2006-05-23

Internalized Shame as a Moderating Variable for Inhibited Sexual Difficulties in Adult Women Resulting From Childhood Sexual Abuse

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INTERNALIZED SHAME AS A MODERATING VARIABLE FOR INHIBITED SEXUAL DIFFICULTIES IN ADULT WOMEN RESULTING FROM CHILDHOOD SEXUAL ABUSE

by

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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 2006

BRIGHAM YOUNG UNIVERSITY

GRADUATE COMMITTEE APPROVAL

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

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As chair of the candidate's graduate committee, I have read the thesis of Kristine Robinson in its final form and have found that (1) its format, citations, and bibliographical style are consistent and acceptable and fulfill the 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.

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ABSTRACT

INTERNALIZED SHAME AS A MODERATING VARIABLE FOR INHIBITED SEXUAL DIFFICULTIES IN ADULT WOMEN RESULTING FROM CHILDHOOD SEXUAL ABUSE

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Master of Science

An adult female sample of childhood sexual abuse survivors (N=467) were surveyed to determine whether internalized shame moderated the effects of sexual inhibited difficulties. Other variables such as severity, duration, and frequency of sexual abuse, as well as whether physical abuse was also part of their experience, were examined to determine their role in later sexual inhibition. It was predicted that there would be a significant positive relationship between 1) Scores on variables of physical abuse, severity of abuse, frequency of abuse, duration of abuse, identity of the perpetrator and scores on the variable of inhibited sexual difficulties; 2) Scores of internalized shame and scores of inhibited sexual difficulties and 3) Scores on variable of physical abuse,

severity of abuse, frequency of abuse, duration of abuse, identity of the perpetrator and scores on the variables of internalized shame.

Through Structural Equation Modeling using AMOS, the results indicated a statistically significant positive relationship between severity, frequency and inhibited sexual disturbances but found no direct relationship between physical abuse, the identity of the perpetrator, the duration of the abuse and inhibited sexual disturbances. Results also indicated that shame had a direct positive relationship to inhibited sexual disturbances. The third finding was that physical abuse and severity of abuse had a significant positive relationship with shame which implies that shame is a moderating variable for inhibited sexual disturbances in adult women survivors of childhood sexual abuse.

Internalized shame may be an important factor for therapists to consider in helping survivors overcome sexual inhibition as a result of childhood sexual abuse. If a woman develops a shame-prone identity she may be at risk for experiencing inhibition in her sexuality.

ACKNOWLEDGMENTS

There are many people that I wish to thank for their support and encouragement as I worked on this project. Thinking about my thesis made me physically ill at times and the knowledge that other people believed that I was capable of finishing this project helped me believe in myself.

First I would like to thank and dedicate this thesis to Paul Pratt, my future husband. Thank you for not asking about my thesis unless I brought up the topic and for being interested in what I said when I did want to talk about it. I appreciated so much your excitement and enthusiasm over this thesis and the work that I accomplished. I will never doubt how proud you are of me and the work I have done. Thank you for emotionally supporting me and being there to listen to me express my worries and concerns and to also listen to my successes and triumphs.

Leslie Feinauer, thank you for meeting with me countless times to guide, direct, and calm me down. Thank you for helping me reduce my anxieties and for pointing out all the positive aspects of my work each time I went through a revision. Thank you for also being such a supportive person in my life. Thank you for helping me explore my strengths and weaknesses and for helping me start to discover who I am. I will always be grateful for your influence in my life.

I would also like to thank my committee members Dr. Stahmann, and Dr. Harper for their corrections to make my thesis better. A special thanks to Dr. Harper for spending hours with my data set and helping me understand the statistical analysis of my study. Dr. Harper made the statistics almost completely painless, I am extremely grateful for the time he spent working with me.

I would like to thank my Heavenly Father for guiding and inspiring me become a Marriage and Family Therapist and for comforting me along the way. Thanks to my cohort as well for their friendship, humor, and listening ears that helped me complete this project.

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CHAPTER ONE

> "Adult sexual abuse of children embodies the darkest forces of human nature. [Child sexual abuse] is a story of misused power, exploitation, and the betrayal of innocence. Society recognizes [child sexual abuse] as a breach of faith with the community of humanity; the individual who has been a victim of [child sexual abuse] understands [it's] legacy of madness" (Miller, 1993, p. 181).

Introduction

Through the 1970's and 1980's there was a surge of research on childhood sexual abuse. Researchers and practitioners began to realize the wide spread prevalence of this type of abuse as well as the devastating effects child sexual abuse has on later adult functioning. This "legacy of madness" is manifest in the plethora of adverse effects that survivors may experience such as depression, anxiety, PTSD, self-harming behaviors, eating disorders, substance and drug abuse, memory impairment, somatization, personality disorders, interpersonal problems, and sexual disturbances (Polusny & Follettte, 1995). Feinauer, Mitchell, Harper, and Dane (1996) suggests that these symptoms occur at leas in part as a consequence of the children's inability to believe they are capable of stopping or coping with hurtful experiences (autonomy). They believe they are powerless, incompetent and consequently see themselves as ineffective and thus flawed (shame).

It is estimated that 15% to 33% of females within the general population experience some form of childhood sexual abuse (Briere & Runtz, 1989). Studies conducted using clinical samples indicate a range of 35% to 75% (Briere & Zaidi, 1989).

Because sexual abuse will affect many of the women clinicians and other professionals see in mental health centers, it is important to clearly understand the long-term effects of this abuse. One such finding has been that women who are sexually abused as children tend to experience more sexual disturbances than women who were not abused (Finkelhor, 1986). Two types of sexual disturbances that affect this group of women are sexual promiscuity and inhibition.

Research has shown that adults, sexually abused as children, engage in voluntary sexual intercourse at a significantly younger age, have briefer sexual relationships, and have more sexual partners than non abused women (Wyatt, 1998). This long-term effect of childhood sexual abuse type is dangerous because it makes women vulnerable to sexually transmitted diseases, the worst being HIV (Johnson & Harlow, 1996; Allers, Benjack, White, & Rousey 1993). It could also impair them from forming meaningful relationships.

At the opposite extreme, sexual inhibition has been studied as a long-term consequence of child sexual abuse among survivors. Some women report negative attitudes towards sexuality, fear of sex, avoidance of sex, inability to enjoy sex or become aroused, and lack of desire (Stein, Golding, Siegel, Burnam, & Sorenson, 1988; Vogeltanz, Wilsnack, Harris, Wilsnack, Wonderlich, & Kristjanson, 1999).

Although there is a plethora of research conducted on sexual disturbances and, more specifically, promiscuity and inhibition, few studies have actually looked at the two disparate reactions simultaneously. It is interesting to note that Merrill, Guimond, and Thompson (2003) determined that many of the women who were promiscuous in some settings and with some partners were inhibited in other situations or periods of their lives.

These researchers prompt others to "identify factors that predict whether women will react to Child Sexual Abuse (CSA) with avoidance of sex and relatively low numbers of sex partner or with high levels of sexual behavior and relatively large numbers of sex partners" (p. 987). They go on to say that no previous research has addressed the identification of specific predictable factors.

Feinauer, et al. (1996) documented a connection between severe childhood sexual abuse, persistent negative perception of self (shame), and psychological symptoms such as anxiety and depression and adjustment difficulties such as the inability to form trusting intimate interpersonal relationships. Response to abusive experiences varied but consistently as the trauma increased the disturbances of intimacy were apparent. One of the most intimate and vulnerable experiences for women is sexual intimacy. In the case of sexually abused women when this vulnerability is associated with a sense of internalized shame (bad, defective, flawed, incompetent, unloved) their ability to connect in an intimate sexual experience is improbable.

This project studied sexual inhibition and their relationship to severity, frequency, duration of abuse, identity of the perpetrator, and internalized shame. It was important to study the effects of sexual abuse on a women's sexuality for a number of reasons. First, having sexual problems related to low sex drive, sexual dysfunctions, and avoidance of sex, can impair the functioning of a relationship and decrease life satisfaction (Jehu, 1989). At the other extreme, women who are sexually promiscuous engage in high risk sexual behavior and have higher chances of contracting a sexually transmitted disease such as AIDS (Johnson & Harlow, 1996; Allers, Benjack, White, & Rousey 1993).

Operational Definition of Terms

Child Sexual Abuse. For the purpose of this study child sexual abuse was defined as coerced or forced sexual behavior imposed on a person under 18 years old. It was also defined as sexual activity between a child and older person (5 years or more), whether or not obvious coercion is involved (Browne & Finkelhor, 1986).

Severity of Abuse. Severity of abuse refers to the type of sexual acts committed in the abuse situation. In this study, severity of abuse was on a continuum that ranged from sexual comments to being threatened into participating in such acts as intercourse and rituals. For purposed of this study, the Severity of Abuse Scale (Wilkin, 1992) was used to measure this variable.

Frequency of Abuse. Frequency was defined as how often sexual abuse occurred before the age of 18. In this study, possible number of approaches ranged from one lifetime incident to more than once a week.

Duration of Abuse. In the present study, duration was defined as the length of time the abuse occurred. This included the age of onset to the age the abuse ended.

Identity of Perpetrator. The identity of the perpetrator was defined as the most abusive person identified by the victim. Possible perpetrators included biological family members, stepfamily, friends, neighbors, and strangers.

Sexual Disturbances. For the purpose of this study, sexual disturbances were defined using the sexual subscale on the trauma symptom checklist. High scores indicated that the survivor experiences distressing sexual symptoms which are promiscuity, inhibited desire, fear of sexual intimacy, and/or comfort with her own sexuality.

Shame. Shame was defined as a chronic perceived sense of being insufficient or flawed as a person (Harper & Hoopes, 1990). Shame was measured using the Internalized Shame Scale (ISS). It consists of four scales: self-esteem, shame, inferiority, and alienation. High scores indicate greater amounts of shame.

Physical Abuse. For the purposes of this study, physical abuse was defined using the following question from the Severity of Abuse Scale: "Physically abused me ___Yes ___No." An affirmative response to this question indicated that physical abuse was connected to their sexual abuse experience.

CHAPTER TWO

Review of Literature

The following review of literature examined the variables that were pertinent to this study. Therefore research findings on sexual disturbances, more specifically inhibition and promiscuity, were be discussed as well as Finkelhor and Browne's (1986) traumagenic dynamics, factors affecting sexual disturbances, and other relevant variables, including severity, duration, and frequency of abuse, the identity of the perpetrator, and internalized shame.

Sexual Disturbances

The sexual disturbances that are often outcomes of child sexual abuse have been opernationalized in a myriad of different ways. Sexual disturbances have been measured by: (1) sexual dysfunction, including diagnosable sexual disorders; personal perception of sexual functioning such as (2) sexual satisfaction, (3) perception of sexual problems, (4) sexual responsiveness, (5) fear of sex; sexual behaviors such as (6) number of sex partners, (7) frequency of sexual activity, (8) age of first intercourse, and (9) number of unwanted pregnancies, and (10) high risk sexual behavior. Many studies explore more than just one sexual disturbance.

Sexual Inhibition

Tsai, Feldman-Summers, and Edgar (1979) studied the psychosexual functioning of adult women who had experienced childhood molestation. They compared three groups of women with 30 participants in each group. The first group was composed of women who were in a clinical population, and the second group was a nonclinical group of women who considered themselves recovered and functioning normally despite the

CSA. The third group was a control group compiled of women who had no sexual abuse in their past. CSA was not operationally defined beyond self-identification of the participants. Researchers found that the clinical group differed in their current psychosexual functioning compared to the nonclinical and control group. The clinical group compared to the other two groups experienced CSA for longer durations, was older when it ended, and experienced it more frequently. The study also revealed that women in the clinical group had a lower frequency of orgasms, less sexual responsiveness, and less satisfaction with their current sexual and intimate relationship with men. The clinical group also stated stronger negative reactions to the CSA, including pressure to participate, pain, guilt, and general distress. Tsai, et al. (1979) speculated that the clinical groups reactions to the CSA led to a stronger conditioned negative response to sexuality which led to the sexual difficulties experienced.

One year previous, Tsai and Wagner (1978) discovered that women in the clinical group who were sexually abused in their childhood reported an ability to achieve an orgasm but subsequently did not find it satisfying or pleasurable. The authors speculate that women learn to be sexually responsive at a young age, but because of the negative associations with the events, they do not enjoy the sexual experience.

In a study composed of 83 nonpsychotic female victims of incest, Becker, Skinner, Abel, and Treacy (1982) found that 75% of respondents reported a fear of sex; 33.3% reported disorders of desire; 41.7% reported disorders of arousal; and 33.3% reported secondary nonorgasmia. Results came from completion of the Sexual Arousal Inventory which is a 28-item inventory that rates the participant's arousal to erotic experiences. This measure has been used to differentiate between dysfunctional and functional women.

The authors hypothesize that since there is such a high level of sexual problems such as fear, arousal, and desire, perhaps victims of incest become anxious during sexual experiences, and this inhibits their sexual feelings. Some weaknesses that need to be addressed in this study are first, they did not define incest and second there was no control group. Therefore, it is unclear whether the sexual dysfunctions are greatly different from that of the general population.

Herman, Russell, and Trocki (1986) studied the long-term effects of incestuous abuse in childhood. They interviewed a nonclinical sample (N=152) and an outpatient sampe (N=53). The definition of CSA was sexual abuse by one or more relatives that occurred in childhood or adolescence. They found that 27.2% of the nonclinical sample estimated that the abuse had greatly affected their lives. When asked specifically how it affected their lives, respondents frequently discussed negative feelings about men, sex, or themselves. Others talked about feeling anxiety and distrust, difficulties in forming meaningful relationships, and sexual problems. Unfortunately the study did not provide definitions of what sexual problems were. This is simply what women reported when asked how the abuse had affected their lives.

Using a sample of 57 non clinical adult women who had experienced CSA, Feinauer (1989) found that most women could achieve orgasm or respond to sexual stimulation (similar to Tsai and Wagner's findings), but this same group of women reported a fear of sex, arousal dysfunction, and desire dysfunction. Women who described their abuse experience as purely negative were unlikely to orgasm. Women who described it in both positive and negative terms were more likely to experience pleasure in adulthood.

Jehu (1989) studied sexual dysfunctions among 51 female victims of CSA who had recently entered therapy. The criteria for women to be included in the study were: the perpetrator had to be "substantially older" than the victim, the victim had to know the perpetrator and experienced abuse at least one time. During therapy, 94% of participants were diagnosed with some type of sexual dysfunction. The most common types of problems were sexual aversion, dissatisfaction with life, and impaired sexual motivation, arousal, and orgasm. Jehu also found that many of the women responded to sexual activity with negative emotional reactions, such as distress, disgust, revulsion, guilt, or self-disparagement. He concluded that there might be a type of classical conditioning in which victims relate all the negative emotions they experienced during the abuse to any type of sexual experience. Because of the CSA, most participants had distorted thoughts and images of sexuality. One weakness with this study is that we do not know how diagnoses were made or what criteria they had to fit to be diagnosed with a sexual dysfunction. Another weakness is that there was no control group.

Jehu (1991) followed up his work two years later and looked at several research findings and conceptualizes why some reactions to molestation occur. He states that many victims respond to the abuse with avoidance to any stimuli that might trigger a remembrance of the experience(s). Any type of sexual behavior, even when in a loving relationship, will be directly related to memories of the abuse. Therefore, many victims prefer to avoid any form of sexuality. This is seen in a lack of interest in sex.

Using a sample of 22 women who had been molested by a family member before the age of 18, and a comparison group of 18, Jackson, Calhoun, Amick, Maddever, and Habif (1990) studied victims' subsequent adjustment. Among other results, Jackson et al.

(1990) found that women who had experienced molestation had less satisfaction in their sexual functioning. This was based on their scores on both the Sexual Satisfaction Scale and the Global Sexual Satisfaction Index of Derogatis Sexual Functioning Inventory (DSFI). They also discovered that 65% of the victims met the criteria for a DSM-III diagnosis of one or more sexual dysfunctions. More specifically 50% of the 65% had inhibited sexual disorder; 45% reported inhibited orgasm; 35% inhibited sexual excitement; 25% dyspareunia, and a small 10% met the criteria for vaginismus.

Using a community sample of 391 adult women, Saunders, Villeponteaux, Lipovsky, Kilpatrick, and Veronen (1992) studied the risk of mental disorders among female victims of CSA. In this sample, 33.5% had been victims of CSA at least once prior to the age of 18. About 63% of respondents experienced contact CSA (contact sexual assault was met if there was penetration of the victim's vagina, anus, or mouth by the perpetrator's penis or penetration of the victim's vagina by the perpetrator's finger or other object, or actually physical contact between the perpetrator and victim without penetration) and met DSM-III criteria for a sexual disorder, while 44% of nonvictims met the same criteria. Authors concluded by saying that contact victims were more likely to have a sexual disorder, but non contact victims were no more likely than the nonvictim group to have a sexual disorder.

Beitchman, Zucker, Hood, DaCosta, Akman, and Cassavia (1992) undertook a review of literature to look at what long term effects are most supported by the literature. Among other findings, they discovered that a great majority of the literature does provide evidence that women who experience CSA are more likely than women who do not

report CSA to show evidence of sexual disturbances or dysfunction and also to show anxiety and fear of being sexual in adulthood.

Similarly, Rind and Tromovitch (1997) conducted a meta-analytic review from the national samples on consequences of CSA. They analyzed 7 different studies and, using meta-analysis, revealed that CSA was in fact related to sexual adjustment, but the effect sizes were very small (r=0.08-0.24). Sexual adjustments from the studies examined were sexual dysfunction, difficulty in reaching orgasm, less pleasurable sex, more difficulty lubricating, more emotional difficulties interfering with sex, and lower satisfaction in their sexual relationships.

Wenninger and Heiman (1998) studied the sexual functioning of 57 women who had been sexually abused during their childhood. They also used a comparison group of 47 nonvictims. When researchers compared victims to nonvictims, they discovered that victims reported higher levels of sexual aversion, less subjective arousal, and fewer signs of physical arousal. This study is unique because it examined physiological arousal during sex.

Fleming, Mullen, Sibthorpe, and Bammer (1999) studied the long-term impact of childhood sexual abuse in a national survey of 710 Australian women.They defined CSA as (1) contact sexual activity prior to age 12 with someone at least 5 years older than the victim or (2) between the age of 12-16 with someone at least 5 years older and the sexual contact was unwanted. Researchers found that CSA victims compared to nonvictims reported more sexual problems which included a lack of interest or pleasure in sex, painful intercourse, and a lack of sexual arousal or lubrication. The investigators also took into account the severity of abuse and found that CSA that involved intercourse was

a significant predictor of sexual problems even when controlling for social and family variables.

Using 201 female undergraduates, Bartaoi and Kinder (1998) examined the effects of child and adult sexual abuse on adult sexuality. They studied three groups, (1) abused in childhood (2) abused as an adult (older than 16) and (3) no abuse. They found that women who were abused in their childhood or adulthood tended to have less satisfying sexual relationships with partners than women who never experienced sexual abuse. One of their hypotheses was that child sexual abuse would be more traumatic than later adult sexual abuse. They hypothesized that adults who experienced child sexual abuse would have higher rates of anorgasmia, vaginisums, sexual avoidance, sexual dissatisfaction, sexual noncommunication, and nonsensuality. They found no difference between CSA and adult sexual abuse survivors. The authors of this study were unclear about whether sexually abused women had higher rates of these variables than the control group.

Alexander and Lupfer (1987) in a study of 586 female undergraduates, found no differences in sexual satisfaction or functioning between the CSA victims and nonvictims. They did, however, find significant differences in regards to sexual promiscuity which will be discussed in more detail in the next section.

It seems clear from the literature that CSA does increase the chances that a woman will be dissatisfied with their sexual experiences in adulthood. Many studies showed that victims met the DSM-III criteria for sexual dysfunctions, had a lack of interest in sex, and also experienced little pleasure from sex.

Sexual Promiscuity

While several of the studies in the previous section described the inhibitions and sexual dysfunctions that characterized many women, they also mentioned that in the same samples victims had more sex partners than the comparison groups. The researchers gave no explanation for the disparate findings. Wenninger and Heiman (1998) found that CSA victims reported more sex partners across their lifetime, but not within the past six months, than nonvictims. Bartoi and Kinder (1998) also found similar results. They discovered that both children and adults who were sexually abused had a higher number of unsafe sex partners than the comparison group. Unsafe sex partners were defined by whether protection was used during intercourse. Rind and Tromovitch (1997) also found that although CSA victims had more sexual problems, CSA victims were more likely to have had more than ten sex partners and to have experienced more variety in their sexual activity. But like their other findings, the effect sizes were small (r=.12-.17). Tsai, et al. (1979) found that 43.3% of the clinical group indicated that they had had sex with 15 or more partners, while 17.2% of the non clinical group and 9.1% of the comparison group fit within that category. Alexander and Lupfer (1987) did not find any differences in sexual functioning or satisfaction between groups, but they did find that CSA victims were more likely to have had sexual intercourse and to have a higher frequency of current sexual behavior. Jackson, et al. (1990) discovered that CSA victims not only met the criteria for DSM-III sexual dysfunctions, but they also became interested in sex at a much younger age than the comparison group.

The rest of this literature review will examine articles that found CSA survivors had more promiscuous behavior. Wyatt (1988) used a sample of 248 women from the

Los Angeles area and found that women who had been sexually abused, especially if the abuse was intrafamilial and perceived the experience as highly negative, had a statistically significant lower mean age of first intercourse. She also had many other findings that were statistically significant. CSA contact victims began noncoital activities much earlier than nonvictims, had more sex partners, and were involved in briefer relationships. There were no differences in sexual activity in the noncontact and comparison groups.

Zierler, Feingold, Luafer, Velentga, Gordon, and Mayer (1991) examined 186 men and women with a nonzero risk of HIV infection. Researchers defined sexual abuse as rape or forced sex during childhood or adolescence. Results indicated that CSA victims, compared to non victims, were more likely to have sex with someone they had no association with and were 2 times more likely to have 2 or more sex partners in one year. They also discovered that survivors of CSA were 4 times more likely to report being a prostitute during their life time compared to those who had not experienced any sexual abuse. They found no differences in condom use between the CSA group and control group. While the majority of respondents (71%) were female, researchers did not report gender differences. Their definition of CSA was also more extreme than others studies which might explain the severity of outcomes.

Employing 248 African-American and White American women from Los Angeles County, Wyatt, Guthrie, and Notgrass (1992) studied CSA victims and ensuing revictimizations. Findings pertinent to the present study were the following: they discovered that adults who experienced at least one incident CSA and who were revictimized at least once in adulthood were more likely to engage in a variety of sexual

activities, such activities as masturbation, consensual sexual activity with a partner, group sex, and partner swapping on a frequent basis. The authors did not define "frequent basis" so it is difficult to fully understand the findings. Researchers also discovered that women who were both abused in childhood and adulthood had higher rates of unintended pregnancies and abortions. Wyatt (1992) et al. speculate that women who were sexually abused in childhood and revictimized in adulthood engage in sexual behavior without any form of contraceptive because the sexual act is perceived in isolation from the consequences of sexual activity, such as pregnancy.

Johnsen and Harlow (1996) studied 94 female undergraduates, 43 of which had experienced CSA as defined by the participant. These researchers reported that CSA victims, compared to nonvictims, were more frequently engaged in a wide range of sexual activities, had more lifetime sexual partners, and reported that first intercourse occurred at a younger age. They also found that victims had more negative psychosexual attitudes which again shows that responses to sexual abuse can fall at two extreme ends of the continuum.

Walser and Kern (1996) studied the relationships between sex guilt, sexual behavior, and CSA in a clinical population. They examined 71 victims of sexual abuse and a 45 member comparison group. The term sexual behavior was operationalized as nonaccepted sexual activity based on (1) number of sex partners, (2) sexual intercourse experiences on initial dates or with someone they had recently met, (3) extramarital sexual affairs, (4) the respondents' age at first intercourse experience, and (5) contraction of sexually transmitted diseases. Researchers reported that CSA victims, compared to nonvictims, had higher levels of sex guilt and more nonaccepted sexual behavior. This is

an unusual yet interesting finding. Researchers thought that more sex guilt would yield less nonaccepted sexual behavior. They concluded that sexual abuse must somehow disrupt the normal relationship between sex guilt and sexual behavior. A major strength of this study was that they looked at a specific variable in relation to sexual behavior which most studies have not done.

Several articles looked at adolescent populations to see if their sexual behavior was altered by sexual abuse. Stock, Bell, Boyer, and Connell (1997) studied data on 3,128 girls in grades 8, 10, and 12. The data was collected as part of the Washington State Survey of Adolescent Health Behaviors. Participants self-identified whether or not they were sexually abused. Researchers were interested in whether or not sexual abuse increased risk for teenage pregnancy. They reported that CSA victims were 3.1 times more likely than those who were not abused to indicate that they had been pregnant. Respondents who were sexually abused were more likely to have had intercourse by 15, to not use birth control during last coitus, and to have more than one sex partner. This researcher concluded that sexual abuse does play a role in risky sexual behavior in adolescents.

Fergusson, Horwood, and Lynskey (1997) studied the association between CSA, adolescent sexual behaviors, and sexual revictimization. They used a longitudinal prospective design with 520 New Zealand young women. Participants were studied at regular intervals from birth to age 18. Researchers divided the girls into 3 groups: noncontanct CSA (mild), contact CSA not involving attempted or completed intercourse (moderate), and CSA involving attempted or completed intercourse (severe). Seventeen point three percent of the sample reported some type of sexual abuse, and 13.1% reported

contact abuse. The results indicated that severe CSA had the highest rates for multiple sex partners, early onset intercourse, and attempted or completed rape during adolescence. When Fergusson, et al. (1997) added age of first intercourse into the regression, multiple sex partners became insignificant in relation to severe CSA. Authors decided that the impact of CSA on adolescent sexual behavior must be mediated by the impact of CSA on age of first consensual intercourse. Therefore, the early onset of intercourse increases the individual's chances for having multiple sexual partners.

Raj, Silverman, and Amaro (2000) also looked at the relationship between CSA and sexual risk taking in high school students. They examined 779 female and 831 male adolescents. CSA was defined as having had sexual contact against their will. Results indicated that sexually abused females were significantly more likely to have had earlier coitus than non abused adolescents. They were also more likely to have had 3 or more sex partners and to be pregnant. Although fewer boys experience sexual abuse, results from this study indicate that the impact of sexual abuse is greater for boys. Sexually abused boys were significantly more likely to have ever had multiple partners, to have had multiple sex partners in the last 3 months, and to engage in unsafe sex resulting in pregnancy. It appears that both girls and boys sexuality is affected by CSA.

Several authors have published reviews of the literature in order to synthesize all the data. Briere and Elliot (1994) found that much of the literature indicates that CSA victims, and more specifically incest victims, have a greater likelihood of frequent, short-term sexual activity, often with a number of different sex partners. They also stated that this is most likely the reason that survivors also are more prone to unintended pregnancies and contracting sexually transmitted diseases. Authors conceptualize why

this response to CSA is likely to occur. They view being sexual as a temporary way to sooth the inner pain they are feeling inside. It provides them with a pleasurable experience that helps them cope with all the negative feelings they carry with them.

In another article Briere and Runtz (1993) discuss this same idea by calling sexual compulsivity and indiscriminate sexual activity tension-reducing activities. Survivors may engage in sexual behavior to temporarily "fill" the emptiness they fill inside. This coping strategy works in the short-term bringing a sense of calmness and relief. Because the coping strategy worked it is positively reinforced and the victim uses this tactic over and over again. Authors also state that promiscuous behavior may be an attempt to meet their needs for emotional closeness since they may have never had these needs met in childhood. They do not know how to go about getting this need met so they use sex to help them fulfill that need.

Widom and Kuhns (1996) found that sexual abuse did not affect sexuality. They examined 338 women who had records of CSA, childhood physical abuse, or neglect before the age of 12. Using elementary school records during the same time period, they identified a comparison group. They matched women on the basis of age, sex, race, and school. Promiscuity was operationally defined as having more than 10 sex partners in a single year. Results indicated that there was no difference between any of the groups. This could have been because of the stringent definition of promiscuity and also where their sample came from. Many of the victims were involved with social services and had received therapy or other interventions which may account for the lack of sexual disturbances in this population.

It seems that although promiscuity was measured differently in many of the studies from number of sex partners to high risk sexual behavior, the research shows that sexually abused children are more likely to engage in promiscuous behavior.

Sexual Inhibition and Promiscuity

Few studies have investigated both sexual inhibition and promiscuity as outcomes of CSA. Merrill, Guimond, and Thomsen (2003) questioned why such extreme opposite reactions occur and what factors might predict each different outcome. Merrill, et al. (2003) proposed a model to describe these two disparate reactions. Using a sample of 547 female U.S. Navy recruits, researchers examined a victims' style of coping to see whether this affected outcomes on sexuality. They found that women who engaged in self-destructive coping (running away from home, using alcohol and drugs, contemplating suicide, etc.) were also more likely to have dysfunctional sexual behavior (which was defined as sexual behaviors that were self-defeating or maladaptive because of the potential for self-harm, indiscriminant quality, or use for non sexual purposes) and have high number of sex partners.

The results indicated that girls who initially use self-destructive coping may be more prone to continue to use self-destructive strategies such as engaging in dysfunctional sexual behavior and engaging in sex with multiple partners. Results also indicated that women who used avoidant coping (suppressing thoughts and feelings, avoiding reminders of the abuse, staying home as much as possible) were more likely to have fewer sex partners. This finding was only partially supported during the analysis. Women who responded to abuse by using avoidant coping mechanisms reported higher levels of sexual concerns and a lower number of sex partners than did women who did

not employ avoidance. Contrary to the researchers' predictions, the effects of avoidant coping on number of sex partners were not mediated by sexual concerns. Sexual concerns were dropped from the model because it was not a significant predictor of the number of sex partners. Researchers also reported that the two forms of coping were positively correlated (r=.50) which indicates that many women use both forms of coping in different situations and at different phases of life. This presents an interesting finding: a woman may use promiscuity at certain points in her life and at other times resort to sexual inhibition. Although Merrill, et al. (2003) concluded that sexually abused women are more likely to have high or low numbers of sex partners based upon whether they employ more self-destructive or avoidant coping strategies, it seems more important to determine which factors cause sexual disturbances rather than specifying inhibition versus promiscuity.

Traumagenic Dynamics

Finkelhor and Browne (1986) devised a conceptualization called traumagenic dynamics which suggests that the experience of CSA can be analyzed in terms of four trauma-causing factors. These include: traumatic sexualization, betrayal, powerlessness, and stigmatization. Since traumatic sexualization is related to the purpose of this study, it will be examined in depth.

Traumatic sexualization "refers to the process in which a child's sexuality (including both sexual feelings and attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of the abuse" (Finkelhor & Browne, 1986, p. 181). Several different dynamics can lead to traumatic sexualization. The child may be rewarded for being sexual or is offered affection and

attention in exchange for sex. The perpetrator may fetishize sexual parts of the child, or he or she may transmit misconceptions about sexual behavior and sexual morality. In addition, the child may be conditioned to associate sexual activity with negative emotions and memories. Authors believe that these different CSA characteristics determine the impact of CSA on the victim's own sexuality.

Traumatic sexualization can express itself in several psychological ways. First, it can increase the salience of sexual issues. This is most readily seen in children during or after their abuse. They may take a developmentally inappropriate interest in sex and sexual parts of their bodies. It can also cause confusion about sexual identity (homosexual, heterosexual, bisexual) and sexual norms. In addition, victims may become confused about the relationship between sex, love, and care-getting or care-giving. Lastly, victims may associate all sexual activities or arousal sensations as negative experiences and consequently avoid sex and intimacy.

The psychological impact of traumatic sexualization can manifest itself in a range of different behaviors. Each victim may respond in different behavioral ways, such as developing sexual preoccupations and compulsive sexual behavior, precocious sexual activity, aggressive sexually behaviors, promiscuity, and prostitution. Other CSA victims may experience sexual dysfunctions, flashbacks, difficulty in arousal, orgasm, avoidance of or phobic reactions to sexual intimacy, or inappropriate sexualization of parenting.

Finkelhor and Browne (1986) further stated that different factors may be associated with the degree of traumatic sexualization a victim experiences. For example, if the offender actively stimulates and forces the child to participate in sexual activity the degree of traumatic sexualization will be greater than if the offender used a passive child

to masturbate. These authors also speculated that the age at which the abuse took place may greatly affect sexualization. They state that children who are older and have full awareness of what is taking place may experience more traumatic sexualization as opposed to a child who does not understand the implications of the behavior. This conceptualization presents a framework to make sense of the effects of CSA on a woman's later sexual behavior.

Factors Affecting Sexual Disturbances

Carlson, Furby, Armstrong, and Shlaes (1997) state that certain characteristics of sexual abuse are more traumatizing than others. Much of the research discussed above as well as other research findings support these authors' claims. They concluded that severity, frequency and duration, and identity of the perpetrator all play a role in the long-term effects of sexual abuse, more specifically sexual disturbances.

Severity

Several researchers asked respondents to indicate the severity of their abuse ranging from sexual comments to penetration and intercourse or noncontact versus contact abuse. In a review of the literature, Browne and Finkelhor (1986) found that the higher the severity of the sexual abuse the more trauma symptoms will be experienced. In another review of the literature, Beitchman, et al. (1992) found that long-term harm was associated with the severity of the abuse. Researchers have used severity as a predictor for extreme trauma (Russell, 1986), poorer adjustment in adulthood (Sedney & Brooks, 1984), and subject's perception of "lasting harm" (Herman, Russel, & Trocki, 1986), lower mental health status (Mullen, Romans-Clarkson, Walton, and Herbison, 1988).

Not all research has found this positive relationship between the severity of abuse and long-term effects (Anderson, Bach , & Griffith, 1981; Finkelhor, 1979; Fromuth, 1983). These studies were unable to demonstrate that severity of abuse was associated with worse effects. However, the majority of research demonstrates that such a relationship exists.

Other researchers have examined the relationship between severity and sexual functioning in women sexually abused as children. Gijseghmen and Guthier (1994) found that severity of abuse was related to sexual behavior disorders in adolescent girls. Several studies show that severity greatly influenced a women's sexual inhibition. Fleming, et al. (1999) found women who experienced abuse involving intercourse had more sexual problems as adults such as no pleasure in sex, painful intercourse, and lack of sexual arousal and lubrication. Sarwer and Durlak (1996) found that 95% of sexually abused women who had a sexual dysfunction had experienced penetration during the abuse. Similarly, Saunders, et al. (1992) found that victims who experienced contact abuse versus noncontact had increased rates of sexual dysfunction as defined by the DSM-III. Herman, et al. found that women who experienced "highly intrusive" sexual abuse reported longer lasting negative effects such as a fear of sex and men.

Other research indicates that severity of abuse affects more promiscuous sexual behavior. Fergusson, et al. (1997) looked at three groups of sexually abused women: noncontanct, contact without penetration, and contact with penetration. They reported that the severe CSA group evidenced the highest rates for multiple sex partners, early onset intercourse, and attempted or completed rape during adolescence. Walser and Kern

(1996) found that victims who experienced more severe abuse reported higher levels of sex guilt and nonaccepted sexual behavior (defined under promiscuity literature review).

While many researchers indicate that severity does increase sexual disturbances, other research has demonstrated no such relationship. No differences were found in women who experienced noncontact versus contact abuse in having more sex partners, briefer relationships, and earlier age at first intercourse (Wyatt, 1988) or promiscuity (Wind & Silverman, 1992). Other research shows that severity was not related to sexual problems (Banyard & Williams, 1996; Elliott & Briere, 1992; Runtz & Roche, 1999), dysfunctional sexual behavior (Runtz & Roche, 1999), or fear of sex (Usher & Bewberry, 1995). Therefore some research indicates that children who experience severe sexual abuse experience a plethora of sexual problems in adulthood, while other research finds no such relationship.

Frequency and Duration

Several studies indicate that more frequent abuse and longer durations of the abuse are associated with greater trauma as a long-term effect (Bagley & Ramsay, 1985; Briere & Runtz, 1985; Friedrich, Urzuiza, & Beilke, 1986; Herman et al., 1986; Peters, 1985; Russell, 1986; Tsai et al., 1979). However Finkelhor (1979) found no such relationship. Interestingly, other studies found an inverse relationship in which greater frequency and duration were related to less trauma (Courtois, 1979; Seidner, Calhoun, & Kilpatrick, 1985; Mullen, Romans-Clarkson, Walton, & Herbison, 1988).

Tsai, et al. (1979) found that the clinical group, compared to the nonclinical group, had experienced more frequent and longer durations of abuse and also indicated lower frequency of orgasms, less sexual responsiveness, and less satisfaction with their current

sexual relationship. Usher & Dewberry (1995) found that longer durations of CSA were related to fear of sex. Other studies that examined frequency found high frequency was associated with disorders of sexual desire, arousal, and orgasm (Kinzl et al., 1995); sexual problems (Charmoli & Athelstan, 1988); and compulsive sexual behavior (Charmoli & Athelstan, 1988).

Other research has found no relationship between duration, frequency and sexual disturbances (Briere, 1988; Briere & Zaidi, 1989; Elliott & Briere, 1992; Gold et al., 1994; Runtz & Roche, 1999). While some of the literature indicates that longer durations and higher frequencies of sexual abuse during childhood lead to more sexual disturbances in adulthood, other research indicates that no such relationship exists.

Identity of the Perpetrator

There is much debate about what type of relationship is most traumatic and has the longest effects on CSA survivors. Some research has found that father-daughter abuse has the greatest impact on victims (Tsai, et al., 1979; Browne & Finkelhor, 1986; Russell, 1986; Beitchman, et al., 1992; Wind and Silvern, 1992). Specifically, Wind and Silvern (1992) found victims reported more promiscuous sexual behavior when the perpetrator was a father-figure. Using the TSC-40, Elliot and Briere (1992) found a small, but significant correlation between parental CSA and sexual problems. Similarly, Charmoli and Athelstan (1988) indicated that parental offenders were associated with more compulsive sex in CSA survivors.

Other research indicates that it is not a father figure, parent, or stranger that makes a difference in outcomes, but rather it is the level of emotional intimacy shared with the perpetrator. Feinauer (1989) found that family relationships did not predict outcome, but

whether the victim had put trust in the abuser did. Similarly, Wind and Silverman (1992) found that the degree of emotional intimacy between the abuser and victim was related to enjoyment of sex and self-reported promiscuity.

Several other studies found no relationship between intrafamily CSA and increased trauma and instead found that unrelated perpetrators were more traumatizing (Anderson, et al. 1981; Friedrich et al., 1986). Finkelhor, (1979) found no difference between family members and others on long-term effects as did other researchers (Seidner & Calhoun, 1984; Tufts, 1984 Russell, 1986). Banyard and Williams (1996) looked at family members as perpetrators and found no association with sexual problems. Seven additional studies did not find a relationship between intrafamiliar CSA and sexual disturbances (Briere, 1988; Briere & Zaidi, 1989; Parker & Parker, 1991; Roesler & McKenzie, 1994; Runtz & Roche, 1999; Sarwar & Durlak, 1996; Usher & Dewberry, 1995). While several studies indicate that parental sexual abuse increases the chance of sexual disturbances in adulthood, many other studies contradict these findings. A greater proportion of the literature confirms that parental sexual abuse as well as family abuse does not increase sexual disturbances in adulthood.

Internalized Shame

Because there is so much debate in the literature about which variables are associated with sexual disturbances, other variables need to be examined to see if they are associated or can predict sexual disturbances such as inhibition or promiscuity. Shame has largely been ignored in the psychological literature even though it is an emotion that people experience universally (Izard, 1977). Kaufman (1996) stated that the reason this has occurred is that shame and guilt have been used interchangeably in the literature.

Whatever the case may be, the fact is that little is known about the development of shame or the effects it can have on an individual's life. Everyone experiences shame at some point in their life, but it becomes a problem when an individual develops a shame-prone identity. When this occurs it results in the formation of a negative personal identity (Harper & Hoopes, 1990). Once this develops a person with a negative personal identity sees him or herself as a flawed person.

Erickson (1950) studied shame and described its development in one of his stages of child development. He viewed shame as the consequence of not successfully negotiating the developmental stage of autonomy versus shame and doubt. Therefore, shame may develop when a child is not able to learn how to develop autonomy. The child feels that he or she is incompetent and consequently sees him or herself as ineffective and thus flawed.

CSA is seen as one event in a child's life that could interfere with this developmental stage (Herman, 1992; Lebowitz, Harvey, Herman, 1993; Roth & Newman, 1991; Zupancic & Kreider, 1998). During the abuse, children learn that their efforts to stop the situation are futile. Therefore they develop a belief that the experience is non-preventable and inescapable. This greatly interferes with a child's ability to develop autonomy and to believe that s/he has influence and control over a situation. Children are also commonly blamed for the abuse either directly or indirectly by the perpetrator (Herman, 1992). When a child develops a learned helplessness and feels responsible for the abuse, s/he will feel internally flawed and thus develop shame.

Soderquist (1993) examined childhood abuse, family-of-origin typology, and shame in women using a sample size of 261 individuals. The researcher found that

shame scores were significantly higher in adults who reported an abusive childhood. Abuse included verbal, physical, and sexual abuse. Also, respondents who indicated that they were raised in "extreme" families, rather than "balanced" families had significantly higher shame scores.

While Soderquist's research indicates that childhood sexual abuse is linked to shame-prone identities in adults, no research has been conducted to determine whether a shame-prone identity plays a role in adult sexual disturbances experienced by CSA survivors. When a woman has a shame-prone identity, she sees herself as flawed and not worthy. Common beliefs and statements made by such women are, "something is wrong with me," and "I will be exploited and harmed by others." Often time's women with shame-prone identities distort incoming information during the perceptual process in order to fit it into their lived reality (Harper & Hoopes, 1990). Although sex drive and sexual desire are natural and normal, shame-prone women may avoid these experiences because they are afraid of being exploited or harmed by others. When their husband or partner approaches them sexually in a loving relationship, they may distort the meaning of the advances and fit it into their previous experiences and truly believe that they will be exploited. They may also feel shame in wanting to fulfill sexual desires and thus avoid them because they view themselves as not deserving pleasure.

Physical Abuse

Few studies have looked at the relationship between sexual abuse and physical abuse. In their conceptualization, Harper and Hoopes (1990) found that internalized shame increased if a person endured physical abuse. Also, as mentioned previously, Soderquist's research indicates that children from physically abusive homes have higher

amounts of shame. With these finding, it is important to include physical abuse in the analysis to see its effects on shame and sexual disturbances. It appears that both physical and sexual abuse can produce the shame-prone identity.

Summary of Literature Review

It is apparent that a long-term effect that many sexually abused women experience is sexual disturbance. Women may experience inhibition, promiscuity, or both throughout different times in their lives. Types of inhibitory responses are sexual dissatisfaction, fear of sex, sexual unresponsiveness, and several DSM-IV disorders such as inhibited sexual disorder, inhibited orgasm, inhibited sexual excitement, dysparenunia, and vaginismus. Women who are more sexually promiscuous as a result of CSA seem to engage in short term sexual encounters, have higher numbers of sex partners, practice unsafe sex or what has been termed high-risk sexual behavior, to have more unintended pregnancies, and to engage in intercourse at a younger age.

While the research clearly shows the results of CSA related to sexual dysfunction, it has not yet decidedly determined which factors influence the development of sexual disturbances. Merrill, et al. (2003) found that coping styles influenced outcomes in sexuality. Interestingly, their research also indicated that promiscuity may be practiced during some phases of life experience and in some settings while inhibited sexual responses may be practiced in others. Also, Finkelhor and Browne have conceptualized why sexual disturbances are a result of CSA, but little research addresses this question.

Research has found that severity, frequency and duration, and the identity of the perpetrator may not only decrease adult adjustment and quality of life but also play a role in increasing sexual disturbances. Although much research validates this idea, many

other findings counter these findings. There is also controversy over whether these different variables are associated with inhibition or promiscuity. Because of these incongruent findings, it is important to look at other variables that may be associated with different sexual outcomes, such as shame.

Significance of Study

It is important to study shame, as well as severity, frequency and duration, the identity of the perpetrator, and physical abuse in order to determine variables that are associated with promiscuity and inhibition. The literature has done an excellent job in pointing out the effects of sexual abuse and specifically looking at different types of sexual responses, but researchers have not geared their studies towards understanding why sexual disturbances occur. As mentioned in the review of literature, shame is a common emotional reaction to childhood sexual abuse. What is not known is whether the shame that is produced could actually be associated with or predict sexual disturbances in sexually abused women. For the purposes of this study sexual inhibition will be examined in relation to all of the independent variables. It seems that shame may have more of a positive relationship with sexual inhibition rather than promiscuity because a woman with a shame prone identity sees herself as inherently flawed and unworthy of satisfying her sexual needs.

Statement of Purpose

The purpose of this study was to examine factors associated with sexual disturbances in women who were sexually abused as children. More specifically, based on the review of literature and ability to operationally define the variables, factors associated with sexual

inhibition including internalized shame, identity of the perpetrator, physical abuse, severity, duration, and frequency of childhood sexual abuse were examine.

Hypotheses

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

Regarding Direct Paths in the Model:

H1: There will be a significant positive relationship between scores on variables of physical abuse, severity of abuse, frequency of abuse, duration of abuse, identity of perpetrator (dummy coded from 1-Unknown other, 2-Known Other, 3-Extended family member, to 4-immediate family member) and scores on the variable of inhibited sexual difficulties.

H2: There will be a significant positive relationship between scores of internalized shame and scores of inhibited sexual difficulties.

Regarding Indirect Paths in the Model:

H3: There will be a significant positive relationship between scores on variables of physical abuse, severity of abuse, frequency of abuse, duration of abuse, identity of perpetrator (dummy coded from 1-Unknown other, 2-Known Other, 3-Extended family member, to 4-immediate family member) and scores on the variables of internalized shame.

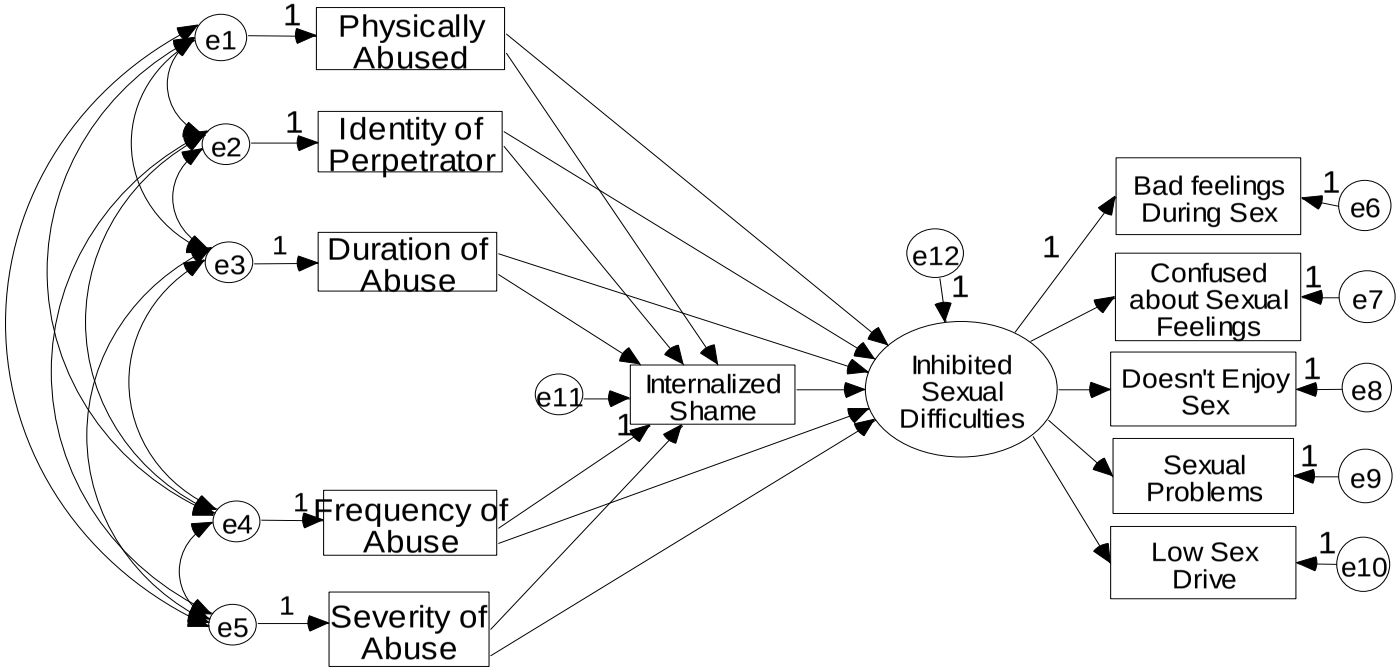


Figure 1. Conceptual Relationship of Identity of Perpetrator, Duration of Abuse, Frequency of Abuse, Severity of Abuse , and Physcial Abuse to Shame and Inhibited Sexual Difficulties.

CHAPTER THREE

Method

Design and Statistical Analysis

For the present study, Structural Equation Modeling using AMOS was used to test the relationships between variables in the model. The first step was to use confirmatory factor analysis to determine how well observed measures factored on the latent variable, inhibited sexual difficulties. Secondly, descriptive means, standard deviations, and range were calculated for all variables in the model. Third, a correlation matrix was constructed and values were examined to assure that there were no problems with multicollinearity. Lastly, AMOS was used to determine the beta loadings for each path in the model and the indices of fit for the model.

Subjects

Data Collection

The data collected for this study were part of the Hardiness and Childhood Trauma Project headed by Professor Leslie Feinauer, Ph.D. of Brigham Young University. Researchers gathered the data from four different communities and households that were randomly selected in Salt Lake City, Utah; San Francisco, California; Chicago, Illinois; and New York, New York. Researchers also gathered data from the Utah State Penitentiary. Surveys were distributed randomly by generating lists from phone books, voter registries, and clearing house lists. Approximately 24,000 questionnaires were sent out to men and women in different cities over a three year period of time. Four-thousand surveys were distributed to Salt Lake City in 1992 with a response rate of 227 (5.7 percent response rate). In 1993, 10,000 questionnaires were sent

to San Francisco, California with a return rate of 355 (3.6 percent response rate). Thirty-eight surveys were also collected from the Utah State Prison, Salt Lake City, Utah (response rate information is not available). The last surveys were distributed in 1994 to Chicago, Illinois, and New York City, New York. Ten-thousand surveys were sent with a yielded return of 334 (3.3 percept response rate). Out of the 24,000 surveys sent to the various locations, 954 respondents returned the questionnaires. The total response rate was 4.0 percent. After excluding the uncompleted surveys, 878 questionnaires were used to create the data set.

In 1992 and 1993 the TSC-33 did not include the sexual subscale; it was not until 1994 that the TSC-40 was created. Therefore only data received in 1994 was used in the following study. Due to this, the total number of woman who experienced CSA in this sample was 467. The Los Angeles County Catchout study indicated that 6.8 percent of respondents reported a history of CSA (Finkelhor, 1984). The return rate in the present study was considered adequate because of the type of study and this particular population (Finkelhor, 1984).

A likely explanation for the low response rate is the sensitive nature of the topic: Many sexual abuse survivors refuse to participate because of embarrassment or because of the trauma they continue to experience. Another factor could be the length of the questionnaires as well as how the questions were worded (Finkelhor 1986). This could have potentially biased the sample because many women who were sexually abused in childhood refused to participate. However, by collecting data using random survey research, researchers were able to assess a nonclinical population which will better represent the general population. There is a disadvantage to this sampling method in that

bias exists as to the type of abused women that were willing to take the time and effort to fill out the lengthy survey. Perhaps education levels could have played a role in who was willing to fill out the survey. Many sexual abuse survivors who function at a low level were probably not assessed because of the data collection design (Bagley, 1991).

Subject Demographics

As indicated in Table 1, there were a total of 467 women in the study. The average age was 37.5 years with a standard deviation of 9.91 and a range from 15 to 82 years old. Fifty-eight percent of the women in the sample were married at the time the survey was administered while 10 percent were in a significant relationship and 36 percent were not in a significant relationship.

With regards to education, only 2 percent had less than a high school diploma, while 25 percent of the women finished high school. Seventy percent advanced beyond high school with 26 percent obtaining a bachelor's degree and 15 percent receiving graduate degrees.

The majority of the sample reported household incomes of 20,000-39,999 (33%) while 20 percent reported earning 0-19,999 per year. Sixteen percent made 40,000-59,999 per year and 15 percent made 60,000-79,999 yearly income. Less than 3 percent made over 100,000 per year.

As indicated in Table 1, the majority of participants were Caucasian (88%) and 4 percent her Hispanic. About 8 percent of the population was made up of the following ethnic groups: Black, American Indian, Asian, and Polynesian.

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

Variable		**Percentages**	
Variable	**Mean**	**S.D.**	**Range**
Age	37.35	9.91	15-82
Marital Status			
Married		57.81%	
In Significant Relationship		9.64%	
Not in Significant Relationship		35.55%	
Education			
Less than High School		2.1%	
High School		25.1%	
Vocational Tech.		9.9%	
Associate Degree		18.2%	
Bachelor's Degree		26.4%	
Graduate Degree		15.0%	
Other		3.3%	
Income			
0-19,999		20.34%	
20,000-39,999		32.98%	
40,000-59,999		16.27%	
60,000-79,999		15.42%	
80,000-99,999		9.21%	
100,000+		2.57%	
Race			
Black		1.7%	
Caucasian		88.2%	
American Indian		1.1%	
Hispanic		3.9%	
Asian		2.6%	
Polynesian		2.1%	
Missing		.4%	

Subject Inclusion Criteria

For the purposes of the present study the following were screened out: men, females under 18 years old, those who did not complete the Trauma Symptom Checklist-40, the Internalized Shame Scale, the Severity of Abuse Scale, the frequency of abuse

question, the duration of abuse questions, the identity of the perpetrator question, and women who had no sexual abuse history.

Instruments

Three scales were used in the present study. The Trauma Symptom Checklist-40 measures sexual disturbances. The Internalized Shame Scale measures the extent to which victims have internalized shame. The Severity of Abuse Scale measures the severity of the sexual assault. Three additional survey questions measure frequency, duration, and the identity of the perpetrator.

The Trauma Symptom Checklist-40 (TSC-40)

Since the TSC-40 has a subscale of 7 items that measure sexual problems, it was selected as the appropriate measure for sexual disturbances. The TSC-40 consists of 40 items that are rated on a Likert Scale which includes the following responses: 1 = Never; 2 = Occasionally; 3 = Fairly Often; and 4 = Very Often. There are six total subscales which include: Dissociation, Anxiety, Depression, Sexual Abuse Trauma Index, Sexual Problems, and Sleep Disturbances.

Elliot and Briere (1992) were the first to test the reliability and validity of the TSC-40. Several other studies measure the reliability and validity of the TSC-33, but the TSC-40 adds the sexual problems subscale. They found that the new Sexual Problems subscale displayed a reliability coefficient of .73. This subscale appears to be a reliable measure and discriminates between women with a sexual abuse history and non abused women. One single question, “bad thoughts or feelings during sex” was placed in the Sexual Abuse Trauma Index (SATI) and this question has a reliability of alpha .62.

Not only was each of the subscales highly significant and good at detecting which women had experienced sexual abuse, but the overall total TSC-40 score was significantly greater for women who experienced sexual abuse. The average victim in this study had a higher TSC-40 score than approximately 68% of non abused participants. Thus the TSC-40 is a measure with both reliability and validity.

Table 2. Factor Loadings for TSC-40 (8 items related to Sexual Problems)

Items	**Initial Factor Loadings**	**Loadings in SEM Model**
Bad thoughts during sex	.92	.97
Being confused about sexual feelings	.94	.96
Having sex that you didn't enjoy	.86	.92
Low Sex Desire	.70	.73
Sexual problems	.82	.76
Having sexual feelings when you shouldn't have them	.33	Dropped
Not satisfied with your sex life	.31	Dropped
Sexual over-activity	.20	Dropped

Cronbach's alpha was run for this sample. The internal validity was .90.

Internalized Shame Scale

The ISS was designed to measures the extent to which subjects have internalized painful levels of shame (Cook, 1991). It is a 30-item Likert scale instrument in which one = never and five = almost always. An answer of "never" would receive a score of 0, while "almost always" would receive a score of 4. The questions were derived from the literature that has been published on shame. Possible scores range from 0 to 96 with high scores indicating more severe shame. According to the ISS Manual, any score above 50 indicates a relatively frequent experience of internalized shame

There are two subscales, the shame scale which consists of 24 questions and the self-esteem scale which has only 6 items. The self-esteem scale was added in order to

curb the possibility for a response set because the shame questions are all worded in the same direction (Cook, 1991). It was not intended to be a valid measure of self-esteem and will not be included in the current study.

Alpha reliability score for the total scale was .96 (Cook, 1991). The 9 week test-retest reliability coefficient was .84. It appears that the ISS is a reliable measure to use for research.

The ISS scale has been correlated with measures for self-esteem and self-concept. The correlation for self esteem was -.66 when using the Tennesse Self Concept Scale with a nonclinical population (Cook, 1981). A number of studies have also explored shame and depression and have generated correlations from .44 to .79. These studies show the strong relationship between the ISS and measures of depression for both clinical and nonclinical populations. Also, these studies show that a score of 60 or above on the ISS indicate clinical depression. Other validity data has been conducted looking at correlations between shame and eating disorders, anxiety, and anger. Each of these studies produced strong correlations which indicate that the ISS is a valid measure (Cook, 1991).

Severity of Abuse Scale

The Severity of Abuse Scale (SAS) was developed by Wilkin (1992) to assess the severity of sexual abuse. This refers to unwanted bodily contact of a sexual nature prior to the age of 18 by a perpetrator who is either a family member or non family member. The SAS has a specific scoring procedure that was not used for the purposes of this study. The SAS will be used to assign the severity of the sexual abuse on a continuum from no abuse, to abuse that did not include touch, touching or fondling excluding such activities

as oral sex, and intercourse and aggressive touch including such activities as oral sex. For the purposes of this study, these 4 categories were created using the questions from the SAS.

A respondent's severity of CSA score was based on the number of statements marked in the affirmative. A respondent who marked none of the statements was categorized in the "no child sexual abuse" category. A respondent who marked any of the statements indicated the occurrence of child sexual abuse. The non-contact child sexual abuse category applied to participants who marked any statement a. through d. which indicated that there was some abuse but no physical contact was made. Examples of this category are "made sexual comments to me" and "forced me to show my genitals (sex organs)." A respondent who marked statements e. through i. which reflected physical contact of a sexual nature but excluded oral sex and intercourse was placed in the "contact child sexual abuse" category. Examples of "contact" statements included, "fondled me (touched me) through my clothes" and "forced me to masturbate him/her (touch, run, feel his/her sex organs) with my fingers or hand." A respondent who marked statements j. through m. which reflected sexual contact including intercourse was placed in the "contact with sexual intercourse" category. An example of a "contact with sexual intercourse" statement is, "forced me to have intercourse with him."

The SAS is a reliable measure of severity of sexual abuse with an alpha coefficient of .77. Concurrent validity was determined by correlating the total SAS scores with the TSC-33 subscale post sexual abuse and yielded a coeffiecient of .53. Correlations with the total TSC-33 scale was .54 which is an acceptable score (Wilkin, 1992).

CHAPTER FOUR

Results

Variable Statistics

Table 3 presents descriptive statistics of the variables of interest in the present study. While all of the participants were sexually abused, more than 75 percent of the sample participants were not physically abused while less than 25 percent were physically abused during the sexual abuse. About 27 percent of the sample did not know the identity of the perpetrator while 73 percent knew their abuser. Twenty-nine percent of respondents stated that the perpetrator was an extended family member, while 28.5 percent was an immediate family member, and 16 percent was a known other.

The mean for the duration of abuse was 2.82 years with a standard deviation of 3.70 years and a range of less than one year to 21 years. The frequency of abuse had a mean of 2.96 (in which a score of 2 means they were approached weekly and a score of 3 means they were approached several times a month) with a standard deviation of 2.13 and a range of 1 to 7. The mean for severity of abuse was 2.22 with a standard deviation of .68 and a range from 1 to 3. The total shame scores of participants had a range of 32-120 with a mean of 64.85 and a standard deviation of 18.97. A score of 50 or above is the clinical cut off score which indicates that the individual's level of internalized shame may be interfering with their ability to function effectively.

To following 5 questions came from the TSC-40, sexual problems subscale and all have a range of 1 to 4. The statement Bad Feelings During Sex had a mean of 2.14 (SD= .74); Confused About Sexual Feelings indicated a mean of 2.27 (SD=.73); Don't

Enjoy Sex had a mean of 1.99 (SD=.69); Sexual Problems mean was 1.87 (SD=1.02); and lastly the statement Low Sex Drive yielded a mean of 2.44 (SD=1.07).

Table 3. Means, Standard Deviations, and Ranges for Continuous Variables and Percentages for Categorical Variables (Physically Abused, Identity of Perpetrator) (N=467).

Categorical Variable	**Percentages**
Physically Abused	
Yes	24.1%
No	75.9%
Perpetrator Identity	
Unknown Other	26.8%
Known Other	15.6%
Extended Family Member	29.1%
Immediate Family Member	28.5%

Continuous Variable	**Mean**	**S.D.**	**Range**
Duration of Abuse	2.82 yrs	3.70 yrs	Less than 1 - 21 yrs
Frequency of Abuse	2.96	2.13	1 - 7
Severity of Abuse	2.22	.68	1 - 3
Total Shame Score	64.85	18.97	32 -120
Bad Feelings During Sex	2.14	.74	1 - 4
Confused About Sex Feelings	2.27	.73	1 - 4
Don't Enjoy Sex	1.99	.69	1 - 4
Sexual Problems	1.87	1.02	1 - 4
Low Sex Drive	2.44	1.07	1 - 4

Correlations Between Variables

Table 4 presents the correlations between all the variables in the study. All of the TSC-40 questions are highly correlated with one another and are significant ($p<.01$). Also as indicated in Table 4, Physical Abuse and the Duration of sexual abuse have a correlation of .29 and Physical Abuse and Severity have a correlation on .28. Both have a p-value less than .01. The Identity of the Perpetrator and the Duration of abuse have a correlation of .39 ($p<.01$). Duration and Frequency of sexual abuse have a correlation of .32 ($p<.01$) and Frequency and Severity have a correlation of .31 ($p<.01$). The

correlation matrix shows that there are no problems with multicollinearity among the independent variables since none exceed .70. Therefore it was not necessary to remove or combine any of the independent variables.

Table 4. Correlations Between All Variables in the Study. (N=467)

	1	2	3	4	5	6	7	8	9	10	11
1	1										
2	.22**	1									
3	.29**	.39**	1								
4	.18**	.23**	.32**	1							
5	.28**	.17**	.20**	.31**	1						
6	.16**	.04	.02	.08	.15**	1					
7	.06	.11*	.04	.09*	.08	.18**	1				
8	.15**	.15**	.05	.20**	.17**	.21**	.52**	1			
9	.11*	.12**	.07	.12**	.12**	.20**	.74**	.58**	1		
10	.12**	.10*	.10*	.18**	.19**	.21**	.57**	.67**	.82**	1	
11	.18*	.08	.09	.23**	.23**	.21**	.57**	.69**	.78**	.93**	1

* p<.05, ** p<.01, ***p<.001

Key
1. Physical Abuse
2. Identity of the perpetrator
3. Duration
4. Frequency
5. Severity
6. Shame
7. Low Sex Drive
8. Sexual Problems
9. Doesn't Enjoy Sex
10. Bad Thoughts Feelings During Sex
11. Being Confused About Sexual Feelings

Study Hypotheses

Three hypotheses were tested during the course of the present study. The first two regard direct paths in the model and the third regards indirect paths in the model. It was predicted that there would be a positive relationship between scores on variables of physical abuse, severity of abuse, frequency of abuse, duration of abuse, identity of perpetrator, and scores on the variable of inhibited sexual disturbances. Second, that there would be a significant positive relationship between scores of internalized shame and scores of inhibited sexual disturbances. And third, that there would be a significant positive relationship between scores on variables of physical abuse, severity of abuse, frequency of abuse, duration of abuse, identity of the perpetrator and scores on the variables of internalized shame.

Results of Hypotheses

Positive Relationship Between Independent Variables and Inhibited Sexual Disturbances

Hypothesis one was partially supported because a positive relationship did exist between frequency of abuse and sexual inhibition and severity of abuse and sexual inhibition. As shown in table 5, the path to inhibited sexual disturbances for frequency of sexual abuse had a regression weight of .11 and a standardized beta of .05 ($p<.01$). The path to inhibited sexual disturbances for severity of sexual abuse had a regression weight of .12 and a standardized beta of .13 ($p<.01$). These paths were significant as shown by standardized betas. Hypothesis one was partially unsupported because physical abuse, identity of the perpetrator, and duration had no significant relationship with inhibited sexual disturbances.

Positive Relationship Between Shame and Inhibited Sexual Disturbances

Hypothesis two was supported by the model. The variable shame had a regression weight of .19 and a standardized beta of .05 in its path to sexual inhibition ($p<.001$). Shame has a positive relationship to inhibited sexual disturbances.

Positive Relationship Between Independent Variables and Shame

Hypothesis three was partially supported by the model. As indicated in Table 5, the regression weight of physical abuse was .14 with a standardized beta weight of 16.44 ($p<.001$) and the regression weight of severity of sexual abuse was .14 with a standardized beta of 8.66 ($p<.05$). Therefore, physical abuse and the severity of sexual abuse have a positive relationship with the moderating variable shame. The identity of the perpetrator, duration of abuse, and frequency of abuse had no significant relationship to shame, their standardized betas were not significant in the model.

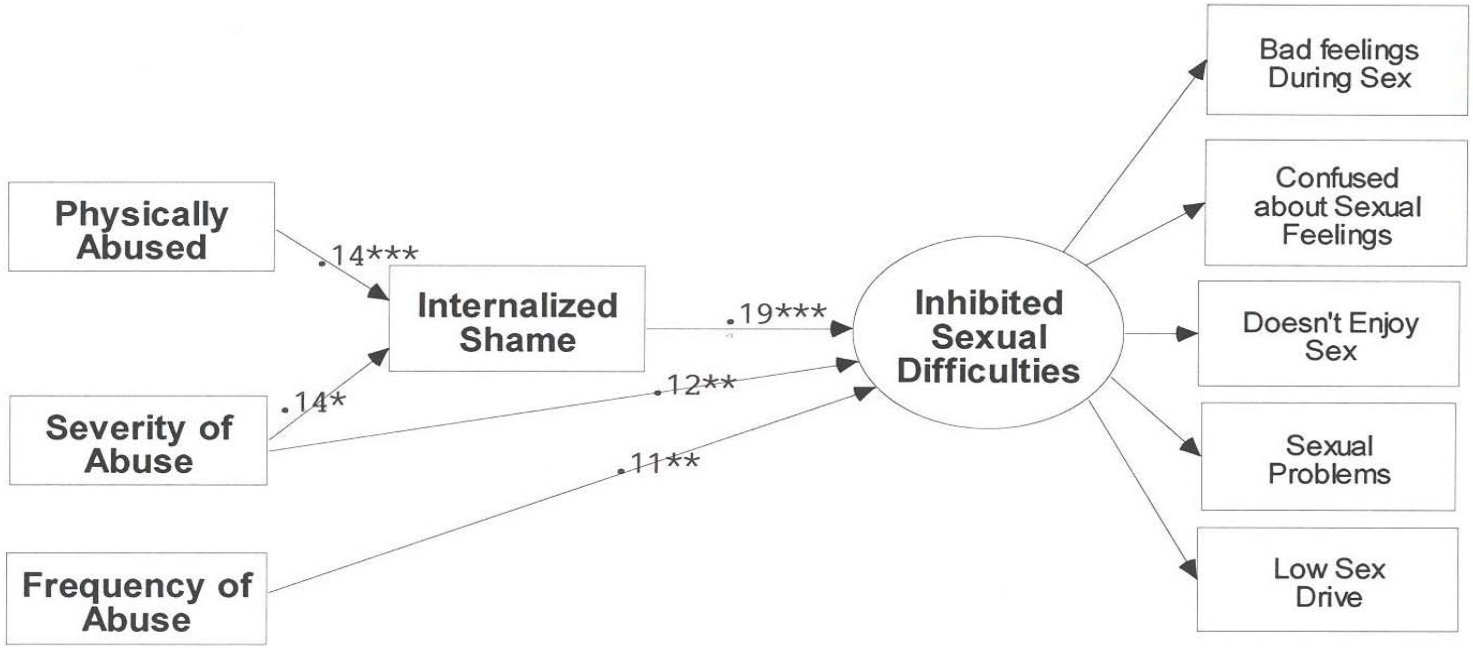
Table 5. Regression Weights and Significance Levels for Direct and Indirect Paths in Model for Inhibited Sexual Difficulties. (N=467, Standardized Betas and Unstandardized Betas in Parentheses)

Direct Paths in SEM Model		
Variables	**Path to Shame**	**Path to Inhibited Sexual Disturbances**
Physical Abuse	.14 (16.44)***	.03 (.05)
Identity of Perpetrator	-.02 (.03)	-.02 (.05)
Duration of Abuse	-.02 (.01)	-.06 (.00)
Frequency of Abuse	.04 (.06)	.11 (.05)**
Severity of Abuse	.14 (8.66)*	.12 (.13)**
Indirect Paths in SEM Model		
Variable	**Path to Inhibited Sexual Disturbances**	
Shame	.19 (.05)***	

*p<.05, **p<.01, ***p<.001

The Chi Square result was 16.7 with 29 degrees of freedom which is non significant. The goodness of fit index (GFI) was .967, and the Comparative Fit Index

(CFI) was .952. The RMSEA was .06. All of these fit indices show that the hypothesized model is an adequate fit to the structure of the data.



Chi Square=16.7, df=29, GFI=.967

Figure 2. SEM Results for Frequency of Abuse, Severity of Abuse, and Physcial Abuse to Shame and Inhibited Sexual Difficulties.

Summary of Results

The most interesting finding of the study was that although severity and frequency of sexual abuse had a direct positive relationship to inhibited sexual difficulties, there is an indirect statistically significant relationship. Physical abuse along with severity of sexual abuse has a positive relationship to internalized shame which has a statistically significant relationship to inhibited sexual difficulties.

CHAPTER FIVE

Discussion

The purpose of this study was to examine factors such as internalized shame, physical abuse associated with sexual abuse, identity of the perpetrator, severity, duration, and frequency of sexual abuse, and their association with inhibited sexual difficulties. Through Structural Equation Modeling using AMOS, results indicated that the frequency and severity of CSA had a direct positive relationship with sexual inhibition. Also, shame had a direct positive relationship with sexual inhibition. Results also showed that two indirect relationships existed; physical abuse and severity of CSA had a positive relationship to shame which had a positive direct relationship to sexual inhibited difficulties. It seems that there is no relationship between the identity of the perpetrator and the duration of abuse with sexual inhibition or shame.

From the findings of this study, it is apparent that responses to abuse, while individual, provide some patterns which help predict sexual responsiveness. These findings indicated that women who were physically abused while severely and frequently sexually abused during their childhood experienced internalized shame associated with significant inhibition during adulthood.

Findings Consistent With Previous Research

Severity and frequency of CSA were demonstrated to directly affect sexual inhibition. These findings were consistent with the reviewed literature. Gijseghmen and Guthier (1994); Felming, et al. (1999); Sarwar and Durlak (1996); and Saunders, et al. (1992) all found that the greater the severity of abuse, the more likely women were to exhibit signs of sexual inhibition, such as fear of sex and men, no pleasure during sex,

painful intercourse, and lack of arousal and lubrication. Other research points out that a higher frequency of abuse leads to greater sexual inhibition (Tsai, et al., 1990; Kinzl, et al., 1995; Charmoli & Athelstan, 1988).

In the present study, no relationship was significant in relation to the duration of CSA and the identity of the perpetrator. Other research has also found that no relationship exists between duration and sexual inhibition (Briere, 1988; Briere & Zaidi, 1989; Elliott & Briere, 1992; Gold, et al., 1994; Runtz & Roche, 1999). Research on the effects on sexual disturbances based on who the perpetrator was varies. But many researchers have found that it has no effect on sexual behavior outcomes (Finkelhor, 1979; Seidner & Calhoun, 1984; Tufts, 1984; Russell, 1986; Banyard & Williams, 1996; Briere, 1988; Briere & Zaidi, 1989; Parker & Parker, 1991; Roesler & McKenzie, 1994; Runtz & Roche, 1999; Sarwar & Durlak, 1996; and Usher & Dewberry, 1995).

Shame as a Moderating Variable

In trying to determine why some women experience sexual inhibition as a result of sexual abuse while others respond with other sexual difficulties, shame seemed to have theoretical and clinical validity but was untested. It is interesting that shame moderated the relationship between physical abuse and severity to inhibited sexual difficulties and had a direct positive relationship to inhibited sexual difficulties.

As stated during the review of literature, women who develop the shame prone identity see themselves as flawed, insufficient, and unworthy of having basic needs met. Common beliefs and statements made by such women are, “something is wrong with me,” and “I will be exploited and harmed by others.” Often time’s women with shame-prone identities distort incoming information during the perceptual process in order to fit

it into their lived reality which states that they are insufficient and unlovable (Harper & Hoopes, 1990). Although sex drive and sexual desire are natural and normal, shame-prone women may avoid these experiences because they are afraid of being exploited or harmed by others. When their husband or partner approaches them sexually in a loving relationship, they may distort the meaning of the advances and fit it into their previous experiences and truly believe that they will be exploited. They may also feel shame in wanting to fulfill sexual desires and thus avoid them because they view themselves as not deserving pleasure.

According to Harper and Hoopes (1990), someone who experiences shame believes that they are fundamentally and internally flawed and therefore do not believe that they can influence their situation and do not wish to disclose their inner selves because they are afraid that no one would be capable of valuing them or be able to see their true self. The act of sexual intimacy is a very vulnerable experience. For many people, trust, love, and acceptance are necessary for them to want to engage in a sexual relationship. Women need to feel connected and needed in order to give of themselves sexually. A shame prone woman cannot be vulnerable and truly connect with others and therefore cannot put herself in vulnerable situations where her true self might be overlooked or exploited. This finding has implications for therapy with individual women who have been abused as well as their husbands and partners.

Physical Abuse and Internalized Shame

Confirming Harper and Hoopes (1990) conceptual model, physical abuse did increase the amount of internalized shame a person experiences. Physical abuse is a situation that inflicts pain and terror in the victim. Physical abuse is very explicit in that a

child is told that they are bad, stupid, or clumsy and they are then punished for their deficits in a cruel manner. They are dismissed by the people they need to be loved by the most. Children have the right to be dependent on their parents, to receive comfort and care, and have their parents be dependable and do what they say they will do. A child who experiences physical abuse does not have these rights because they are constantly told they are worthless and then have their basic childhood rights taken from them. When physical abuse is combined with childhood sexual abuse is clear to see why there was such a positively significant relationship to internalized shame. Through both types of abuse, the messages that the abusers send children is that they are worthless and they do not deserve to be treated with love and care. Because they are constantly being hurt and victimized the child assumes and incorporates into their belief system that she is flawed and therefore no one should have to love her.

When physical abuse is added to sexual abuse as it was measured in this study, it increases the vulnerability of the victim exponentially. More severe sexual abuse would lead to shame because the child has to endure more explicit sexual acts that make little sense and may be physically or emotionally painful and intrusive for the child. These situations can be even more confusing to a child because the sexual exchanges may feel physically good, yet deep down they feel that this should not be happening and in fact they do not want it to be happening. The sexual abuse makes them feel dirty, defiled, and undeserving of love and care. In some cases more severe sexual abuse such as penetration may be extremely painful for a child. In these situations they may be getting two incongruent messages. One is the perpetrator telling the child to enjoy it and relax because they love the child yet the “expression of love” is physically painful. A child

who is made to believe that the way to receive love is through sexual exchanges may feel shamed that they cannot accept it and enjoy it like their perpetrator tells them to.

Traumatic Sexualization: Positive Relationship Between Frequency, Severity, and Inhibited Sexual Difficulties

The direct relationship that frequency and severity had on inhibited sexual difficulties can be understood by examining Finkelhor and Browne's (1986) conceptualization. They state the severity of abuse may be associated with the degree of traumatic sexualization a victim experiences. For example, if the offender actively stimulates and forces the child to participate in sexual activity the degree of traumatic sexualization will be greater than if the offender used a passive child to masturbate. This may lead the child to associate all sexual activity with negative emotions and memories. As an adult the negative associations will be so engrained that an avoidance of sex may be necessary for some women to cope. This association of sex with negative memories and emotions might also lead a woman who does engage in sex to disassociate, disconnect, or numb herself to the experience which would therefore make sex not enjoyable. Women who are unable to dissociate from the event may experience bad feelings or confusion during sex because they are re-experiencing the emotions they felt during the CSA. It seems that if the frequency of abuse is often that the severity they experience would also increase. It seems unlikely that a perpetrator would abuse a child weekly and maintain less severe abuse consistently. Therefore high frequency might lead to more severe acts of sexual abuse which could make inhibited responses more likely.

Implications for Clinical Practice

This research has many implications for Marriage and Family Therapists who are working with clients who have experienced sexual abuse. If a female survivor of childhood sexual abuse is married and is inhibited sexually, it will most likely cause some strain on not only the sexual relationship but the overall marital relationship as well. Wendy Maltz (1988) proposed an approach to sex therapy for couples in which one partner is an adult survivor of sexual abuse. One of her main goals is to help clients determine what sexual acts remind them of the abuse and to avoid those specific acts. She also suggests changing old initiation patterns, what sex consists of, the frequency of sexual relating, and the type of communication that takes place during sex. While these are good suggestions and may be helpful for some couples, this research points to the fact that a therapist must deal with the shame in order to help a woman become less inhibited sexually. If the woman was shamed by her sexual abuse she may not be able to enjoy and participate in sex even with all the best sex therapy until she has processed and worked through the beliefs that she is flawed and insufficient as a human being.

Appropriate sex therapy for inhibited sexual difficulties is done in the context of good marital therapy that deals with shame. If a therapist is aware that his or her client experienced physical as well as sexual abuse and experienced more severe sexual abuse, the therapist should be keenly aware that shame might be a factor worth exploring. Because humans all have different temperaments and different levels of resiliency, it is important not to rule out shame based on the fact that the abuse was not severe. Shame may be more based on the individual's interpretation of the events and the meaning they gave to them. A therapist needs to be able to explore and validate feelings of shame

despite not seeing good reason for it's presence in a client's life.

More common sex therapy techniques and those that are specific for CSA survivors may become more effective once shame has been properly dealt with and challenged in therapy. A women needs to feel worthwhile, valuable, and deserving basic human rights in order for her to regain what she lost during the abuse, one such right being the right to enjoy human sexuality.

Limitations and Strengths of the Study

This study included 467 women who had been sexually abused as children and were willing to discuss their sexual difficulties. This is a large sample in comparison to many of the previous research studies on sexual disturbances in sexual abuse survivors. Secondly, the participants were a non-clinical population where many studies have looked only at clinical populations. These strengths make these findings quite significant contributions to the literature. That having been said, there are several limitations in the present study.

One of the biggest limitations is that this study was based on a preexisting data set. Therefore, tailored questions that fit the specific purposes of the study could not be asked. The data set is also about 10 years old.

The questionnaire was extremely long which could have been part of the reason for lower response rates. This data did come from several different geographical locations, however the response rate, although adequate, was low. The participants who chose to take the time to respond to the lengthy questionnaire are likely to be a somewhat biased sample in terms of functioning, time to invest, or their inherent interest in furthering research on CSA.

The data is also retrospective, therefore adult women were asked to recall experiences from their childhood. This gives us information on how participants chose to remember their abuse experiences. Another weakness was that all the 7 sexual problems subscale questions did not hold together in the model so only 5 were used as part of the dependent variable inhibited sexual difficulties.

Future Research

Sexual abuse has been studied by many scholars. Consistently, there appears to be much damage done in the process of abuse. Unfortunately, most of the research is focused on the direct results of the abuse such as anxiety and depression. Limited research has addressed the interactions of variables which protect the victims or intensify the symptoms. The present study found that shame was statistically significant and had a positive relationship to inhibited sexual difficulties. Shame may play a role in promiscuity as well. Future research should examine the relationship between shame and promiscuity.

Another research question that should be explored is the interplay between family type and later sexual outcomes. Perhaps some family types such as "chaotic" would increase the amount of shame a child experienced thus not allowing him or her to heal from the experience. Answering this research question would help therapists know whether family therapy or individual therapy would be more helpful in overcoming feelings of shame and thus decreasing chances of inhibited sexual difficulties later on in adult life.

Conclusions

Based on the current study it is apparent that internalized shame, severity of sexual abuse and frequency of sexual abuse are factors in predicting inhibited sexual disturbances. With the strong indirect relationship between severity of abuse and physical abuse it is clear that as the abuse becomes more intense, internalized shame increases and the probability that these women will experience sexual inhibition increases.

The major implication of this study is that sexual abuse has a significant impact on the ability of survivors to be involved in intimate relationships. Many women who were sexually abused as children cannot be vulnerable and truly connect with others when they believe that their true selves might be overlooked or exploited. Since the act of sexual intimacy is a very vulnerable experience. For many people, trust, love, and acceptance are necessary for them to want to engage in a sexual relationship. Unless the underlying loss of self is addressed, therapy with sexually abused women will not be successful. Therefore, it is important that treatment of sexual difficulties in women who have been sexually abused as children include work on internalized shame as well as work directed at the specific symptoms.

APPENDICES

Appendix A

Trauma Symptom Checklist 40 (TSC-40) Sexual Subscale

COPING AND SATISFACTION: 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.

1=NEVER 2=OCCASIONALLY 3=FAIRLY OFTEN 4=VERY OFTEN				
h. **Low sex drive**	1	2	3	4
v. **Sexual Problems**	1	2	3	4
w. Sexual over-activity	1	2	3	4
hh. Not feeling satisfied with your sex life	1	2	3	4
jj. **Having sex that you didn't enjoy**	1	2	3	4
ll. **Bad thoughts or feelings during sex**	1	2	3	4
mm. **Being confused about your sexual feelings**	1	2	3	4
nn. Having sexual feelings when you shouldn't have them	1	2	3	4

*Bolded items used in this study

Appendix B

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.

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 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 I have much to be proud of.
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.

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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. stimulated (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. physically abused me ____ Yes ____ No. At what AGE?___ By WHOM_____

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