample of 3,220 women in Ruggiero’s study, 428 of them answered affirmatively to at least one of the questions regarding rape, and 288 of those women indicated that the incident(s) occurred before 18 years of age. The researchers analyzed the following variables for their correlations with diagnosable posttraumatic stress disorder (PTSD), major depressive episode(s) (MDE), and substance abuse: (a) whether respondents ever disclosed the child rape to another person; (b) among respondents who disclosed, whether disclosure occurred within one month of the rape; and (c) whether respondents ever disclosed to their mothers. Participant data was then placed into three categories including nondisclosers, short-delay disclosers (disclosure within one month of rape), and long-delay disclosers. Researchers found that the prevalence of current PTSD and past-year MDE was significantly higher for long-delay disclosers relative to nondisclosers and short-delay disclosers. Differences between the disclosure categories for substance abuse were nonsignificant. Limitations of this study include the fact that men were not included in the study and that the information was retrospective in nature.

Arata (1998) conducted a study to research how childhood disclosure of CSA affected current mental health functioning. Of the 860 undergraduate women from a southeastern university who participated in the study, 204 reported a history of sexual abuse. Childhood sexual abuse was defined on a continuum from being coerced into doing something sexual to actual intercourse before the participant was fourteen and by a perpetrator who was five or more years older. The researchers examined the variables of whether or not the participant disclosed at the time of abuse and how that impacted psychological functioning, taking into consideration reactions to the disclosure, current age of participant, and severity of abuse. Measurements included behavioral questions on childhood victimization (Finkelhor, 1979), the Sexual Experiences Survey (Koss & Oros, 1982), the Global Severity Index of the Symptom Checklist 90—Revised (SCL-90), the Trauma Symptom Checklist-40 (TSC-40; Briere & Runtz, 1989), and the Impact of Events Scale (IES).

Researchers found partial support for their hypothesis that disclosure at the time of the abuse would result in a decrease in negative consequences. Women who had disclosed were less likely to have had times in their lives when they did not have memories of the incident occurring. The association between disclosure and a decreased likelihood of revictimization reportedly approached significance. Further, although disclosure of CSA did not have a direct relationship to any of the global measures of current functioning according to the SCL-90 or the TSC-40, researchers did find a significant relationship between disclosure and symptoms of avoidance and intrusive symptoms as indicated on the IES. Limitations of the study included the limited generalizeability of the sample, the

retrospective and self-reporting nature of the data, and the use of written surveys that may not have given participants the freedom to include other pertinent information.

Further studies have reported a positive relationship between disclosure and fewer long-term symptoms; however, there is some ambiguity about how this occurs. In a study of 50 women who were asked to write out a disclosure of traumatic life events, distress (including depression, interpersonal sensitivity, anxiety, and somatization) was found to have decreased following the written disclosures (Hemenover, 2003). Although other studies have concluded that the written disclosure itself is not sufficient to provide lasting psychological benefits (Batten, Follette, Hall, & Palm, 2002), the outcome from Hemenover indicated that telling the story had some positive impact on the teller.

Clearly, there are other significant factors related to disclosure that will affect the beneficial or detrimental result of disclosing CSA. Bleiberg (2000) found that, regardless of whether victims of CSA disclosed at childhood or waited until adulthood to disclose, the nature of the responses to their disclosure were a key element in moderating psychological symptoms of distress. Similar conclusions and elaboration of other important variables (such as desiring to tell and suppressing traumatic memories) have been found in other research (Lamb & Edgar-Smith, 1994; Sinclair & Gold, 1997). Moreover, the interventions following disclosure can significantly affect the later functioning of CSA survivors (Berliner & Conte, 1995).

Abuse Factors that Affect Disclosure and Symptomology

There are undoubtedly a myriad of important factors that influence the likelihood of a CSA survivor disclosing her abuse. Paine and Hansen (2000) conducted a comprehensive review that examined what abuse characteristics affect disclosure. The factors they identified included severity of abuse, victim-perpetrator relationship, and coercion and threats. Other studies (Feinauer, 1989; Finkelhor et al., 1986) make similar assertions and add frequency and duration of abuse as significant factors. For the purposes of this study, severity of abuse as it relates to shame and disclosure will be examined.

Severity

In a review of the literature, Paine (2002) found that the likelihood of disclosure decreases according to the extremes of abuse severity. Specifically, both victims who had experienced intercourse and victims who had experienced attempted sexual activity or noncontact abuse were largely unlikely to disclose their abuse. Sauzier (1989) reported similar findings. Arata (1998) found that the likelihood of disclosure decreases as severity of abuse increases.

Traumagenic Dynamics

In 1986, Finkelhor and Browne developed a conceptual model of CSA in which they identified four “trauma-causing factors” or traumagenic dynamics: traumatic sexualization, stigmatization, betrayal, and powerlessness (Finkelhor et al., 1986, p. 180). Traumatic sexualization indicates the process through which a child’s sexuality is inappropriately and dysfunctionally developed. Betrayal is defined as children’s discovery that “someone on whom they are vitally dependent has caused them harm,” (Finkelhor et al., 1986, p. 182).

Powerlessness refers to the course through which a child's sense of efficacy is continually stolen. Finally, stigmatization indicates the denigrating opinions of themselves that victims hear from others and then incorporates into their own self-image. This stigmatization can be conceptualized as internalized shame and will be examined in more depth.

Internalized Shame

Feinauer (2003) defines shame as "chronic and persistent negative evaluation of self" (p. 66). Such negative evaluations can include cognitions of being tainted, unlovable, powerless, of no value, and/or defective. Childhood sexual victimization seems to quite naturally, tragically, result in significant internalized shame.

Because children's experience of sexual abuse is one that they cannot prevent or control and from which they cannot escape, the victims learn that they are helpless and their actions have little power to change their environment. . . The implicit and explicit blaming, discounting, and being held responsible for their unwanted experiences...combine to create a belief within them that they are internally flawed. (Feinauer et al., 2003, p. 66)

Such a sense of utter powerlessness combined with completely unwarranted acceptance of responsibility for destructive actions would surely produce the sort of mental torture in a child that would lead to negative evaluations of self and the world. Moreover, Judith Herman (1997) states, "Shame is a response to helplessness, the violation of bodily integrity, and the indignity suffered in the eyes of another person," (p. 53). Child sexual abuse certainly qualifies as such a shame-promoting experience. Numerous studies have further

validated these claims through empirical means (Deblinger & Runyon, 2005; Feiring, Taska, & Chen, 2002; Feiring & Taska, 2005; Roth & Newman, 1991; Soderquist, 1993; Wilkin, 1992).

The fact that CSA often leads to internalized shame in survivors is clear; how to moderate those feelings of shame is not quite so clear. Several studies have sought to identify potential moderators of the negative sequelae of CSA. Hardiness, defined as the ability to positively adapt to stressful events, has been identified as a moderator of shame in survivors of CSA (Feinauer et al., 2003). Social support has been found to moderate symptoms in adult survivors of sexual abuse (Testa, Miller, Downs, & Panek, 1992), with self-esteem and appraisal being the most powerful factors for moderating PTSD symptomology (Bourdeau, 1994; Hyman, Gold, & Cott, 2003). As mentioned above, disclosure of abuse has also been identified as having a moderating effect on the psychopathy following CSA (Bradley & Follingstad, 2001; Gries et al., 2000; Ruggiero et al., 2004; Sauzier, 1989).

Much of the existing literature regarding the potential benefits of disclosing sexual abuse discusses its effect on diagnosable symptoms such as depression, PTSD, and substance abuse (e.g., Batten et al., 2002; Berliner & Conte, 1995; Bleiberg, 2000; Hemenover, 2003; Ruggiero et al., 2004; Sauzier, 1989). However, there is little research available documenting the moderating effects of disclosure of sexual abuse on shame. Shame has been identified as an impediment to disclosure of CSA (Crisma, Bascelli, Paci, & Romito, 2004); disclosure has even been identified as a potential source of shame when the legal system is involved (Ghetti, Weede Alexander, & Goodman, 2002).

Nevertheless, some studies have been found that examine the relationship between disclosure and shame. Several studies have found that CSA survivors who do not disclose exhibit greater nonverbal expressions of shame than survivors who did disclose their abuse (Bonanno et al., 2002; Bonanno, Noll, Putnam, O'Neill, & Trickett, 2003). Bonanno, et al, (2002) studied how the disclosure or nondisclosure of CSA would affect nonverbal expressions of shame. The researchers differentiated between Duchenne and non-Duchenne smiling to assess the level of shame experienced by the participants. (Genuine, or Duchenne, smiles are identified by activity in the muscles surrounding the eye and are associated with positive emotion, whereas non-Duchenne smiles are not associated with positive emotion [Bonanno et al., 2002, p. 97].) The researchers utilized a sample of 163, roughly half of whom had a history of CSA. They then assessed for self- and perpetrator blame, the incidence of purposeful disclosure, and facial expressions of emotions. Measures used included a scale of PTSD symptoms, the Caseworker Abuse History Questionnaire to assess abuse characteristics, the Comprehensive Trauma Interview to assess disturbing experiences, DSM criteria for PTSD, the nature and extent of traumatic experiences, the Youth Self Report to assess internalizing and externalizing symptoms, and additional questions to assess for disclosure. Finally, physiological sensors were attached to the participants to assess for Duchenne or non-Duchenne smiling.

Researchers found that nondisclosers exhibited a significantly greater ratio of expressions of shame and significantly greater magnitudes of shame. Limitations of the study include the inability to conclusively assess if the non-Duchenne smiles were a direct result of the shame they were feeling because of the abuse and not the shame of an

unwillingness to acquiesce to researchers' requests. Also, the subjective interpretation of participants' emotional expressions poses a significant limitation to the study. Researchers present these findings in a preliminary sense and encourage other researchers to expand on their assertions.

Although the aforementioned study provides a useful connection between disclosure of CSA and shame, the limited nature of analyzing only facial expressions leaves other, more generalizeable information to be desired. The lack of research on how disclosure affects shame compels other researchers to examine the question more fully.

Summary of the Review of Literature

Research on the potential benefits of disclosing CSA largely deals with how disclosure moderates diagnosable psychopathology. Though some studies deny the curative powers of disclosure, a significant amount of research indicates disclosure's role in positive outcomes. In addition to simple disclosure, other factors, including whether survivors' disclosures were believed and abuse characteristics, play into the moderating effects of disclosure on psychopathology. The abuse characteristic of severity of abuse was examined for the purposes of this study.

Shame is identified as a common reaction and symptom of the aftermath of CSA. The traumatic stigmatization associated with CSA results in a sense of powerlessness and self-blame for the negative sequelae of the trauma. Despite the fact that shame is well-accepted as a traumagenic dynamic, a lack of research examining disclosure's moderating effect on it exists. The most relevant study found in a thorough review of the literature

examined how disclosure moderated facial expressions of shame in CSA survivors. Both the lack of consensus regarding the healing potential of CSA disclosure and the lack of research on how that healing potential could expand into the category of shame provide an opportunity for useful, new research.

Significance of Study

Based on a review of the literature, there does not appear to be a consensus in the field regarding the effect of disclosure on shame. This lack of consensus is characterized both by questions of whether disclosure has a positive or negative effect and whether disclosure has a conclusive effect at all. Yet the common occurrence and known detriment of shame in survivors of sexual abuse prompts a strong desire to shed more light on this issue. The analysis of the concept of shame, both as a mediating variable for other symptomology and as a negative symptom in itself, carries with it the possibility of generating significant insight into the experience of adult survivors of sexual abuse. By shedding light on these important aspects of CSA survivors' experiences, clinicians will have increased ability to effectively treat survivors by helping them to improve their lives and to promote their needful healing and recovery from the trauma.

Statement of Purpose

The purpose of this study is to determine if disclosure of abuse is related to the amount of internalized shame experienced by victims. More specifically, the study will address if

disclosure has a moderating effect on the amount of shame experienced by the victim when severity of abuse is considered.

Hypotheses

Based on a review of the literature, the following hypotheses were tested:

H1: Severity of abuse will be a significant predictor of internalized shame (see Figure 1).

H2: Disclosure experience will also be a significant predictor of internalized shame (see Figure 2).

H3: Disclosure experience moderates the relationship between severity of abuse and internalized shame (see Figure 3).

Figure 1. Conceptual Model with Severity of Abuse Predicting Internalized Shame (Model 1).

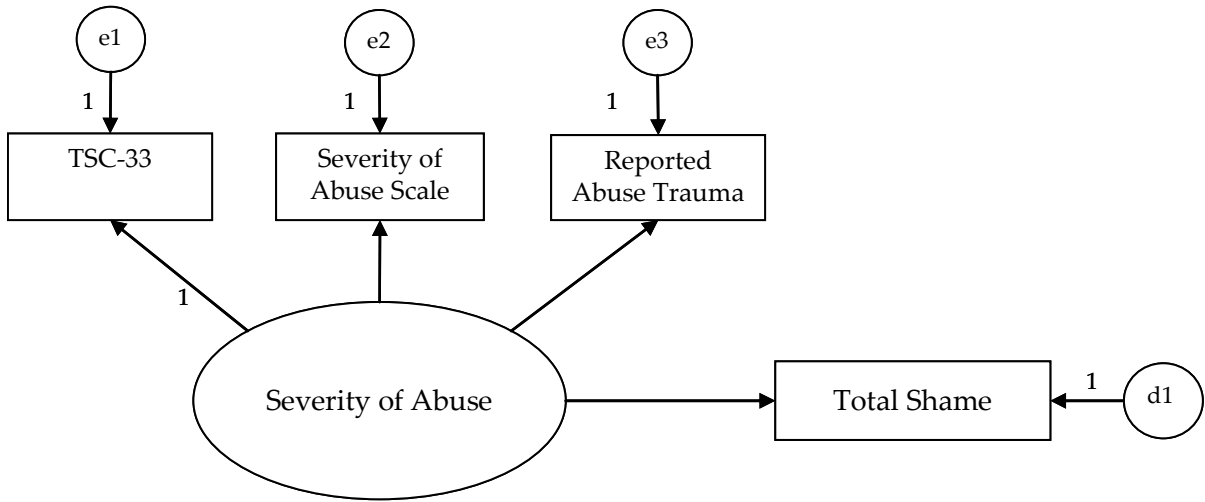


Figure 2. Conceptual Model with Experience of Disclosure Predicting Internalized Shame (Model 2).

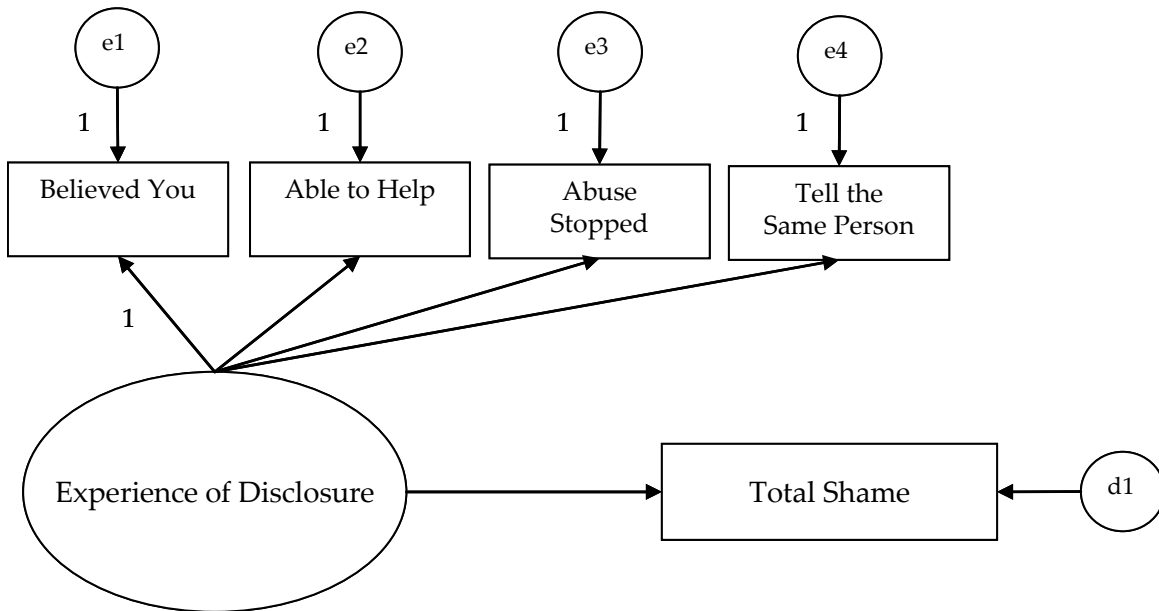
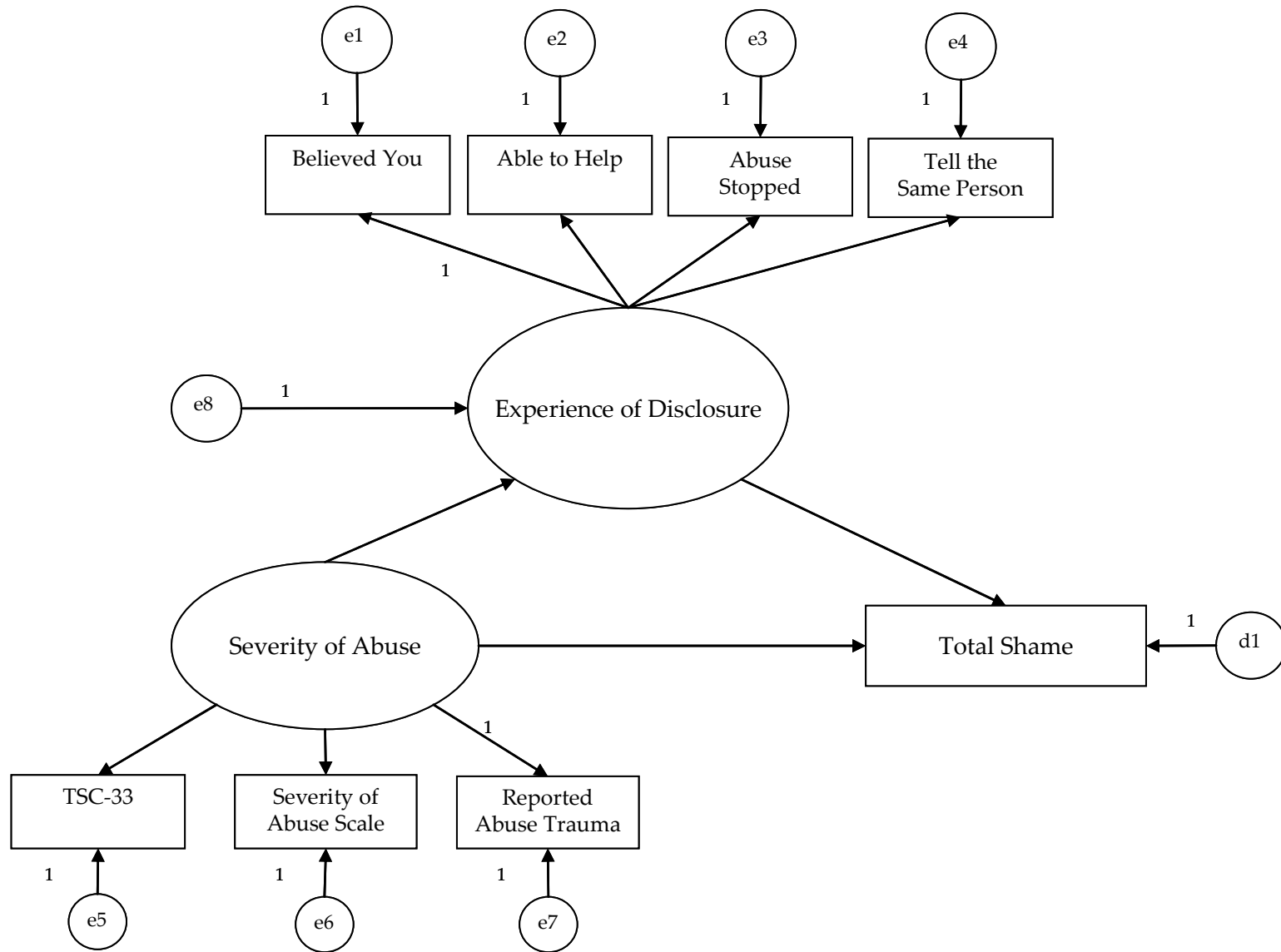


Figure 3. Conceptual Model with Severity of Abuse and Experience of Disclosure as Predictors of Internalized Shame (Model 3).



CHAPTER THREE

Methods

Procedures

The data gathered for this study is part of the Hardiness and Childhood Trauma Project headed by Professor Leslie L. Feinauer, Ph.D., of Brigham Young University. The involved researchers collected the data from randomly selected households in four communities: Chicago, Illinois; New York City, New York; Salt Lake City, Utah; and San Francisco, California. Data was also collected from the Utah State Penitentiary. Surveys were distributed randomly by generating lists from phone books, voter registries, and clearing house lists. Roughly 24,000 questionnaires were sent to women and men in the aforementioned cities over a three-year period. The first installment of 4,000 surveys was distributed in Salt Lake City in 1992, producing a response rate of 227 (a 5.7% response rate). The second installment, consisting of 10,000 questionnaires, was sent to San Francisco with a return rate of 355 (a 3.6% response rate). The third installment was distributed in 1994, dividing 10,000 surveys between Chicago and New York City. This final installment yielded a return of 334 (a 3.3% response rate). Nine hundred sixteen respondents out of the 24,000 distributed questionnaires produced a 3.8% response rate. After excluding uncompleted surveys, 878 questionnaires were utilized to create the data set.

Out of the 878 respondents whose information was used in the data set, 467 comprised women who had experienced CSA and had completed the information needed

for this study. The Los Angeles county catchment study found that 6.8% of respondents reported having experienced CSA (Finkelhor, 1984). Though the response rate in this study was lower than that of Finkelhor's study, the response rate is considered adequate for this kind of study and for this specific population (Finkelhor, 1984). The low response rate can likely be attributed to the sensitive nature of the subject matter; it is not uncommon for CSA survivors to decline participation due to embarrassment, shame, or the continuing difficulty of dealing with their histories. Further, the length and wording of the questionnaires could have affected the response rate as well (Finkelhor et al., 1986). Nevertheless, collecting a random sample allows researchers to access information about the general population. Potential drawbacks to this sampling method include the possibility of introducing a bias toward abused women who were willing to take the time to complete a lengthy questionnaire. Higher education levels may have played a role in determining who would fill out the questionnaire, which biases the sample; CSA survivors who function at a lower intellectual level may not have been assessed due to this flaw in the design (Bagley, 1991b).

Participants

Demographics

The average age in the sample of 467 women was 37.79 years, ranging from 15 to 85 years old with a standard deviation of 10.68. Of these women, 16.2% were married at the administration of the survey. The vast majority (86.5%) of participants was Caucasian, 2.8% reported being Hispanic, and approximately 7.3% of the sample consisted of blacks, American Indians, Asians, and those who specified themselves as other.

Over seventy percent of the women in the sample continued their education beyond high school, with 30.8% obtaining a college degree and 16.2% obtaining graduate degrees. Further, the highest level of education for 23.5% of the women was high school, and only 2.8% obtained less than a high school diploma.

A summary of the preceding information is presented in Table 1.

Table 1. Demographic Characteristics of the Sample (N=467)

Variable	Mean	S.D.	Range
Age	37.79	10.68	15–85
Percentages			
Gender			
Males		20.4	
Females		79.1	
Missing Data		0.4	
Marital Status			
Married		16.2	
Divorced/Separated		3.3	
Widowed		0.4	
Never Married		11.4	
Same Sex Relationship		0.9	
Missing Data		68.2	
Race			
Black		1.3	
Caucasian		86.5	
American Indian		1.1	
Hispanic		2.8	
Asian		3.4	
Other		1.5	
Missing Data		1.4	
Income			
< \$19,999		13.0	
\$20–29,999		11.8	
\$30–39,999		11.5	
> \$40,000		29.6	
Missing Data		3.4	

Education	
< High School	2.8
High School	23.5
Some College/Voc	24.4
College Graduate	30.8
Graduate Degree	16.2
Other	2.7
Missing Data	0.5

Subject Inclusion Criteria

In the current study, subject inclusion criteria consisted of adult females who completed the Trauma Symptom Checklist-33, the Internalized Shame Scale, the Severity of Abuse Scale, the traumatic experience of abuse question, and the disclosure of abuse questions. As such, men, females under 18, those who did not complete the required questionnaires, and women with no history of sexual abuse were excluded.

Instruments

Internalized Shame Scale (ISS)

The ISS measures the degree to which participants have internalized hurtful levels of shame (Cook, 1991). The assessment consists of 30 items that use a Likert scale ranging from one (never) to five (almost always); “never” scores a zero and “almost always” scores a four. The 30 items comprise 24 negatively worded questions which make up the shame scale and 6 positively worded questions which make up the self-esteem scale. The self-esteem scale is included to increase face validity and is not intended to be a valid measure of self-esteem (Cook, 1991); therefore, the self-esteem subset will not be included in this study. Possible

scores range from 0 to 96, with higher scores indicating more severe levels of shame. Scores above 50 indicate frequent experiences of internalized shame (Cook, 1991).

Alpha reliability for the total assessment is 0.96 (Cook, 1991). The nine-week test-retest reliability coefficient is 0.84 (Cook, 1991). The ISS is therefore considered a reliable measure for internalized shame. Moreover, it has been correlated with the Tennessee Self Concept Scale (-0.66 with a non-clinical population) (Cook, 1991). Various studies correlating the ISS with depression, eating disorders, anxiety, and anger produce strong correlations and indicate that the ISS is indeed a valid measure (Cook, 1991). See Appendix A.

Trauma Symptom Checklist 33 (TSC-33)

The TSC-33 consists of 33 items rated on a Likert scale ranging from one to three. The five subscales include anxiety, depression, dissociation, post-sexual abuse trauma, and sleep disturbances. Total scores represent the emotional adjustment of the CSA survivors. Scores range from 0 to 99, with a lower score indicating fewer symptoms and better adjustment.

Test-retest reliability for the TSC-33 has been found to be 0.79 for a one-month interval between test administrations (Briere & Runtz, 1989). The internal consistency of the five TSC-33 subscales indicates reliability, with an average subscale alpha of 0.71. Alpha for the assessment in its entirety was 0.89 (Briere & Runtz, 1989).

Validity of the TSC-33 was correlated with the Middlesex Hospital Questionnaire, the Center for Epidemiological Studies in Depression (CESD) Scale, and Coopersmith's self-esteem inventory (Bagley, 1991a). Bagley (1991a) found that correlations among the other measures and the TSC-33 indicated good concurrent validity. See Appendix B.

Severity of Abuse Scale (SAS)

Wilkin (1992) developed the SAS in order to assess the severity of sexual abuse, with sexual abuse being defined as unwanted bodily contact of a sexual nature prior to age 18 by a perpetrator who is either a family member or a non-family member. The scale includes 16 items with scores ranging from zero (lowest level of severity of abuse) to three (highest level of severity of abuse). The SAS thus indicates a range of abuse from no abuse to abuse that did not include touch, touching or fondling excluding oral sex, and intercourse and aggressive touch including oral sex. The severity of abuse score is generated from the number of statements marked in the affirmative.

The alpha coefficient of the SAS has been found to be 0.77, indicating that it is a reliable measure (Wilkin, 1992). Wilkin (Wilkin, 1992) also found concurrent validity with the post-sexual abuse trauma scale of the TSC-33 to yield a coefficient of 0.53, and a correlation with the complete TSC-33 scale was found to be 0.54. See Appendix C.

Traumatic Experience Self-Report

In addition to the TSC-33 and the SAS, participants' perceptions of the severity of their abuse was determined by a self-report question in which participants rated how traumatic the abuse experience was for them on a five-point Likert scale. The scale ranged from one indicating that the abuse was not at all traumatic to five indicating that the abuse was extremely traumatic. For the purposes of this study, a composite score of severity of abuse was created by combining the scores of the TSC-33, the SAS, and the self-report question.

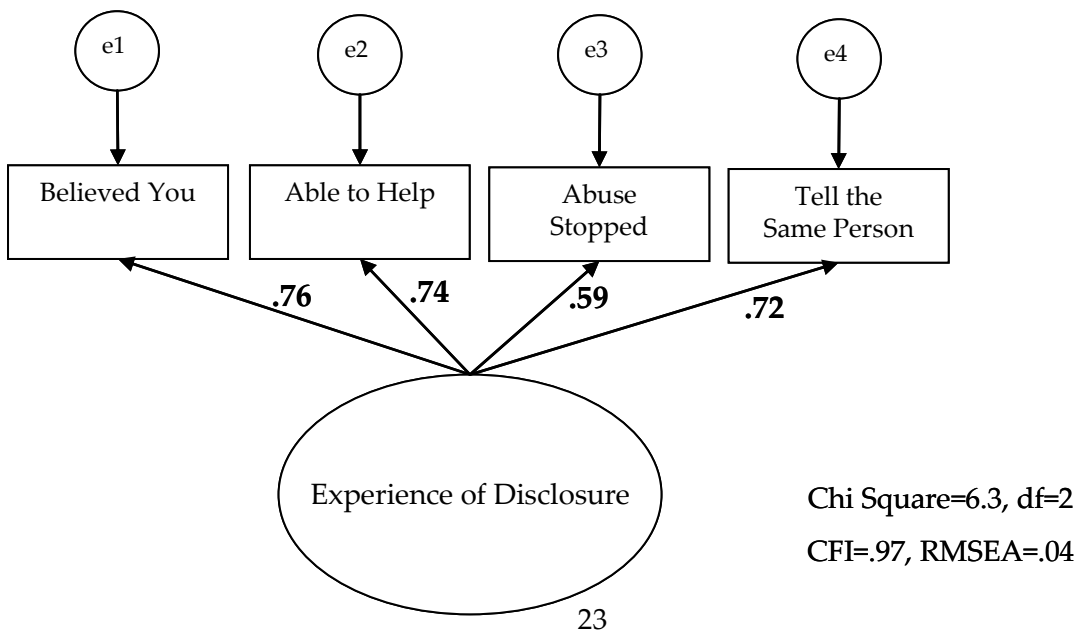
Disclosure Questionnaire

Questions from the larger questionnaire were used to determine disclosure experience. Once participants were identified as having disclosed in the first question, the subsequent questions became relevant. In order to create a measurement model for the experience of disclosure, a structural equation model of the latter five items was run:

Were you able to tell anyone about your sexual abuse while it was happening to you?	_____ Yes _____ No
Did they believe you?	_____ Yes _____ No
Were they able to help?	_____ Yes _____ No
Did the abuse stop?	_____ Yes _____ No
If you could do it over again, would you tell?	_____ Yes _____ No
If yes, would you tell the same person?	_____ Yes _____ No

A model utilizing all five of the latter questions did not produce a good fit. Nevertheless, once the fourth item was removed (If you could do it over again, would you tell?), the model proved to be a good fit (see Figure 4).

Figure 4. Measurement Model for Experience of Disclosure.



Design and Statistical Analysis

In order to estimate the association between severity of abuse, disclosure of CSA, and internalized shame, several statistical procedures were used. Multiple regression analysis was utilized to determine the relationship between the three variables, coding the categorical variables of disclosure as dummy variables. The regression analysis allows for illumination of the direction and strengths of the relationship and the significance of these findings while controlling for the effects of severity of abuse. Also, structural equation modeling using AMOS allowed for testing of both direct and indirect paths using multiple variables.

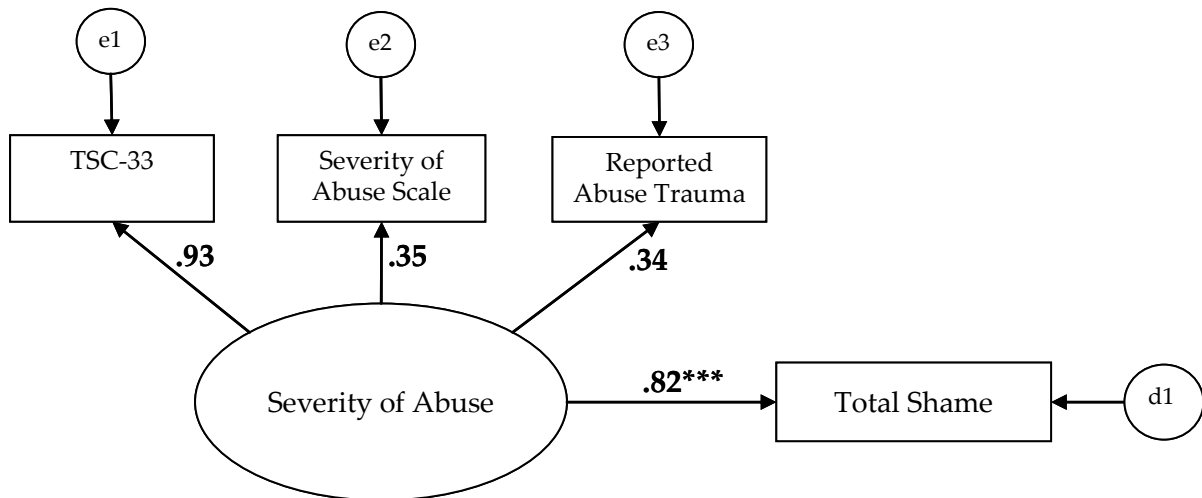
CHAPTER FOUR

Results

Severity of Abuse as a Predictor of Internalized Shame (Model 1)

As indicated in Figure 5, a significant standardized path coefficient of .82 between severity of abuse and shame was found. This standardized path coefficient indicates a positive correlation between severity of abuse and internalized shame. Chi square value for this path coefficient is 40.2 (df=2), comparative fit index (CFI) is .961, and root mean square error of approximation (RMSEA) is .05. All of these goodness of fit tests demonstrate that this model is a good fit for the data. In other words, severe abuse was associated with higher internalized shame.

Figure 5. Standardized Coefficients for Model 1.



Chi Square=40.2, df=2, p<.01

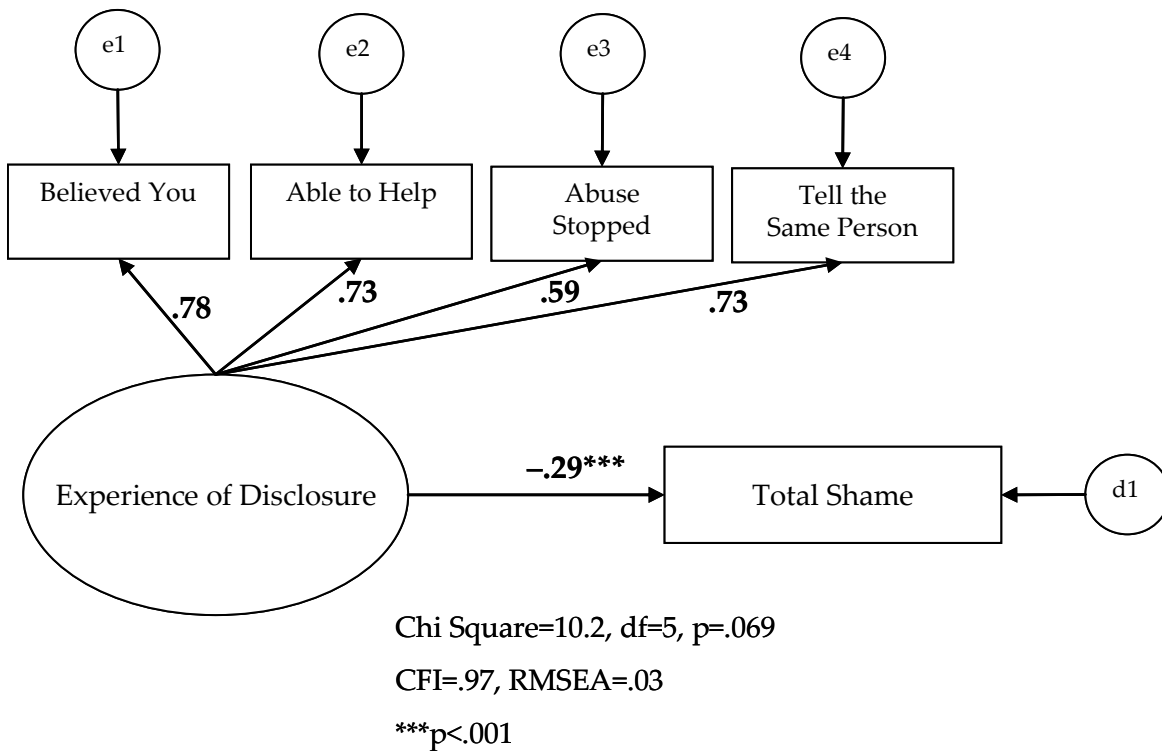
CFI=.961, RMSEA=.05

***p<.001

Experience of Disclosure as a Predictor of Internalized Shame (Model 2)

As shown in Figure 6, a significant standardized path coefficient of $-.29$ between experience of disclosure and internalized shame was found. This standardized path coefficient indicates a negative correlation between experience of disclosure and internalized shame. Chi square value for this path coefficient is 10.2 ($df=5$), CFI is $.97$, and RMSEA is $.03$. All of these goodness of fit tests demonstrate that this model is a good fit for the data. Stated differently, it appears that shame was lower in women who disclosed their abuse.

Figure 6. Standardized Coefficients for Model 2.

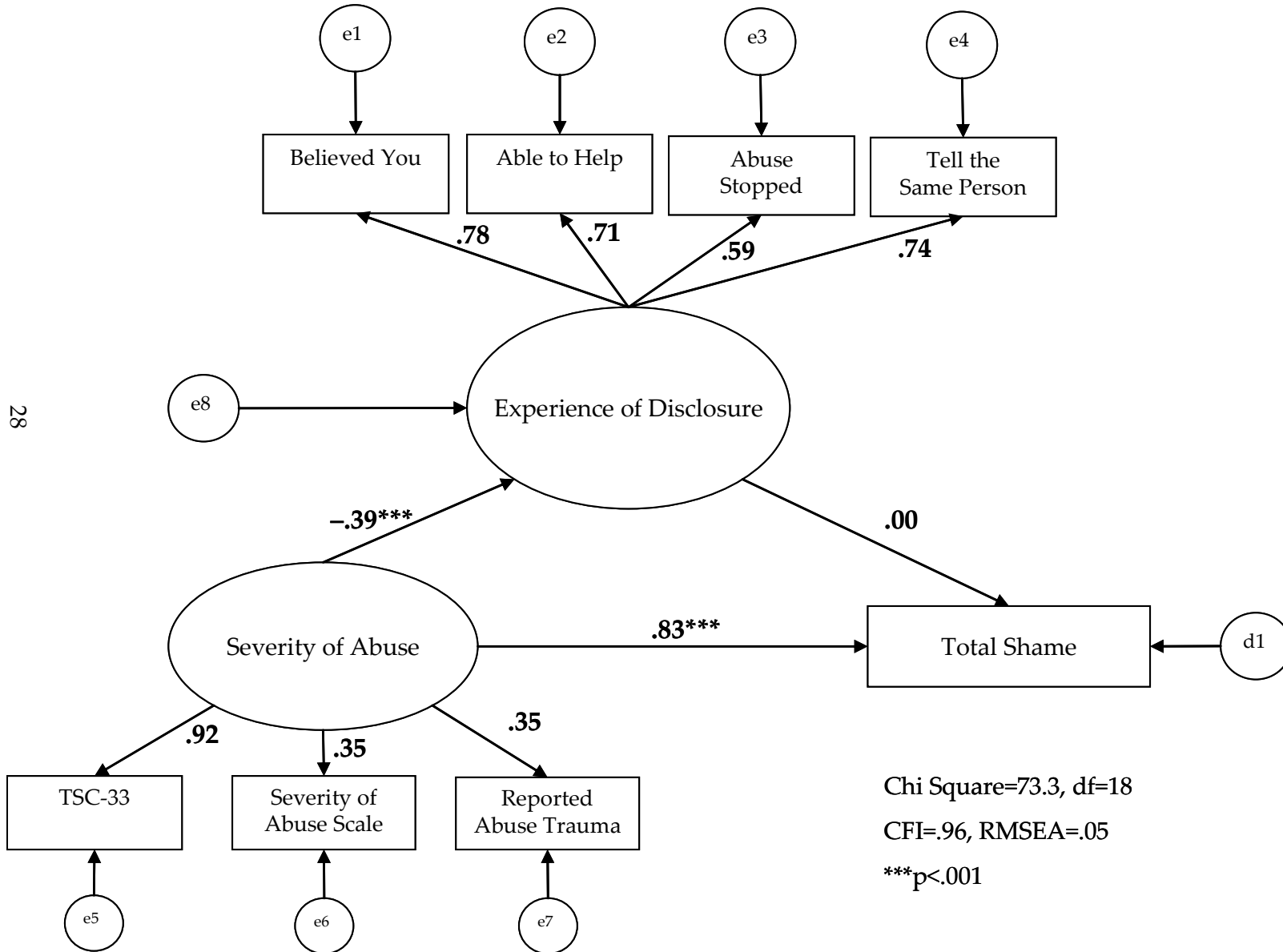


Severity of Abuse and Experience of Disclosure as Predictors of Internalized Shame (Model 3)

Upon running structural equation modeling for Model 3, it was found that a significant standardized path coefficient of $.83$ remained between severity of abuse and total shame.

Further, a significant standardized path coefficient of $-.39$ between severity of abuse and experience of disclosure was found, indicating a negative correlation. However, when controlling for severity of abuse, there appeared to be no significant correlation between experience of disclosure and internalized shame. The standardized path coefficient of $.00$ between experience of disclosure and internalized shame suggests that experience of disclosure is not associated with a moderating effect on internalized shame. Chi square value for this model is 73.3 ($df=18$), CFI is $.96$, and RMSEA is $.05$. All of these goodness of fit tests demonstrate that this model is a good fit for the data.

Figure 7. Standardized Coefficients for Model 3.



CHAPTER FIVE

Discussion

The purpose of this study was to examine the possibility of disclosure of abuse having a moderating effect on the internalized shame that follows childhood sexual abuse. The results found through structural equation modeling with AMOS indicated that severity of abuse is associated with a significant increase in internalized shame. This finding is consistent with the first hypothesis. Results also showed that disclosure of abuse is associated with a significant decrease in internalized shame, which supported the second hypothesis; however, this finding was not upheld when controlling for severity of abuse. Indeed, when factoring in severity of abuse, disclosure of abuse was shown to have no moderating effect on internalized shame, which did not support the third hypothesis. Finally, the findings of this study also indicate that severity of abuse is associated with a significant decrease in experience of disclosure; as severity of abuse increases, the experience of disclosure score decreases.

Findings Consistent with Previous Research

Severity of abuse was demonstrated to have a significant, positive association with internalized shame in adult survivors of child sexual abuse. This finding is consistent with previous research. Feiring and Taska (2005), Feiring, et al (2002), and Wilkin (1992) all found that shame was associated with severity of abuse. Further, Deblinger and Runyon

(2005), as well as Finkelhor and Browne (1986) have conceptualized the dynamics of severe abuse that lead to shame.

In examining the interaction between disclosure and shame in the sequelae of child sexual abuse, a thorough review of the literature did not provide a consensus on the role of disclosure on internalized shame. Previous research has shown that disclosure of abuse moderates shame in survivors (e.g., Bonanno et al., 2002), which the present study does not corroborate. Yet, the methodology of this previous research differed greatly from the present study. As mentioned in the review of literature, Bonanno's study utilized direct observation of facial expressions. Although the Internalized Shame Scale has shown good reliability, the fact that it requires self-report could result in a less accurate measure of shame than direct observation would.

Disclosure as a Moderating Variable

Despite the finding that disclosure is not associated with a moderating effect on shame when factoring in severity of abuse, it is interesting to note the finding that severity of abuse is significantly associated with a decrease in the disclosure experience score (see Figure 7). Perhaps disclosure is not a moderating effect of shame when considering severity of abuse because an increase in severity of abuse is associated with a more negative disclosure experience. It stands to reason that a negative disclosure experience (i.e., an experience in which the survivor was not believed, the abuse did not stop, or the survivor regrets telling the person they did) would not moderate the amount of shame the survivor would feel.

Moreover, the analysis showed that disclosure is negatively associated with internalized shame (see Figure 6). A better disclosure experience for the survivor (i.e., an experience in which the survivor was believed, the abuse did stop, and the survivor would tell the same person again) is associated with a lower internalized shame score. When a person's disclosure experience was positive and led to a cessation of abuse, it seems fairly intuitive that she would feel less shame. Being believed, initiating the catalyst that led to the abuse stopping, and having others offering help to the survivor all communicate positive messages of self-efficacy, support, and worth. These powerful messages can arguably serve to counteract the messages of "chronic and persistent negative evaluation of self" (Feinauer et al., 2003, p. 66) that may have developed during the course of the abuse.

The fact that the negative association between disclosure and internalized shame does not remain when controlling for severity of abuse seems to indicate the importance of severity in post-abuse dynamics. Perhaps the potential benefits of disclosure simply do not outweigh the detrimental effects of severe abuse. Further, previous research has shown that the likelihood of disclosure is negatively associated with severity of abuse (e.g., Arata, 1998; Paine & Hansen, 2002; Sauzier, 1989), and these studies further assert that the shame survivors feel following severe abuse may in fact decrease the likelihood of disclosure in the first place. Severely abused individuals may therefore never have the opportunity to experience the potential beneficial effects of disclosure. Finally, it can perhaps be assumed from the data that the isolated act of telling is not enough; follow-up and some duration of support are required. Future research might therefore seek out how being believed and

having social support moderate shame in adult survivors of sexual abuse. Further, the person to whom the survivor actually discloses may also play a part in moderating shame.

Implications for Clinical Practice

Based on the results of this analysis, it appears that disclosure of childhood sexual abuse (CSA) does not have a significant effect on internalized shame when controlling for severity of abuse, neither a positive effect nor a negative one. For clinicians working with survivors of CSA, this may be useful to consider when discussing the dynamics of a client's abuse experience. Depending on the client's perceived severity of the abuse, the opportunity for timely disclosure and the current shame that she feels may be clinically significant; in other words, the client may wonder if her situation would be better if she had told, or she may feel ashamed that she did not tell anyone until years after the fact. It may be helpful for the client to know that disclosure itself does not seem to have a significant relationship with the shame she feels now; having told or not told does not have to be another source of shame.

Also, clinicians may find it helpful to understand that a survivor's internalized shame is perhaps more clinically significant than her disclosure experience. Rather than focusing therapy on the disclosure experience and telling the whole story of abuse, it may in fact be more valuable to focus on her current level of shame and the way it affects herself and her life. In her classic book on trauma, Judith Herman asserts that "the survivor needs the assistance of others in her struggles to overcome her shame and to arrive at a fair assessment of her conduct...Realistic judgements diminish the feelings of humiliation and guilt...and they include the recognition of psychological harm and the acceptance of a

prolonged recovery process,” (Herman, 1992, p. 66). This type of validation, respect, and expectation empowers the survivor to see herself in a new way that her previous perceptions of shame would not allow, paving the way for recovery.

Strengths and Limitations

The data used in this study included a large sample size of 467 participants; this sample size is larger in comparison to other studies of this nature. The participants also came from a nonclinical population with a wide range of ages, educational levels, and backgrounds. Further, the sample was taken from various geographical locations. These factors all contribute to a greater generalizeability and make this study a notable contribution to the literature.

Limitations of the study include the nature of the questionnaire; its length and the sensitive subject matter may have contributed to its adequate but low response rate. Further, participants who chose to complete the questionnaire may have been biased in terms of psychological functioning, interest in furthering research on sexual abuse, and ability to fill the time commitment.

Another limitation is the retrospective, self-reported data. Participants answered questions that may have required recalling information from decades earlier. This leaves the integrity of the data at the mercy of participants’ fallible memories and how they have chosen to conceptualize their abuse through the years. The fact that this study utilized an existing dataset prevented more specific, detailed questions that may have more aptly fit the

purposes of the study. Also, the data is now over ten years old and may no longer be current.

Finally, the rich, complex nature of abuse, shame, and disclosure is not fully expressed in the quantitative questionnaire. The limitations of such a questionnaire do not give justice to the intricacies of a survivor's personal abuse and disclosure experiences. A more in-depth, qualitative study may help shed more light on this subject in the future. Additionally, further quantitative analysis of the interaction between severity of abuse and disclosure would provide more complete information on the experience of disclosure as it relates to internalized shame.

Conclusion

The present study offers new insights on the interactions between severity of abuse, disclosure, and internalized shame. Specifically, the results of the analysis show that severity of abuse is associated with an increase in internalized shame, that disclosure of childhood sexual abuse (CSA) is associated with a decrease in internalized shame, and that this second association does not hold true when controlling for severity of abuse.

Overall, the results lend some support to the idea that disclosure of sexual abuse can be helpful in decreasing internalized shame. However, the influence of severity of abuse appears to be significant enough to warrant greater examination of this idea. As the prevalence and effects of CSA become more fully understood and disseminated, clinicians and laypeople alike will have the opportunity to offer support and information to survivors to aid in their recovery. As they do so, it will be important to consider the potential

significance of disclosure and the probable presence of internalized shame in the survivor. The importance of a positive disclosure experience for survivors suggests a need for those in her support system (be they mental health professionals, child protection services, or family and friends) to know how to provide that positive experience through respect, understanding, and an effort to help her regain control of her life. As the survivor's story gains supportive witnesses, and as those witnesses help her reexamine her negative evaluation of herself, she will proceed down the path toward recovery.

REFERENCES

- Alaggia, R. (2004). Many ways of telling: Expanding conceptualizations of child sexual abuse disclosure. *Child Abuse & Neglect, 28*(11), 1213–1227.
- Arata, C. M. (1998). To tell or not to tell: Current functioning of child sexual abuse survivors who disclosed their victimization. *Child maltreatment, 3*(1), 63–71.
- Bagley, C. (1991a). The long-term psychological effects of child sexual abuse: A review of some British and Canadian studies of victims and their families. *Annals of Sex Research, 4*(1), 23–48.
- Bagley, C. (1991b). The prevalence and mental health sequels of child sexual abuse in a community sample of women aged 18 to 27. *Canadian Journal of Community Mental Health, 10*(1), 103–116.
- Batten, S. V., Follette, V. M., Hall, M. L. R., & Palm, K. M. (2002). Physical and psychological effects of written disclosure among sexual abuse survivors. *Behavior Therapy, 33*(1), 107.
- Berliner, L., & Conte, J. R. (1995). The effects of disclosure and intervention on sexually abused children. *Child Abuse & Neglect, 19*(3), 371–384.
- Berliner, L., & Conte, J. R. (1990). The process of victimization: The victims' perspective. *Child Abuse & Neglect, 14*(1), 29–40.

- Bleiberg, K. L. (2000). The disclosure of childhood sexual abuse and post-traumatic stress disorder and related symptoms of cognitive and affective impairment. *Dissertation Abstracts International*, 61(2), 1072. (UMI No. AAI9962595)
- Bonanno, G. A., Keltner, D., Noll, J. G., Putnam, F. W., Trickett, P. K., & LeJeune, J. et al. (2002). When the face reveals what words do not: Facial expressions of emotion, smiling, and the willingness to disclose childhood sexual abuse. *Journal of Personality and Social Psychology*, 83(1), 94–110.
- Bonanno, G. A., Noll, J. G., Putnam, F. W., O'Neill, M., & Trickett, P. K. (2003). Predicting the willingness to disclose childhood sexual abuse from measures of repressive coping and dissociative tendencies. *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children*, 8(4), 302–318.
- Bootzin, R. R. (1997). Examining the theory and clinical utility of writing about emotional experiences. *Psychological Science*, 8(3), 167–169.
- Bourdeau, P. A. (1994). Child Sexual Abuse and the Mother-Daughter Relationship: Moderating Effects. *Dissertation Abstracts International*, 54(11), 5936.
- Bradley, R. G., & Follingstad, D. R. (2001). Utilizing disclosure in the treatment of the sequelae of childhood sexual abuse: A theoretical and empirical review. *Clinical Psychology Review*, 21(1), 1–32.

- Briere, J., & Runtz, M. (1989). The trauma symptom checklist (TSC-33): Early data on a new scale. *Journal of Interpersonal Violence, 4*(2), 151–163.
- Briere, J., & Zaidi, L. Y. (1989). Sexual abuse histories and sequelae in female psychiatric emergency room patients. *American Journal of Psychiatry, 146*(12), 1602–1606.
- Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological Bulletin, 99*(1), 66–77.
- Cook, D. R. (1991). *Manual for the internalized shame scale*. Menomonie, Wisconsin: University of Wisconsin-Stout.
- Crisma, M., Bascelli, E., Paci, D., & Romito, P. (2004). Adolescents who experienced sexual abuse: Fears, needs and impediments to disclosure. *Child Abuse & Neglect, 28*(10), 1035–1048.
- Deblinger, E., & Runyon, M. K. (2005). Understanding and treating feelings of shame in children who have experienced maltreatment. *Child Maltreatment, 10*(4), 364–376.
- Elliott, D. M., & Briere, J. (1994). Forensic sexual abuse evaluations of older children: disclosures and symptomatology. *Behavioral Sciences & the Law, 12*(3), 261–277.
- Farrell, L. T. (1988). Factors that affect a victim's self-disclosure in father-daughter incest. *Child Welfare Journal, 67*(5), 462–468.

- Feinauer, L. L. (1989). Comparison of long-term effects of child abuse by type of abuse and by relationship of the offender to the victim. *American Journal of Family Therapy, 17*(1), 48–56.
- Feinauer, L., Hilton, H. G., & Callahan, E. H. (2003). Hardiness as a moderator of shame associated with childhood sexual abuse. *American Journal of Family Therapy, 31*(2), 65–78.
- Feiring, C., & Taska, L. S. (2005). The persistence of shame following sexual abuse: A longitudinal look at risk and recovery. *Child Maltreatment, 10*(4), 337–349.
- Feiring, C., Taska, L., & Chen, K. (2002). Trying to understand why horrible things happen: Attribution, shame, and symptom development following sexual abuse. *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children, 7*(1), 26–41.
- Finkelhor, D. (1984). *Child sexual abuse : New theory and research*. New York: The Free Press.
- Finkelhor, D. (1979). *Sexually victimized children* (2nd ed.). New York: The Free Press.
- Finkelhor, D., Araji, S., Baron, L., Browne, A., Peters, S. D., & Wyatt, G. E. (1986). *A sourcebook on child sexual abuse*. Newbury Park, CA: Sage Publications, Inc.

- Finkelhor, D., & Browne, A. (1986). Initial and long-term effects: A conceptual framework. In D. Finkelhor (Ed.), *A sourcebook on child sexual abuse* (1st ed., pp. 180–198). Newbury Park, CA: Sage Publications, Inc.
- Finkelhor, D., Hotaling, G., Lewis, I. A., & Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors. *Child Abuse & Neglect, 14*(1), 19–28.
- Finkelhor, D., Ormrod, R., Turner, H., & Hamby, S. L. (2005). The victimization of children and youth: A comprehensive, national survey. *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children, 10*(1), 5–25.
- Ghetti, S., Weede Alexander, K., & Goodman, G. S. (2002). Legal involvement in child sexual abuse cases: Consequences and interventions. *International Journal of Law and Psychiatry, 25*(3), 235–251.
- Gries, L. T., Goh, D. S., Andrews, M. B., Gilbert, J., Praver, F., & Stelzer, D. N. (2000). Positive reaction to disclosure and recovery from child sexual abuse. *Journal of Child Sexual Abuse, 9*(1), 29–51.
- Hemenover, S. H. (2003). The good, the bad and the healthy: Impacts of emotional disclosure of trauma on resilient self-concept and psychological distress. *Personality and Social Psychology Bulletin, 29*(10), 1236.

- Herman, J. L. (1997). *Trauma and recovery: The aftermath of violence—from domestic abuse to political terror*. New York: Basic Books.
- Herman, J. L. (1981). *Father-daughter incest* (2nd ed.). Cambridge, MA: Harvard University Press.
- Hyman, S. M., Gold, S. N., & Cott, M. A. (2003). Forms of social support that moderate PTSD in childhood sexual abuse survivors. *Journal of Family Violence, 18*(5), 295–300.
- Jones, L. M., & Finkelhor, D. (2003). Putting together evidence on declining trends in sexual abuse: A complex puzzle. *Child Abuse & Neglect, 27*(2), 133–135.
- Kilpatrick, D. G., Saunders, B. E., Amick-McMullan, A., & Best, C. L. (1989). Victim and crime factors associated with the development of crime-related post-traumatic stress disorder. *Behavior Therapy, 20*(2), 199–214.
- Koss, M. P., & Oros, C. J. (1982). Sexual experiences survey: A research instrument investigating sexual aggression and victimization. *Journal of Consulting and Clinical Psychology, 50*(3), 455–457.
- Lamb, S., & Edgar-Smith, S. (1994). Aspects of disclosure: Mediators of outcome of childhood sexual abuse. *Journal of Interpersonal Violence, 9*(3), 307–326.
- Paine, M. L., & Hansen, D. J. (2002). Factors influencing children to self-disclose sexual abuse. *Clinical Psychology Review, 22*(2), 271–295.

- Paine, M. L. (2000). Children's self-disclosure of sexual abuse: Effects of victim, perpetrator, and abuse characteristics. *Dissertation Abstracts International*, 61 (4), 2215. (UMI No. AAI9967400)
- Pennebaker, J. W., & Francis, M. E. (1996). Cognitive, emotional, and language processes in disclosure. *Cognition & Emotion*, 10(6), 601–626.
- Rosenthal, M. Z., Hall, M. L. R., Palm, K. M., Batten, S. V., & Follette, V. M. (2005). Chronic avoidance helps explain the relationship between severity of childhood sexual abuse and psychological distress in adulthood. *Journal of Child Sexual Abuse*, 14(4), 25–41.
- Roth, S., & Newman, E. (1991). The process of coping with sexual trauma. *Journal of Traumatic Stress*, 4(2), 279–297.
- Ruggiero, K. J., Smith, D. W., Hanson, R. F., Resnick, H. S., Saunders, B. E., & Kilpatrick, D. G. et al. (2004). Is disclosure of childhood rape associated with mental health outcome? Results from the National Women's Study. *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children*, 9(1), 62–77.
- Sauzier, M. (1989). Disclosure of child sexual abuse: For better or for worse. *Psychiatric Clinics of North America*, 12(2), 455–469.
- Sinclair, B. B., & Gold, S. R. (1997). The psychological impact of withholding disclosure of child sexual abuse. *Violence and Victims*, 12(2), 137–145.

- Soderquist, J. N. (1993). *Childhood abuse, family of origin, and shame in women*. Unpublished doctoral dissertation, Brigham Young University, Provo, UT.
- Stuewig, J., & McCloskey, L. A. (2005). The relation of child maltreatment to shame and guilt among adolescents: Psychological routes to depression and delinquency. *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children*, 10(4), 324–336.
- Testa, M., Miller, B. A., Downs, W. R., & Panek, D. (1992). The moderating impact of social support following childhood sexual abuse. *Violence and Victims*, 7(2), 173–186.
- Ullman, S. E., & Filipas, H. H. (2005). Ethnicity and child sexual abuse experiences of female college students. *Journal of Child Sexual Abuse*, 14(3), 67–89.
- Whiffen, V. E., & MacIntosh, H. B. (2005). Mediators of the link between childhood sexual abuse and emotional distress: A critical review. *Trauma, Violence, & Abuse*, 6(1), 24–39.
- Wilkin, C. M. (1992). *Internalized shame as a long-term effect of childhood sexual abuse in women*. Unpublished master's thesis, Brigham Young University, Provo, UT.
- Zlotnick, C., Zakriski, A. L., Shea, M. T., & Costello, E. (1996). The long-term sequelae of sexual abuse: Support for a complex posttraumatic stress disorder. *Journal of Traumatic Stress*, 9(2), 195–205.

APPENDICES

Appendix A

Internalized Shame Scale

DIRECTIONS: Read each statement carefully and circle the number to the left of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below. DO NOT OMIT ANY ITEM.

- | 1=NEVER | 2=SELDOM | 3=SOMETIMES | 4=FREQUENTLY | 5=ALMOST ALWAYS | |
|----------------|-----------------|--------------------|---------------------|------------------------|--|
| 1 2 3 4 5 | | | | | 1. I feel like I am never quite good enough. |
| 1 2 3 4 5 | | | | | 2. I feel somehow left out. |
| 1 2 3 4 5 | | | | | 3. I think that people look down on me. |
| 1 2 3 4 5 | | | | | 4. All in all, I am inclined to feel that I am a success. |
| 1 2 3 4 5 | | | | | 5. I scold myself and put myself down. |
| 1 2 3 4 5 | | | | | 6. I feel insecure about others' opinions of me. |
| 1 2 3 4 5 | | | | | 7. Compared to other people, I feel like I somehow never measure up. |
| 1 2 3 4 5 | | | | | 8. I see myself as being very small and insignificant. |
| 1 2 3 4 5 | | | | | 9. I feel as if I am somehow defective as a person, like there is something basically wrong with me. |
| 1 2 3 4 5 | | | | | 10. I feel intensely inadequate and full of self-doubt. |
| 1 2 3 4 5 | | | | | 11. I feel I have much to be proud of. |
| 1 2 3 4 5 | | | | | 12. When I compare myself to others, I am just not as important. |
| 1 2 3 4 5 | | | | | 13. I have an overpowering dread that my faults will be revealed in front of others. |
| 1 2 3 4 5 | | | | | 14. I feel I have a number of good qualities. |

- 1 2 3 4 5 15. I see myself striving for perfection only to continually fall short.
- 1 2 3 4 5 16. I think others are able to see my defects.
- 1 2 3 4 5 17. I could beat myself over the head with a club when I make a mistake.
- 1 2 3 4 5 18. On the whole, I am satisfied with myself.
- 1 2 3 4 5 19. I would like to shrink away when I make a mistake.
- 1 2 3 4 5 20. I replay painful events over and over in my mind until I am overwhelmed.
- 1 2 3 4 5 21. I feel I am a person of worth at least on an equal plane with others.
- 1 2 3 4 5 22. At times I feel like I will break into a thousand pieces.
- 1 2 3 4 5 23. I feel as if I have lost control over my body functions and my feelings.
- 1 2 3 4 5 24. Sometimes I feel no bigger than a pea.
- 1 2 3 4 5 25. At times I feel so exposed that I wish the earth would open up and swallow me.
- 1 2 3 4 5 26. I have this painful gap within me that I have not been able to fill.
- 1 2 3 4 5 27. I feel empty and unfulfilled.
- 1 2 3 4 5 28. I take a positive attitude toward myself.
- 1 2 3 4 5 29. My loneliness is more like emptiness.
- 1 2 3 4 5 30. I feel like there is something missing.

Appendix B

Trauma Symptom Checklist 33

Directions: How often have you experienced each of these reactions in the LAST TWO MONTHS? Please circle the number that best fits your answer. Put an answer for each item. These experiences are similar to those some women have identified as occurring to them. It is important for us to know how frequently they occur for most women who were sexually abused.

	1=NEVER	2=OCCASIONALLY	3=FAIRLY OFTEN	4=VERY OFTEN
1. Insomnia (trouble getting to sleep)	1	2	3	4
2. Restless sleep	1	2	3	4
3. Nightmares	1	2	3	4
4. Waking up early in the morning and can't get back to sleep	1	2	3	4
5. Weight loss (without dieting)	1	2	3	4
6. Feeling isolated from others	1	2	3	4
7. Loneliness	1	2	3	4
8. Low sex drive	1	2	3	4
9. Sadness	1	2	3	4
10. "Flashbacks" (sudden, vivid, distracting memories)	1	2	3	4
11. "Spacing out" (going away in your mind)	1	2	3	4
12. Headaches	1	2	3	4
13. Stomach problems	1	2	3	4
14. Uncontrollable crying	1	2	3	4
15. Anxiety attacks	1	2	3	4
16. Trouble controlling your temper	1	2	3	4
17. Trouble getting along with others	1	2	3	4
18. Dizziness	1	2	3	4
19. Passing out	1	2	3	4
20. Desire to hurt yourself physically	1	2	3	4

21. Desire to hurt others physically	1	2	3	4
22. Sexual problems	1	2	3	4
23. Sexual overactivity	1	2	3	4
24. Fear of men	1	2	3	4
25. Fear of women	1	2	3	4
26. Unnecessary or very frequent washing	1	2	3	4
27. Feelings of inferiority	1	2	3	4
28. Feelings of guilt	1	2	3	4
29. Feelings that things are "unreal"	1	2	3	4
30. Memory problems	1	2	3	4
31. Feeling of not always being in your body	1	2	3	4
32. Feeling tense all the time	1	2	3	4
33. Trouble breathing	1	2	3	4

Appendix C

Severity of Abuse Scale

SEXUAL ABUSE EXPERIENCES—The following section deals with questions related to childhood sexual abuse. These questions may bring back some unpleasant memories; however, they will help us to know more about how you survived your specific situation. Individuals have times when they are/were approached with or forced to have unwanted and/or uninvited sexual experiences.

Below is a list of explicit experiences people have described as these kinds of events. Please mark (X) any of the following types of abuse you have experienced. When identifying the person either write in their relationship to you or use one of the letters below:

- | | | | |
|----------------|----------------|-------------------|------------------|
| A. Grandmother | E. Uncle | I. Stepbrother(s) | M. Stranger |
| B. Father | F. Aunt | J. Stepfather | N. Family friend |
| C. Brother(s) | G. Mother | K. Stepmother | O. Neighbor |
| D. Sister(s) | H. Grandfather | L. Boyfriend | P. Other _____ |

WITHOUT MY WANTING IT TO OCCUR, SOMEONE

- ___a. made sexual comments to me. At what AGE___ By WHOM_____
- ___b. exposed his/her genitals (sex organs). At what AGE___ By WHOM_____
- ___c. forced me to view pornography (dirty pictures).
At what AGE___ By WHOM_____
- ___d. forced me to show my genitals (sex organs).
At what AGE___ By WHOM_____
- ___e. fondled me (touched me) through my clothes.
At what AGE___ By WHOM_____
- ___f. touched my sex organs directly (no clothes).
At what AGE___ By WHOM_____
- ___g. forced me to masturbate him/her (touch, run, feel his/her sex organs) with my fingers or hand. At what AGE___ By WHOM_____
- ___h. simulated (acted out but did not do) intercourse with me.
At what AGE___ By WHOM_____
- ___i. put his/her finger into my vagina or rectum.
At what AGE___ By WHOM_____

- ___j. forced oral sex on me (touched my genitals with his/her mouth or tongue).
At what AGE___ By WHOM_____
- ___k. forced me to have oral sex with him/her (put his penis in my mouth).
At what AGE___ By WHOM_____
- ___l. forced me to have intercourse with him.
At what AGE___ By WHOM_____
- ___m. forced me to have anal intercourse with him.
At what AGE___ By WHOM_____
- ___n. did bizarre/strange things to me (rituals, black magic, took pictures of me doing sexual things). At what AGE___ By WHOM_____
- ___o. threatened me with a knife or gun to make me participate.
At what AGE___ By WHOM_____
- ___p. physically abused me.
At what AGE___ By WHOM_____
- ___q. I do not know or remember what I was forced to do, but I know I was abused.
At what AGE___ By WHOM_____

NOTE: Items n–q were not utilized in this study.