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THE RELATIONSHIP BETWEEN SEVERITY OF CHILDHOOD
SEXUAL ABUSE AND ADULT PERCEPTIONS OF INTIMACY
WITH INTERNALIZED SHAME AS A MEDIATOR

by

Sarah Williamson

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 2009

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BRIGHAM YOUNG UNIVERSITY

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ABSTRACT

THE RELATIONSHIP BETWEEN SEVERITY OF CHILDHOOD SEXUAL ABUSE AND ADULT PERCEPTIONS OF INTIMACY WITH INTERNALIZED SHAME AS A MEDIATOR

Sarah Williamson

Department of Marriage and Family Therapy

Master of Science

A community sample of adult women (N = 581) were surveyed to determine whether internalized shame mediated the relationship between severity of childhood sexual abuse and adult perceptions of intimacy in couple relationships. Characteristics of abuse, duration of abuse, frequency of abuse, age when the abuse began, and physical force used during the abuse were used to determine severity of abuse. It was predicted that 1) women sexually abused as children (N = 318) and non-abused women (N = 263) would significantly differ in their levels of internalized shame and their perceptions of intimacy; 2) severity of abuse would be inversely related to perceptions of intimacy; 3) severity of abuse would be positively related to internalized shame; and 4) internalized shame would significantly mediate the relationship between severity of abuse and

perceptions of intimacy. Through a MANOVA and structural equation modeling using AMOS, the results indicated a statically significant difference between levels of shame and perceptions of intimacy in abused and non-abused women. Results also indicated as severity of abuse increases, perceptions of intimacy decrease and as severity of abuse increase, internalized shame increases. Shame was found to be a complete mediator of the relationship between severity of abuse and perceptions of intimacy. Clinical implications, study strengths and limitations, and direction for future research are discussed.

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TABLE OF CONTENTS

| | |
|---------------------------------------|----|
| CHAPTER ONE..... | 1 |
| Introduction..... | 1 |
| Operational Definition of Terms | 3 |
| CHAPTER TWO..... | 5 |
| Review of Literature..... | 5 |
| Severity of Abuse..... | 5 |
| Intimacy..... | 9 |
| Internalized Shame..... | 22 |
| Summary of Review of Literature..... | 24 |
| Significance of Study..... | 25 |
| Statement of Purpose | 26 |
| Hypotheses | 26 |
| CHAPTER THREE..... | 27 |
| Methods..... | 27 |
| Subjects and Data Collection..... | 27 |
| Design and Statistical Analysis | 30 |
| Measures | 31 |
| Severity Latent Variable..... | 31 |
| Shame Latent Variable..... | 34 |
| Intimacy Latent Variable..... | 35 |
| CHAPTER FOUR | 37 |

| | |
|--|----|
| Results..... | 37 |
| Variable Statistics | 37 |
| MANOVA Results..... | 37 |
| Correlation Results for Abused Women | 38 |
| Results of Hypotheses..... | 39 |
| CHAPTER FIVE..... | 43 |
| Discussion | 43 |
| Findings Consistent with Previous Research | 43 |
| Clinical Implications..... | 44 |
| Strengths and Limitations of Study | 47 |
| Future Research | 48 |
| Conclusions | 49 |
| REFERENCES..... | 51 |
| APPENDICES..... | 60 |
| Appendix A | 60 |
| Appendix B | 62 |

LIST OF TABLES

| | |
|---|----|
| Table 1. Demographic Characteristics of Sample (n = 581)..... | 29 |
| Table 2. Means and Standard Deviations for All Variables | 38 |
| Table 3. MANOVA Results..... | 38 |
| Table 4. Correlations Between All Variables in the Study (n = 318)..... | 40 |

LIST OF FIGURES

| | |
|--|----|
| Figure 1. Measurement and Conceptual Model Examining the Role of Shame as a Mediator Between Severity of Childhood Sexual Abuse and Intimacy | 32 |
| Figure 2. Standardized Betas for Structural Model with Shame Mediating the Relationship Between Severity of Sexual Abuse and Intimacy, Controlling for Relationship Type, Relationship Length, and Distance from Age of Abuse..... | 41 |

CHAPTER ONE

Introduction

Despite the growing awareness of childhood sexual abuse (CSA) in the United States, it remains a significant problem with considerable long-term effects. Predicted prevalence rates of CSA vary widely, spanning from 2% to 46% (Bolen & Scannapieco, 1999). Overall prevalence rates are difficult to come by, especially given how under-reported CSA is; however, meta-analysis findings estimated between 30% and 40% of women have a history of CSA (Bolen & Scannapieco, 1999; Gorey & Leslie, 1997). Individual study analysis estimates are more conservative and estimate between 21% and 32% of women were sexually abused as children (Vogeltanz, et al., 1999). When conducting a national survey, Finkelhor, Ormrod, Turner, and Hamby (2005) found that 8% of the children and youth surveyed had experienced some sort of sexual victimization during the previous year.

As clinicians, it is important to understand the effects CSA may have on clients because such abusive acts have the potential to devastate victims. Some long-term effects of CSA include depression, anxiety, post-traumatic stress disorder, eating disorders, interpersonal problems, marital discord, sexual disturbances, substance abuse and self-harming behaviors (Hunter, 2006; Mullen, Anderson, Romans, & Herbison, 1996; Plousny & Follette, 1995). Experiencing problems with intimacy and feelings of guilt and shame are also long-term effects of CSA (Davis & Petretic-Jackson, 2000). Generally, the more severe the abuse, the more likely survivors will experience negative outcomes and the more intense the effects (Coffey, Leitenberg, Henning, Turner, & Bennett, 1995; Dube et al., 2005).

Recent studies which examine the quality of intimate relationships among CSA survivors were not found; however, intimacy in survivors of childhood sexual abuse attracted a great deal of attention in the late 1990s. In 1996, Feinauer, Mitchell, Harper, and Dane clearly documented the connection between severe childhood sexual abuse, persistent negative perceptions of self (shame), psychological symptoms, and adjustment difficulties. Adjustment difficulties included the inability to establish trusting intimate interpersonal relationships. While physical intimacy has often been the focus of research on intimacy, there is evidence that other aspects of intimacy are also affected. In general, survivors of CSA perceive their relationships as poorly adjusted when compared to non-abused study participants (Feinauer, Callahan, & Hilton, 1996). CSA survivors and their partners frequently report difficulties with emotional communication and emotional intimacy (Pistorello & Follette, 1998). In both clinical and community samples, female survivors reported having difficulty in relationships with men (Romans, Martin, Anderson, O'Shea, & Mullen, 1995). Although problems with intimacy have been identified as an effect of CSA, there is little or no research which explains the variance in ability of CSA survivors to create and maintain intimate relationships. While guilt and shame have been postulated as factors which may contribute to problems with intimacy, they have not been adequately studied.

Guilt and shame have been identified as common effects of sexual abuse (Zlotnick, Zakriski, Shea, & Costello, 1996). Shame, in turn, has been identified as a mediating or moderating factor for other symptoms commonly seen in CSA survivors such self-harm behaviors and depression (Milligan & Andrews, 2005; Cheung, Gilbert, & Irons, 2004). Specifically in reference to CSA, Whiffen and MacIntosh (2005) found that

shame, along with interpersonal difficulties and avoidant coping strategies, acts as a mediator for symptoms of depression, anxiety, dissociation, and trauma.

As indicated above, relationship distress and intimacy issues are frequently associated with CSA and shame has been identified as an influential factor for many of the effects of CSA; however, there are few empirical studies investigating the relationship of shame to survivors' relationship intimacy. The purpose of this study was to identify how severity of childhood sexual abuse is related to adult intimacy and how internalized shame mediates that relationship. The relationship between shame and quality of intimacy is important to establish so therapists can effectively treat intimacy problems which may stem from internalized shame resulting from sexual abuse.

Operational Definition of Terms

Child sexual abuse (CSA). Child sexual abuse was defined in this study as a child or adolescent under the age of 16 being involved in sexual activities she does not and cannot fully comprehend and to which she does not fully consent (Feinauer, 1989).

Severity of abuse. For this paper, severity of abuse was stratified according to different types or levels of sexual acts committed by the perpetrator. Three levels of abuse were identified using the Severity of Abuse Scale (Wilkin, 1992): non-contact abuse, contact abuse, and intercourse. Duration of abuse, frequency of abuse, age at which the abuse occurred, and the amount of force used were also used to determine severity.

Internalized shame. Shame was defined as a persistent perceived sense of being insufficient or flawed as a person (Harper & Hoopes, 1990). Shame was measured using the three subscales of the Internalized Shame Scale (Cook, 1991). The three subscales are

inferiority, empty/lonely, and exposed/fragile. Higher scores indicate higher amounts of shame.

Intimacy. Intimacy in a relationship occurs when individuals share bonding experiences in several domains of the relationship and there is the expectation that the relationship and experiences will continue over time (Schaefer & Olson, 1981). Intimacy was measured using Schaefer and Olson's Personal Assessment of Intimacy in Relationships Scale (PAIR). The scale measures both the respondents' perceived and ideal levels of emotional, social, sexual, intellectual, and recreational intimacy. Only perceived intimacy will be used for this study.

CHAPTER TWO

Review of Literature

The following review of literature will examine the research on the variables pertinent to this study, including victim and abuse characteristics that contribute to severity of abuse; relationship of intimacy as affected by child maltreatment in general and sexual abuse in particular; and internalized shame and its relationship to CSA. Each area will be explored and a summary of the literature will be included.

Severity of Abuse

As with other types of abuse, sexual abuse experiences differ in severity. One focus of early CSA research attempted to determine what factors contributed to the severity of abuse. Many researchers were interested in whether or not variables such as duration and frequency of abuse, the age of the victim when abuse occurred, and the amount of force used, and the level of intrusiveness had any impact on how traumatic the abuse was to the victim.

Duration and Frequency of Abuse

Brown and Finkelhor conducted a comprehensive review of the literature in 1986. This study has become a classic article for the study of childhood sexual abuse. Browne and Finkelhor reviewed victim and abuse characteristics to determine which were empirically shown to be more traumatic for CSA survivors. Duration and frequency were highly correlated and consequently, Browne and Finkelhor (1986) did not separate these two characteristics. The authors noted that clinicians take for granted that the longer and more frequent the abuse, the more trauma is experienced by victims. The research they reviewed, however, did not necessarily support this. Some of the studies they reviewed

showed a clear positive association between duration, frequency and trauma (Bagley & Ramsay, 1985; Briere & Runtz, 1985; Friedrich, Urzuiza, & Beilke, 1986; Russell, 1986). Other studies found no such relationship (Finkelhor, 1979) and others, surprisingly, showed the opposite to be true. Courtois (1979), for example, found adult victims with the longest occurring abuse to be the most self-accepting.

Though there is not a great deal of more recent information, there does appear to be more consensus that frequency and duration do have an impact on the severity of symptoms the survivor experiences. Kendall-Tackett, Williams, and Finkelhor (1993) concluded in their review of literature that both frequency and duration were associated with a greater number of symptoms for the victims. In a recent study, Zink, Klesges, Stevens, and Decker (2009) found that the number of abuse occurrences was linearly related to the amount of trauma experienced by the victim. Zinc et al. (2009), did not examine duration as a severity factor.

Age Abuse Occurred

Browne and Finkelhor (1986) also reviewed the literature on the impact of the age of the victim when the abuse occurred. They noted that there had been some debate as to whether older children or younger children would be more traumatized by the abuse. Browne and Finkelhor (1986) noted that some scholars were of the mind that younger children would experience more trauma because of their impressionability, whereas others thought perhaps younger children would be protected from the negative effects of abuse by their naïveté.

Browne and Finkelhor (1986) found that there were a few studies that showed younger children are somewhat more vulnerable to the trauma of sexual abuse

(Meiselman, 1978; Courtois, 1979). Other research showed small, but nonsignificant positive associations between the age the abuse occurred and the amount of trauma the child experienced (Finkelhor, 1979; Russell, 1986). In their 1993 review, Kendall-Takett et al. concluded that the relationship between a victim's age and severity remains unclear. However, the small amount of recent data shows an association between age of the first abusive experience and trauma, with trauma decreasing as age of abuse gets older. (Zink et al, 2009).

Force Used During Abuse

In their first review, Browne and Finkelhor (1986) noted that although several studies they examined had difficulty finding an association between trauma and other variables, they did find positive associations between trauma and the amount of force or aggression used during the abusive experience. Some research indicated that force, more than any other variable, accounted for the victim's negative reactions (Finkelhor, 1979; Russell, 1986). Though there were a few studies that had different findings, Kendall-Tackett et al. (1993) noted that force used during the abuse was consistently associated with negative outcomes among CSA survivors.

Intrusiveness of Abusive Act

One of the most consistent findings throughout the literature has been that the more intrusive the abusive act, the more traumatized the child and the more likely the survivor will suffer long-term effects. Though some researchers used simple dichotomous scales to measure the intrusiveness of sexual abuse (Marcenko, Kemp, & Larson, 2000), most researchers attempted to determine some degree of abusiveness. Most measures of abuse have used a scale with some variation of three categories such as no abuse, genital

contact, and penetration or attempted penetration (Dube et al., 2005; Mullen et al., 1996; Testa, VanZile-Tamsen, & Livingston, 2005).

Past and recent research has consistently indicated that the more severe the abuse itself (meaning the intrusiveness of the abusive acts), the more severe the outcomes for the survivors. Both Browne and Finkelhor (1986) and Kendall-Tackett et al. (1993) found that abuse involving penetration was related to an increase in symptoms. Bagley and Ramsay (1985) found penetration to be the most important variable when explaining the severity of mental health problems in survivors of CSA. More recent research (Coffey, et. al., 1995) confirms these early findings. Coffey et al. (1995) found the level of sexual activity involved in the abuse accounted for much of the variation in the level of stigmatization the victims felt, as well as the amount of self-blame they felt. Higher, or more severe, levels of sexual activity involved in the abuse increased these negative self-perceptions. Other researchers found that the severity of the abuse increased the risk of victims abusing alcohol, using illicit drugs, attempting suicide, marrying an alcoholic, and reporting current marital or family problems (Dube et al., 2005).

In summary, there are many possible factors that can contribute to the overall severity of sexual abuse. These factors include abuse frequency and duration, the age of the victim, the amount of force used, and the level of intrusiveness. The more frequent and the longer the abuse went on, the younger the victim, the more force was used, and the more intrusive the abuse, the more traumatic the abuse is to the victims and the greater the symptomology in adulthood. The more severe the abuse, the more the survivors experience both short and long-term negative effects. These associations between severity and long lasting effects are important to keep in mind when examining

any adult outcomes that are known to be influenced by a history of childhood sexual abuse.

Intimacy

According to Bacon and Lein (1996), interpersonal issues are often a primary worry of CSA survivors. They often report relationship discord, difficulty in developing or maintaining trust and intimacy in relationships, and sexual dysfunction. All of these issues have the potential to interfere with intimacy. Various forms of child abuse and maltreatment have been found to impact the adult survivor's relationships (Davis, Petretic-Jackson, & Ting, 2001) and therefore will be briefly reviewed. All child maltreatment is destructive, but according to Finkelhor and Browne (1985), sexual abuse is particularly damaging. Finkelhor and Browne's reasoning for this will be examined, followed by a review of common relationship patterns seen in the survivors of CSA, as well as some of the issues surrounding survivors' partners. Lastly, possible moderators of adult intimacy for CSA survivors will be discussed.

General Child Abuse/Maltreatment and Adult Intimacy

According to Davis et al. (2001), child abuse in general is associated with adult interpersonal difficulties. Women who experienced multiple forms of abuse (i.e., physical and sexual) reported a greater fear of intimacy when compared to women who experienced either a single type of abuse or no abuse at all. Ducharme, Koerola, and Battle (1997) found in their review of literature that most clinicians report that physical abuse interferes with intimacy development and consequently the ability to create intimate relationships in adulthood.

Other researchers have expanded their research to study both child abuse and neglect and also what was termed “child maltreatment.” DiLillo, Lewis, and Di Loreto-Colgan (2007) looked at the effects of five types of child maltreatment including emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect. Of the 174 participants, 117 were female and all were in committed, heterosexual, dating relationships. Of these women, 44.4% reported having experienced child maltreatment. Five aspects of relationship functioning were measured. DiLillo et al. (2007) found that females with a history of child maltreatment had significantly higher scores on measures of poor relationship functioning and psychological distress, except negative sexual attitudes. Female maltreatment survivors were more likely to respond to sexual overtures with disgust, fear, or shame. Female survivors were also 28% more likely to experience aggression in their intimate partner relationships than their counterparts who experienced no maltreatment.

Colman and Widom (2004) obtained a sample of individuals who were involved in court documented cases of child abuse or neglect during 1967-1971. The participating children were matched with a control group and 25 years later, they were interviewed. Of the original sample, 1,196 agreed to participate as adults. Colman and Widom (2004) found that stability and quality of intimate relationships of adults maltreated as children significantly differed from these qualities of relationships in non-abused adults. Abused and neglected adults reported significantly more relationship disruption. Even when controlling for disadvantaged backgrounds, it was the abuse and neglect that appeared to contribute most to the relationship outcomes. Abused and neglected women were

especially at risk for experiencing intimacy related difficulties such as relationship dissatisfaction and sexual unfaithfulness.

Sexual Abuse: Interpersonal Violation and Traumagenic Dynamics

Though all abuse is harmful to its victims, sexual abuse appears to have greater potential to be so because it represents such an extreme violation of interpersonal trust. Finkelhor and Browne (1985) theorized that the reason for this has to do with what they called traumagenic dynamics. These dynamics distort children's cognitive and emotional orientation of the world. These theorists postulated that trauma is created by distorting children's self-concept, world view, and affective capacities. For example, traumatized children do not have a clear understanding of the control they have over their lives or their self-worth. The four traumagenic dynamics presented are traumatic sexualization, betrayal, powerlessness, and stigmatization.

Traumatic sexualization. Traumatic sexualization occurs when "sexuality is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion because of sexual abuse" (Finkelhor & Browne, 1985, p. 531). The level of traumatic sexualization may differ depending on numerous factors. For example, if a perpetrator tries to stimulate the child's sexual response cycle or uses manipulation instead of force, the child may experience more traumatic sexualization than a child who did not experience these factors. The theorists also presented the possibility of children who are older and have more understanding of sexuality in general experience more traumatic sexualization when compared to younger children.

The results of this type of trauma are many for both children and adult survivors. Children may have an inappropriate repertoire of behavior, be confused or have

misconceptions about their sexual self-concept, or experience unusual emotions associated with sexual activity. Children may also have a preoccupation with sexual things, engage in repetitive sexual behavior such as masturbation, and sometimes even become sexually aggressive toward other children. As adults, survivors may experience aversions to sex and intimacy. They may also have flashbacks, difficulty with arousal or orgasm, and/or have negative attitudes about sex or their bodies (Bacon & Lein, 1996; Cobia, Sobansky, & Ingram, 2004). As adults CSA survivors may also be confused about sexual norms and standards (Finkelhor & Browne, 1985).

Betrayal. Finkelhor and Browne (1985) describe betrayal as the realization that someone on whom the child was vitally dependent has caused them harm. This realization may occur during the abuse or afterward. Betrayal can also result from the realization that they were manipulated or treated with disregard by someone who did not believe them when they disclosed the abuse. There is more potential for betrayal among survivors who were abused by a family member.

The effects of betrayal include grief reactions and depression over the loss of a trusted figure in their life. The survivor may feel disenchanting or disillusioned. Children may demonstrate clinginess to safe adults as a way of regaining trust and security. Children may also have impaired judgment about the trustworthiness of adults. This impaired judgment potentially continues into adulthood and can become barriers to survivors having successful marriages. Hostility, anger, and distrust may manifest by the survivor isolating or demonstrating an aversion to intimate relationships (Bacon & Lein, 1996; Cobia et al., 1996; Finkelhor & Browne, 1985).

Powerlessness. The third traumagenic dynamic proposed by Finkelhor and Browne (1985) is powerlessness, which could also be called disempowerment. This occurs when the child's will, desires, and sense of efficacy are continually disregarded. The child feeling powerless is a result of their territory and body being invaded against his/her will. Powerlessness is likely to be exacerbated if attempts to stop the abuse are thwarted or if the child attempts to report the abuse and is not believed. When greater force is used to accomplish the abuse, a greater sense of powerlessness may result, although this is not always true.

The effects of powerlessness can begin in childhood and extend into adulthood. Survivors are known to have experienced nightmares, phobias, clinging behavior, hypervigilance, and somatic complaints (Zink et al., 2009). At least some of these effects are likely a result of the anxiety that surrounds the feeling of not having control (Cobia et al., 2004). Powerlessness could explain learning problems, running away, and employment problems seen in survivors. Survivors may also feel the need to control and dominate people and situations around them (Finkelhor & Browne, 1985).

Stigmatization. The fourth and last traumagenic dynamic is stigmatization, or “the negative connotations (e.g., badness, shame, and guilt) that are communicated to the child around the experiences and that then become incorporated into the child's self-image” (Finkelhor & Browne, 1985, p. 532). Stigmatization may be communicated by the perpetrator or others that the child is to blame for the abuse. The child may also be demeaned or shamed by the experience. Pressure to keep the experience a secret may also compound guilt the child feels. Their secret is likely to make the child feel different than others which also perpetuates the problem. Stigmatization is easily enforced by what the

child hears in their community or family. For example, the child is likely to feel more stigmatized when they here others making comments about “spoiled goods” or “loose morals.”

The results of stigmatization include feelings of guilt or shame that can persist into adulthood (Coffey et al., 1995). Teens and adults may become involved in substance abuse, criminal activity or prostitution (DiLillo, 2001; Hunter 2006). They may engage in self destructive behavior as extreme as suicide attempts (Dube et al., 2005; Hunter, 2006). Low self-esteem and the feeling of being different are also effects of stigmatization (Cobia et al., 2004; Fassler et al., 2005; Finkelhor & Browne, 1985).

Given the traumatic sexualization, betrayal, powerlessness, and stigmatization that CSA survivors may experience, it is no surprise that interpersonal functioning in adult survivors’ relationships may be affected. Although there is a body of literature that suggests survivors’ adult relationships may be characterized by lack of trust and intimacy, there has been only minimal investigation into the nature of the partner relationships of the survivors (Polusny & Follette, 1995). This lack of research is surprising given the severity of the breach of trust CSA entails and the possibility of it having long term effects on how these children as adults, experience relationships that should be trusting. There has, however, been some research published on specific relationship patterns often seen in the survivors of CSA.

Common Patterns of Interpersonal Responses by Survivors of CSA

Davis and Petretic-Jackson (2001) presented three relationship patterns seen in CSA survivors based on a review of literature. The first pattern consists of the survivor having difficulties with or fear of intimacy. Often the survivor experiences great mistrust

and does not know how to relate to others, but they still attempt to establish relationships. Because of possible boundary issues or the sexualization of relationships that should not be sexual, relationships (including sexual relationships) are brief and transient. Perhaps it should not be surprising that many victims of CSA sexualize relationships given that Herman (2000) found many of the CSA survivors she interviewed expressed the belief that “men are only after one thing,” meaning sex. Given the mixed messages they received as children, it makes sense that survivors would seek to form connections with men through sexuality. Davis and Petretic-Jackson (2001) also note that some CSA survivors may not be able to separate sex from affection and therefore pursue sexual relationships in an attempt to feel cared for.

The second relationship pattern identified by Davis and Petretic-Jackson (2001) is similar to the first in that the CSA survivor experiences fears of intimacy, but instead of attempting to form any sort of intimate relationships, she avoids both intimacy and sex. The authors note that this is likely a result of the breach of trust the survivor experienced as a child and that she uses isolation as protection against the painful possibility of further misplaced trust.

Unlike the first pattern in which survivors engage in relationships that tend to be based on physical intimacy and are often transient in nature, the third relationship pattern commonly seen by CSA survivors involves the individual having issues with both intimacy and sexuality, but these concerns are superseded by the need to be in a relationship. This contributes to longer, though not necessarily healthy, relationships. As a result, she continues to search for a relationship in which she will not be afraid, will not distrust, and will not feel vulnerable. Survivors who demonstrate this pattern may lack

the judgment necessary to wisely determine who they can trust. They may also have low self-worth, and when combined with a lack of judgment, these women sometimes end up in relationships where they are re-victimized (Davis & Petretic-Jackson, 2001).

Given these various relationship patterns, it is perhaps not a surprise to find that overall CSA survivors have lower relationship satisfaction than their non-abused counterparts. DiLillo and Long (1999) found that CSA survivors have lower levels of relationship satisfaction and attribute it to the host of emotional and behavioral problems associated with sexual abuse and how those problems can interfere with healthy couple functioning. DiLillo and Long (1999) further analyzed their data and found that when controlling for marital status, age, and socioeconomic status, survivors still reported less relationship satisfaction, as well as poorer communication, and a lower quality of trust than non-abused women. There is also evidence that CSA survivors have less secure attachments than non-abused women (Whiffen, Judd, & Aube, 1999) and have ambivalent feelings (e.g., disillusionment, mistrust, idealization) about men in general (Briere, 1996). All of these factors can contribute to difficulties with intimate relationships.

CSA and Relationship Intimacy

A great deal of research has been devoted to the intimacy or relationship problems seen in CSA survivors' relationships. When examining various reviews on the topic, the most frequently identified relationship dynamic among CSA survivors is that they tend to report lower marital satisfaction and lower relationship quality than their non-abused counterparts (Cobia et al., 2004; Colman & Widom, 2004; DiLillo, 2001; Rumstein-McKean & Hunsley, 2001). Past research has also often found CSA survivors have a

mistrust of men in general and often a fear or mistrust of their partners (Cobia et al, 2004; DiLillo, 2001). Research has also indicated women with a history of CSA are more likely to get divorced or separate from their partners (DiLillo, 2001; Hunter, 2006; Rumstein-McKean & Hunsley, 2001). Other relationship and intimacy issues seen in CSA survivors, albeit less frequently noted in the current literature include difficulty forming and maintaining relationships, an increased likelihood of unfaithfulness on the part of the survivor, more marital discord, and poorer communication (Cobia et al., 2004; DiLillo, 2001; DiLillo & Long, 1999; Hunter, 2006)

Severity of Abuse and Relationship Intimacy

Research has indicated that there is disruption in most survivors' intimate relationships, but this is more pronounced in survivors who experienced more severe abuse. Mullen, Martin, Anderson, Romans, and Herbison (1994) found that victims of CSA were more likely to begin cohabiting before the age of 20 and this was particularly marked in the survivors who experienced intercourse as part of the abuse. All survivors reported less satisfying relationships, but intercourse victims reported the lowest. Of all the CSA cases, 23% stated they had no meaningful communication with their partner on an intimate level, but this increased to 36.8% when considering intercourse victims alone.

Liang, Williams, and Siegel, (2006) indicated that the more severe the sexual abuse, the more dissatisfied the survivor was with her marriage. Dube et al. (2005) also examined the effect of CSA on several outcomes. The authors surveyed 17,337 adult HMO members in San Diego, California. One quarter of the 9, 367 women surveyed had been sexually abused as children. Dube and her colleagues (2005) specifically included marital problems in their research. They found that CSA increased the magnitude of

negative outcomes, including marital problems, and reported that more severe abuse was consistently associated with an increase in these negative outcomes.

Experience of Partners of CSA Survivors

When reviewing literature regarding adult family relationships of CSA survivors, Rumstein-McKean and Hunsley (2001) found very few articles discussing the experience the partners of survivors of CSA. Reid, Mathews, and Liss (1995) found that partners feel isolated, angry, frustrated, and unsatisfied with their partner relationship. Reid, Wampler, and Taylor (1996) reported that marital communication between spouses was seen as problematic, confusing, and frustrating. The partners of survivors viewed these issues as stemming from the CSA.

Bacon and Lein (1996) also studied the partners of CSA survivors. They found that wives were often triggered by events not related to the marriage and reacted emotionally with their husbands. Husbands tended to find this confusing. The authors noted that the unpredictability of the CSA survivors was a consistent theme throughout the interviews. At the initial discovery of the CSA, partners of survivors reported feelings of shock, anger, grief, and a sense of being robbed. The healing process was seen as an emotional roller-coaster for both the men and their wives.

Partner Characteristics

Another issue that seems to contribute to intimacy issues in CSA survivors' relationships is their choice of partner. Testa, VanZile-Tamsen, and Livingston's (2005) research suggests that the connection of CSA and low relationship satisfaction in adult relationships is not due to the survivor's hostility toward men or other causes previously listed, but is in fact due to survivor's choosing partners that make relationship satisfaction

difficult. They consistently found that the relationship between CSA and satisfaction was mediated by the characteristics in the men with whom the survivors formed relationships. The partners of CSA survivors were more likely than non-abused persons' partners to be sexually aggressive, to have had significantly more past sexual partners, and to have been sexually unfaithful to their partners. Partners of CSA survivors also tended to be more physically aggressive than partners of non-abused wives. This approached statistical significance. The authors concluded that it was not surprising that satisfaction was lower in relationships where the men are more aggressive and sexually risky (Testa et al., 2005).

Whether marital satisfaction and intimacy are mediated by partner characteristics or not, the fact remains that CSA survivors show a trend of choosing partners who are less than ideal. Mullen et al. (1994) stated a strong case for the correlation between CSA and marital unhappiness, but warned that this may be because, or at least partly because, of the choice of partner and his behavior. They went on to suggest the possibility CSA survivors may be especially vulnerable to accepting and falling prey to men who are uncaring and over-controlling. The partners of CSA survivors have been described as often putting their own needs above that of the survivor. Some women with a history of CSA find loving supportive partners who are well-meaning and outwardly support the survivor, but then simultaneously hold her entirely responsible in some way for the couples' marital troubles. This "benevolent blame" perpetuates feelings of shame and stigmatization that already exist (DiLillo, 2001).

If CSA survivors choose less desirable partners it would help explain why they experience higher rates of re-victimization when compared to non-abused women.

DiLillo, Giuffre, Tremblay, and Peterson (2001) found that CSA survivors were twice as likely to experience at least one incident of physical violence in current couple relationships. Cyr, McDuff, and Wright (2006) also found that victims of CSA were more likely than non-abused women to be victimized by their partners. Interestingly, if the CSA survivor experienced more severe abuse, meaning abuse involving intercourse, she was even more likely to experience physical abuse in later romantic relationships.

Moderators/Mediators of CSA and Adult Functioning

A last important factor to consider when examining intimacy is the idea that other variables may act as mediators of moderators between it and CSA. Although this idea has not received a great deal of attention, some researchers have focused on general adult functioning in terms of psychological distress. Coffey et al. (1995), for example, determined an indirect link between CSA and its long-term effects. They focused on how perceived stigma, betrayal, powerlessness, and self-blame mediate the relationship between CSA and adult psychological distress. They found that the survivor's current perceptions of stigma and self-blame did indeed mediate the relationship between a childhood sexual abuse experience and adult psychological distress.

Roche, Runtz, and Hunter (1999) were also able to find a mediator between CSA and psychological distress. They determined that though a history of CSA predicted attachment style and psychological adjustment, CSA no longer predicted psychological adjustment when adult attachment style was considered a mediator. The problem with this model, however, is that because CSA is such a detrimental breach of trust, the adult attachment style CSA survivors develop is potentially influenced to a significant degree by the abuse. Indeed, Roche et al. (1999) also found that women with a history of CSA

had less secure attachments and more fearful attachments than women who did not experience abuse. The insecurity in relationships with CSA survivors has also been noted by other researchers (i.e., Whiffen et al., 1999).

DiLillo et al. (2007) looked specifically at couple functioning, including fear of intimacy. They found that the relationship between an abusive history and different areas of couple functioning (i.e., fear of intimacy, negative attitudes about sexuality, negative reactions to sexuality, and physical aggression) were significantly reduced when current psychological functioning was taken into account. They proposed that abuse history operates indirectly through psychological distress to influence the relationship of the couple. An area of psychological distress for CSA survivors that is particularly of interest for this study is that of shame.

Child abuse has been found to have a profound effect on survivors' adult intimate relationships (Davis et al., 2001; Ducharme, Koerola, & Battle, 1997; DiLillo et al., 2007). Finkelhor and Browne's (1985) exposition of traumagenic dynamics suggest that sexual abuse is particularly destructive. Because of the traumatic sexualization, betrayal, powerlessness, and stigmatization, survivors often exhibit relationship patterns that do not demonstrate healthy patterns of intimacy (Davis & Petretic-Jackson, 2001). Some researchers propose that the reason survivors have such problems with intimacy is due to their early experiences with abuse, while others postulate it is because survivors tend to pick partners that make intimacy difficult (Mullen et al. 1994). Regardless, there appears to be another variable that helps to explain both the inability of survivors to create close, intimate relationships and/or to select disrespectful partners. That variable is internalized shame. Although numerous variables have been proposed as mediators between CSA and

some areas of adult functioning, the literature search revealed no studies of mediators between CSA and intimacy specifically.

Internalized Shame

According to Talbot (1996), shame is a core emotion of sexually abused women. For most people, the experience of feeling shame is not a major obstacle to developing a healthy identity. However, for some shame becomes a chronic condition. Shame becomes a problem when an individual develops a shame-prone or shame-based identity which leads to the formation of a negative personal identity (Harper & Hoopes, 1990). An individual with a shame-prone, negative self identity, views him or herself as fundamentally and irreparably flawed or damaged.

Shame in Abuse Survivors

Erickson (1950) identified shame as the outcome of a child not developing autonomy. Others have built on Erickson's theory, adding new elements, such as helplessness and powerlessness, to the idea of shame resulting from a lack of autonomy. These new elements clarify why CSA survivors often develop shame-prone identities. Feinauer, Hilton, and Callahan (2003), add that victims of CSA endure experiences they cannot prevent, control, or escape from, thus learning they are powerless. They do not have the power to control their environment. Other factors such as victims being implicitly and explicitly blamed, discounted, and held responsible for unwanted experiences, combined with feelings of powerlessness, create a sense in victims that they are internally flawed, and thus they experience high levels of internalized shame.

Even after abuse stops, shaming experiences often continue. As female CSA survivors get older, they may better understand the societal taboo against sexual contact

with children. Coffey et al. (1995) found that women who experienced CSA, especially abuse that involved higher levels of sexual activity, experienced higher levels of self-blame. They suggest that higher levels of sexual activity may result in an increased sense of being tainted or damaged goods. The authors also theorize that because of the more extensive sexual contact, survivors may feel they had more of an opportunity to stop the abuse and therefore experience more self-blame.

Survivors frequently continue to experience blame for the abuse. Herman (2000) found that most incest survivors in her study obtained some kind of pleasure from the abusive experiences. The pleasure was sometimes physical, but often it was emotional and a result of the victim being singled out as special, given special treatment, or put into the role of mother. Because they enjoyed some sort of reward through the abuse, survivors' guilt and shame intensified. Herman proposed that the guilt victims felt over this confirmed the women's beliefs that they did not deserve to be loved and cared for and deserved only men who would manipulate and abuse them.

As shaming and blaming experiences continue even after the abuse stops, it is not surprising that feelings of shame are common among CSA survivors. Andrews (1995) found that in her sample of 101 women, there was a significant correlation between childhood sexual abuse and bodily shame. In 1994, Pisoni found that when compared to a nonclinical female sample, her sample of 172 female CSA survivors also experienced significantly higher levels of shame.

Although shame is not always specifically identified in empirical studies, researchers have been interested in behaviors and attitudes stemming from a shame-prone belief system. McGinn (2006) studied cognitive schemas of CSA survivors and found

that survivors learn to believe that they are defective, which is the basis of a shame-prone identity. Herman (2000) reported that almost all of the incest survivors in her clinical sample referred to themselves in negative or derogatory terms (i.e., bitches, witches, or whores), again demonstrating the internal belief these women had that their very being is flawed or bad.

Summary of Review of Literature

Not all CSA survivors are affected by abuse in the same way. Various factors such as the frequency and duration of abuse, the age of the victim when the abuse occurred, the amount of force used, and the intrusiveness of the abuse contribute to how traumatizing the abuse is, and therefore contributes to the amount of harm done.

Though all child abuse is potentially harmful to survivors' adult relationships, sexual abuse is especially damaging. It is very apparent that adult survivors of CSA have more difficulty in intimate relationships than their non-abused counterparts. Patterns of interpersonal responses include having only transient relationships based mostly on a sex, completely avoiding intimate relationships, and continually searching for a redeeming relationship. Specific facets of adjustment in intimate relationships are also affected. CSA survivors experience more marital discord, more divorce and separation, less meaningful communication, and lower overall satisfaction than non-abused women. CSA survivors are also more likely to see their partners as less caring. Research has also indicated women with histories of CSA may be more likely to choose less caring partners. The severity of abuse impacts these outcomes with women who experienced more severe abuse having more difficulty with intimacy.

Shame has also been identified as a common result of CSA. A sense of powerlessness and helplessness restrict the development of autonomy and can lead to a shame-prone or shame-based self-concept. Victims of CSA experience higher rates of shame than women without an abusive past. There have also been findings regarding specific aspects of shame, such as victims referring to themselves in derogatory terms, which indicate shame in CSA survivors is relatively high. As other variables have been found to mediate the relationship between CSA and adult outcomes, shame also has the potential to mediate the relationship between CSA and intimacy.

Significance of Study

Treating relationship issues which arise for women sexually abused as children requires the clinician to understand any underlying dynamics which might interfere with the ability to trust or risk connecting to their partner. Sexual abusive experiences contaminate later intimate experiences. If in addition, the sexual abuse distorts the victim's sense of self so that they see themselves as defective, not worth loving, and as a burden, and they attempt to hide these feelings from others. This internalized shame must be treated or relationship intimacy cannot be achieved.

When determining what variables were associated with intimacy difficulties in CSA survivors, it is important to look at shame as well as the severity of the abuse. The literature clearly established the effects of sexual abuse on intimacy, but the research had not fully investigated the reasons CSA had such a detrimental effect on intimacy. As previously mentioned, shame is a common emotional experience in children who experience sexual abuse. However, it is unclear if the shame stemming from abusive experiences is associated with or could predict the intimacy difficulties so often seen in

survivors. By exploring the connection between shame and intimacy, clinicians will have an increased ability to assist survivors in creating and maintaining healthy intimate relationships by treating the deeper problem of shame which colors intimacy, instead of the more surface level social skill development, increased comfort with sexuality, or other common treatments for “intimacy issues.”

Statement of Purpose

The purpose of this study was to identify how severity of childhood sexual abuse is related to adult intimacy and how internalized shame mediates that relationship.

Hypotheses

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

H1: Survivors of childhood sexual abuse will have significantly more internalized shame and significantly lower perceptions of intimacy than women with no history of sexual abuse.

H2: Severity of abuse will be inversely related to the adult survivors’ perception of intimacy in their adult couple relationship.

H3: Severity of abuse will be positively related to internalized shame.

H4: Internalized shame will significantly mediate the relationship between severity of abuse and the perception of intimacy.

CHAPTER THREE

Methods

Subjects and Data Collection

The data for this study were collected as part of the Hardiness and Childhood Trauma Project (Feinauer et al., 1996). Data was gathered from four different communities that were randomly selected in Salt Lake City, Utah; San Francisco, California; Chicago, Illinois; and New York, New York. Households were randomly selected to receive surveys from generated lists from phone books, voter registries, and clearing house lists. Approximately 28,000 questionnaires were sent to men and women in different cities over a four year period.

The most recent information on the prevalence rates is the general population indicates approximately 8% of the population experienced sexual abuse as children (Finkelhor, 2005). As the researchers were specifically targeting individuals with a history of CSA, given Finkelhor's estimate, it was anticipated that of the 28,000 questionnaires sent out, the sampling population would only be approximately 2240. The total of 1054 questionnaires being returned represents a response of about 47%. Given that some of the questionnaires were returned by individuals who did not experience CSA, the response rate is actually somewhat lower than 47%. In 1991, 4,000 surveys were sent to residents of the Salt Lake City area. One-hundred fifty-eight surveys were returned for a 4% response rate. Four-thousand questionnaires were again distributed in the Salt Lake City area in 1992 with 227 returned for a response rate of 5.7%. In 1993, 355 of the 10,000 surveys distributed in San Francisco, California were returned for a response rate of 3.6%. The last surveys were distributed to both Chicago, Illinois, and

New York, New York in 1994. Of the 10,000 surveys sent out, 334 were returned for a response rate of 3.3%. Of the 28,000 questionnaires, 1054 were returned for a total response rate of 3.8%.

Overall, the response rate was low, but according to Dillman, Sinclair, and Clark (1993), there are several possible explanations for this. One explanation is the sensitive nature of the topic. Sexual abuse survivors sometimes refuse to participate in research because of embarrassment or because remembering the abusive experiences is traumatic. Another possible reason for the low response rate is the length of the questionnaires or how the questions were worded. This means the sample may be biased because many women who were sexually abused in childhood refused to participate. The sample may also be biased by the type of abused women that were willing to take the time to complete the lengthy survey. Education levels could also have played a role in who was willing or able to fill out the survey. Many sexual abuse survivors who had lower levels of functioning were probably not assessed due to this particular data collection design (Bagley, 1991). Despite these drawbacks, by collecting data using random survey research, researchers were able to better assess a nonclinical population and how it represents the general population.

Subject Demographics

For the purpose of this study, subject inclusion criteria consisted of adult females who completed the Severity of Abuse Scale, the Internalized Shame Scale, and the Personal Assessment of Intimacy in Relationships. Men, females under 18 years of age, and those who did not complete the required questionnaires were excluded.

As shown in Table 1, there were 581 women in the study. The total number of participants was split into two groups: abused (n = 318) and non-abused (n = 263). The average age for the women in the abused category was 36.42 with a standard deviation of 7.86. The average age for the women in the non-abused category was 35.47 with a standard deviation of 7.52. Of the abused women, 74.7% were married and 25.3% were in cohabiting with their romantic partner. On average, these women had been in their current relationship for 12.16 years with a standard deviation of 8.29 years. Of the non-abused women, 77% were married and 23% were in cohabiting with their romantic partner. These women had been in their current relationship for an average of 11.60 years, with a standard deviation of 8.13 years.

Table 1. Demographic Characteristics of Sample (n = 581)

| Variable | Abused | | Non-Abused | |
|-------------------------------|---------|--------------------|------------|--------------------|
| | Mean | Standard Deviation | Mean | Standard Deviation |
| Age | 36.42 | 7.86 | 35.47 | 7.52 |
| Length of relationship | 12.16 | 8.29 | 11.60 | 8.13 |
| Variable | Percent | | Percent | |
| Type of relationship | | | | |
| Married | 74.7% | | 77.0% | |
| Cohabiting | 25.3% | | 23.0% | |
| Education | | | | |
| Less than high school | 0.4% | | 2.4% | |
| High school graduate | 25.0% | | 28.2% | |
| Some college | 25.4% | | 28.5% | |
| Bachelors degree | 31.6% | | 26.9% | |
| Graduate/professional degree | 2.0% | | 11.0% | |
| Other | 0.6% | | 3.0% | |

In regard to education, .4% of abused women had less than a high school education, 25% were high school graduates, 25.4% had some college experience, 31.6%

were college graduates, 2% had a graduate or professional degree, and .6% had unknown educational levels. Of the non-abused sample, 2.4% had less than a high school education, 28.2% were high school graduates, 28.5% had some college experience, 36.9% were college graduates, 11% had a graduate or professional degree, and 3% had unknown educational levels.

Design and Statistical Analysis

Structural Equation Modeling (via AMOS 16.0) was used to test the relationship among the latent variables in the model (see Figure 1 below). The first step in data analysis was to determine how well the proposed indicators loaded on their respective latent variables.

The second step was to calculate descriptive means, standard deviations, and ranges for all of the measured variables. Third, MANOVA was conducted to establish the difference between abused and non-abused women on the shame and intimacy scales. Fourth, a correlation matrix was constructed for all of the variables in the model to ensure there were not multicollinearity problems among the variables.

Lastly, SEM modeling was used for the abused sample only to determine the strength and significance of paths in the model and the fit of the overall model. Control variables included type of relationship (whether marital or cohabiting) the length of this relationship and the amount of time that had passed since the abuse. The amount of time elapsed since the abuse occurred could potentially affect both shame and intimacy and was also included as a control variable.

Measures

Three latent variables were created for this study, severity of childhood sexual abuse, shame, and intimacy. Indicators for severity included self reported frequency of the abuse, self reported duration of abuse, self reported age of the victim when the abuse began, and self reported force used during the abuse. The second latent variable, shame, had three indicators (Inadequate/Deficient, Empty/Lonely, and Exposed/Fragile) which were the subscales of the Internalized Shame Scale (Cook, 1991) determined by Del Rosario and White (2006) through factor analysis. The dependent latent variable, intimacy, had five indicators, each of the subscales of the Personal Assessment of Intimacy and Relationships, PAIR (Shafer & Olson, 1981).

Severity Latent Variable

Characteristics of childhood sexual abuse

The Severity of Abuse Scale (SAS) was modified by Wilkin (1992) from Wyatt et al.'s (1992) measure. Wilkin (1992) modified the Wyatt Sex History Questionnaire to specifically assess the severity of childhood sexual abuse with sexual abuse being defined as unwanted bodily contact of a sexual nature before the age of 18 by a perpetrator who may or may not be a family member of the victim. The measure consists of 16 items with respondents indicating whether certain events had occurred. Respondents received a score ranging from 1 to 3 based on the kinds of sexual abuse experiences they reported. The three levels of severity were non-contact abuse (e.g, the perpetrator exposing his or her genitals, the child being forced to view pornography), contact abuse which includes touching or fondling that did

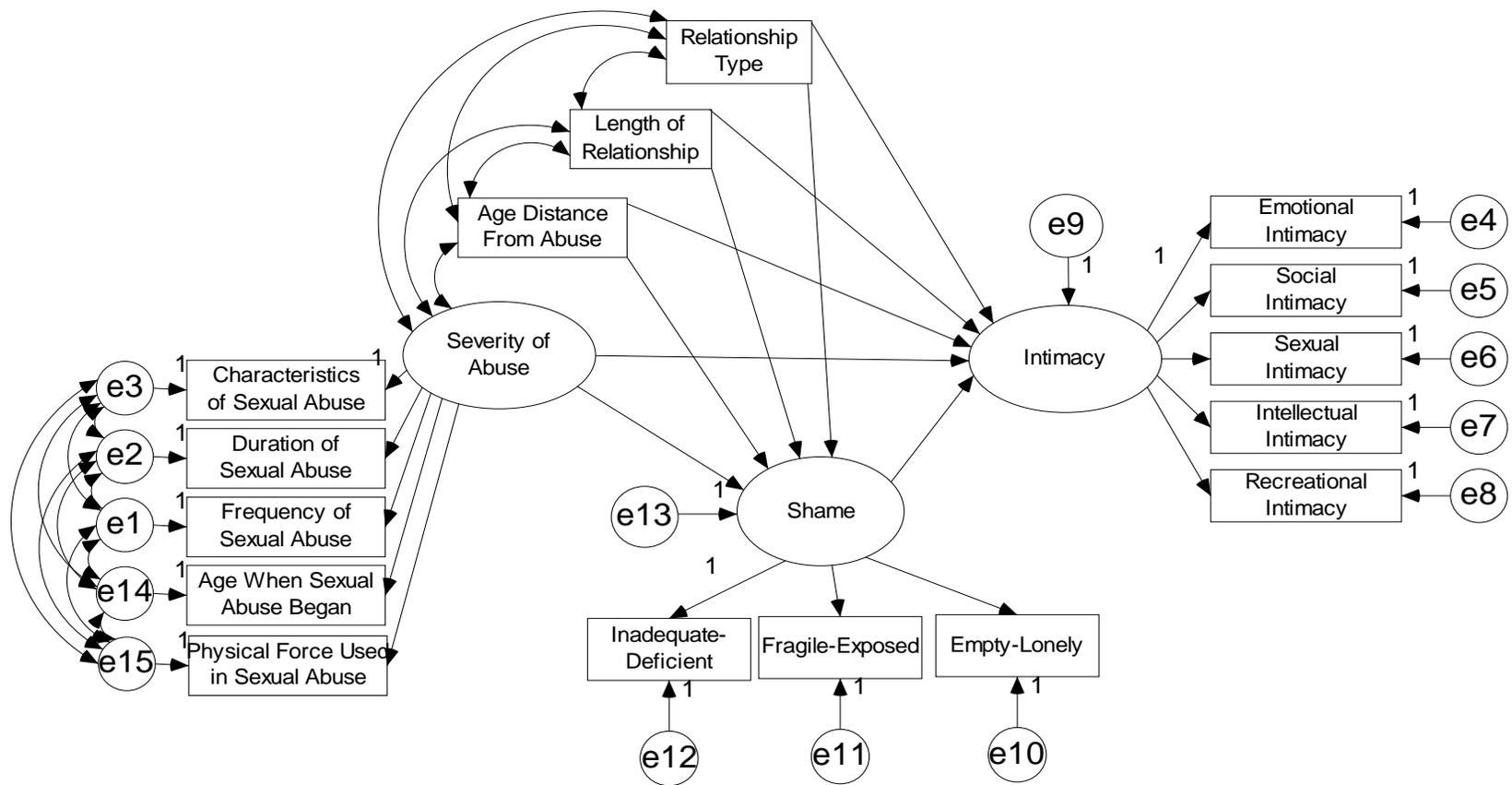


Figure 1. Measurement and Conceptual Model Examining the Role of Shame as a Mediator Between Severity of Childhood Sexual Abuse and Intimacy

not involve oral sex, and contact abuse which encompasses aggressive touch including vaginal and anal intercourse and oral sex.

Previous studies have shown that this measure exhibits high alpha coefficients, and the Cronbach's alpha coefficient for this sample was .77. Wilkin (1992) also showed that this measure was highly correlated with the overall and subscales of the Trauma Symptom Checklist-33.

Frequency, duration, age, and force

The frequency and duration of the abuse, age of the victim when the abuse began, and the amount of force used during the abuse were taken as individual questions from various other scales used in the questionnaire. Frequency of abuse was taken from one question: "How frequently were you approached sexually prior to the age of 18?" Possible answers ranged from it only occurring once to it occurring more than once a week. Scores were then assigned to the various answers with one being more than once a week, two being weekly, three being several times a month, etc. Scores ranged from one to seven with seven meaning the abuse occurred only once. Duration and age were taken from the same question which asked at what age the sexual abuse began and ended. Duration was measured in years. Force was measured using two questions that were originally a part of the Severity of Abuse Scale asking if they were physically abused during the abuse or if the perpetrator used a gun or knife to threaten them into participating. Scores ranged from zero to two with zero meaning the respondent answered no to both questions, a one meaning they answered yes to one questions, and a two meaning they answered yes to both questions.

Shame Latent Variable

The three subscales, Inadequate/Deficient, Empty/Lonely, and Exposed/Fragile of the Internalized Shame Scale, ISS (Cook, 1991) were used as indicators of this variable. The ISS measures the extent to which subjects have internalized levels of shame (Cook, 1991). The assessment contains 24 items that are divided into three subscales. The questions were answered on a Likert-scale with possible answers ranging from never to almost always. An answer of “never” would be scored as a zero and an answer of “almost always” would be scored as a four. Possible scores range from 0 to 96 with higher scores indicating higher amounts of shame. Del Rosario and White (2006) concluded that the ISS could be factored into three subscales called inadequate/deficient, empty/lonely, and exposed/fragile. The inadequate/deficient subscale consisted of twelve questions such as “When I compare myself to others, I am just not as important.” The range of scores for this subscale is 0 to 48. The empty/lonely subscale consisted of five questions such as “I feel like there is something missing.” The range of scores for this subscale is 0 to 20. The exposed/fragile subscale consists of eight questions such as “I think others are able to see my defects.” The range of scores for this subscale is 0 to 28. These three subscales will also be used to create the latent variable of internalized shame. The alpha reliability score for the complete measure was .96 (Cook, 1991). The nine week test-retest reliability coefficient was .84. Both of these scores indicate the ISS is a reliable research measure.

The ISS has also been correlated with instruments measuring self-esteem and self-concept. When correlating the ISS with the Tennessee Self Concept Scale using a non-clinical population, Cook (1981) found that there was a -.66 correlation. Several studies have also identified a connection between shame and depression and have indicated

correlations between .44 and .79. These studies demonstrate a strong relationship between the ISS and measures of depression. They have also shown that a score above 60 on the ISS indicate depression. Other data correlating the ISS with depression, eating disorders, anxiety, and anger produce strong evidence that the ISS is indeed a valid measure of internalized shame (Cook, 1991).

Intimacy Latent Variable

The Personal Assessment of Intimacy in Relationships, PAIR (Schaefer & Olson, 1981) is a 36-item Likert-type assessment with six subscales, each consisting of six items. Five of the subscales measure different aspects of intimacy: emotional, social, sexual, intellectual and recreational. The sixth subscale is included to measure conventionality or the tendency to respond to questions in a socially desirable way. With scores for both perceived and expected intimacy, it is easy to see the degree to which individuals see their ability to be intimate as acceptable or lacking. Only perceived scores were used in this study. Scores for both perceived and expected intimacy have a range of 0 to 96. The PAIR's internal reliability was tested using a split-half method of analysis. The alpha coefficient was found to be at least .70 for all six subscales. In this particular study, the alpha coefficient for emotional intimacy was .83, for social intimacy it was .78, for sexual intimacy it was .77, for intellectual intimacy it was .80, and for recreational intimacy it was .81. Validity was assessed by correlating the PAIR subscale scores to the Lock-Wallace Marital Adjustment Scale. Each subscale currently included in the PAIR was found to have correlation coefficients consistently exceeding .30. Most of the correlation coefficients were found to be significant at $p < .001$, except for a very few that were still found to be significant at $p < .01$ (Schaefer & Olson, 1981). Validity was

further assessed by correlating the PAIR with the Waring Intimacy Questionnaire (Waring & Reddon, 1983). The two measures were found to be significantly correlated with a coefficient of .77.

CHAPTER FOUR

Results

Variable Statistics

Table 2 shows the means, standard deviations for the non-abused and abused sample for all of the variables included in the present study. Of the sample, 55% (n=318) experienced childhood sexual abuse and 45% (n=263) reported they were not abused. For the abused sample only, the characteristics of abuse, with higher scores indicating more intrusiveness, the mean was 1.96 with a standard deviation of 0.82. The average duration of abuse was 2.95 years with a standard deviation of 3.39. The average frequency of abuse was 2.48 (with a score of 2 meaning they were approached weekly and a score of 3 meaning they were approached several times a month) with a standard deviation of 2.15. The average age the abuse began was 11.54 years with a standard deviation of 5.34 years. The mean for the amount of physical force used during the abuse was .29, with a standard deviation of .56, meaning relatively few of the respondents reported force as part of the abusive experience.

MANOVA Results

Two MANOVAs were separately conducted, one with the three subscales of shame as the dependent variable and one with the 5 subscales of intimacy as the dependent variable to examine differences between abused and non-abused women. As shown in Table 3, the overall MANOVA results show that abused and non-abused women were significantly different from each other for both shame and intimacy. The univariate results showed significant differences between the two groups on each subscale for shame and on each subscale for intimacy.

Table 2. Means and Standard Deviations for All Variables

| Variable | Abused (n=318) | Non-Abused (n=263) | | |
|--------------------------|---------------------------------|---------------------------------|----------|-------------------|
| | Mean (Standard Deviation) | Mean (Standard Deviation) | α | Factor Loading |
| Shame – empty/lonely | 9.96 (4.90) | 7.72 (3.84) | .94 | .82 |
| Shame – fragile/exposed | 19.06 (7.26) | 15.28 (5.56) | .90 | .93 |
| Shame – inad/def | 33.93 (11.07) | 28.08 (9.17) | .95 | .91 |
| Emotional intimacy | 54.92 (26.26) | 64.73 (24.23) | .83 | .91 |
| Social intimacy | 56.81 (17.11) | 60.46 (16.23) | .78 | .69 |
| Sexual intimacy | 62.64 (25.35) | 71.65 (21.85) | .77 | .70 |
| Intellectual intimacy | 58.57 (24.49) | 66.56 (22.29) | .80 | .93 |
| Recreational intimacy | 65.95 (21.11) | 71.08 (18.84) | .81 | .70 |
| Characteristics of abuse | 1.96 (.82) | N/A | N/A | .72 |
| Duration of abuse | 2.95 (3.39) | N/A | N/A | .72 |
| Frequency of abuse | 2.48 (2.15) | N/A | N/A | .68 |
| Age abuse occurred | 11.54 (5.34) | N/A | N/A | -.82 |
| Physical force | .29(.56) | N/A | N/A | .62 |

Table 3. MANOVA Results

| IV's | DV's | Multivariate analysis | | | Univariate analysis | | |
|-----------------------|------------------------------|-----------------------|----------|----------|---------------------|----------|----------|
| | | <i>df</i> | <i>F</i> | <i>p</i> | <i>df</i> | <i>F</i> | <i>p</i> |
| Abused vs non-abused | Shame – empty/lonely | 3, 577 | 17.53 | .001 | 1, 580 | 36.44 | .001 |
| | Shame – fragile/exposed | | | | 1, 580 | 47.88 | .001 |
| | Shame – inadequate/deficient | | | | 1, 580 | 46.76 | .001 |
| Abused vs. non-abused | Emotional intimacy | 5, 575 | 5.34 | .001 | 1, 580 | 21.58 | .001 |
| | Social intimacy | | | | 1, 580 | 6.87 | .001 |
| | Sexual intimacy | | | | 1, 580 | 20.60 | .001 |
| | Intellectual intimacy | | | | 1, 580 | 16.62 | .001 |
| | Recreational intimacy | | | | 1, 580 | 9.34 | .001 |

Correlation Results for Abused Women

Table 4 presents the correlations between all the variables in the study for the abused women. These correlations calculated to determine if there was a problem with multicollinearity among the independent variables. As show in Table 4, all of the ISS

subscales are highly correlated with each other. The PAIR subscales were also all significantly correlated which would be expected since these variables are being used as indicators for the latent variable, intimacy. All of the severity of abuse variables (characteristics of abuse, duration, frequency, age abuse began, and force used) were significantly correlated. The severity variables also were highly correlated to the shame subscales.. The shame and intimacy variables also had significant negative correlations. The strongest correlations between the severity variables and intimacy was seen among characteristics of abuse (intrusiveness) and all types of intimacy, as well as frequency and all types of intimacy. Although the independent variables (severity of abuse, internalized shame, and perception of intimacy) were significantly correlated, none were correlated above 0.6, which according to Hoffman (2005), indicates there are no problems with multicollinearity. It was, therefore, unnecessary to remove or combine any of the variables.

Results of Hypotheses

According to the MANOVA results in Table 3, the first hypothesis that there would be significant differences between abused and non-abused women on the shame and intimacy subscales is accepted.

As seen in Figure 2, the standardized regression weight for the path from severity of abuse to intimacy was .07 and not statistically significant. However, an SEM model (not shown) was also conducted to determine the significance of the relationship between severity and intimacy when shame is not included as a variable. The standardized beta (β) for an SEM model with severity and intimacy without shame was -.26 ($p < .01$). Therefore,

Table 4. Correlations Between All Variables in the Study (n = 318)

| | | | | | | | | | | | | | | | | |
|----|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-------|-------|-------|-------|----|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 1 | 1 | | | | | | | | | | | | | | | |
| 2 | -.48** | 1 | | | | | | | | | | | | | | |
| 3 | -.14* | .57** | 1 | | | | | | | | | | | | | |
| 4 | .03 | -.07 | -.12* | 1 | | | | | | | | | | | | |
| 5 | -.05 | .04 | .21** | .27** | 1 | | | | | | | | | | | |
| 6 | .02 | -.09 | .09 | .27** | .38** | 1 | | | | | | | | | | |
| 7 | .04 | -.09 | -.53** | -.31** | -.34** | -.30** | 1 | | | | | | | | | |
| 8 | .03 | -.04 | .10 | .32** | .22** | .17** | -.24** | 1 | | | | | | | | |
| 9 | .12* | -.09 | .04 | .24** | .17** | .25** | -.15** | -.19** | 1 | | | | | | | |
| 10 | .04 | -.03 | .04 | .29** | .12* | .24** | -.18** | -.19** | .77** | 1 | | | | | | |
| 11 | .01 | -.04 | .03 | .24** | .14* | .18** | -.16** | .20* | .75** | .85** | 1 | | | | | |
| 12 | .05 | -.09 | -.05 | -.19** | -.09 | -.16** | .03 | -.14* | -.51** | -.45** | -.43** | 1 | | | | |
| 13 | -.18** | .04 | -.08 | -.21** | -.10 | -.17** | .09 | -.15** | -.41** | -.27** | -.27** | .42** | 1 | | | |
| 14 | .13* | -.18** | -.20** | -.13* | -.10 | -.18** | .05 | -.14* | -.48** | -.39** | -.38** | .64** | .33** | 1 | | |
| 15 | .05 | -.13* | -.09 | -.21** | -.08 | -.17** | .05 | -.12* | -.51** | -.48** | -.46** | .85** | .45** | .58** | 1 | |
| 16 | .07 | -.03 | -.01 | -.16** | -.08 | -.12* | .03 | -.07 | -.44** | -.35** | -.34** | .65** | .46** | .46** | .65** | 1 |

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

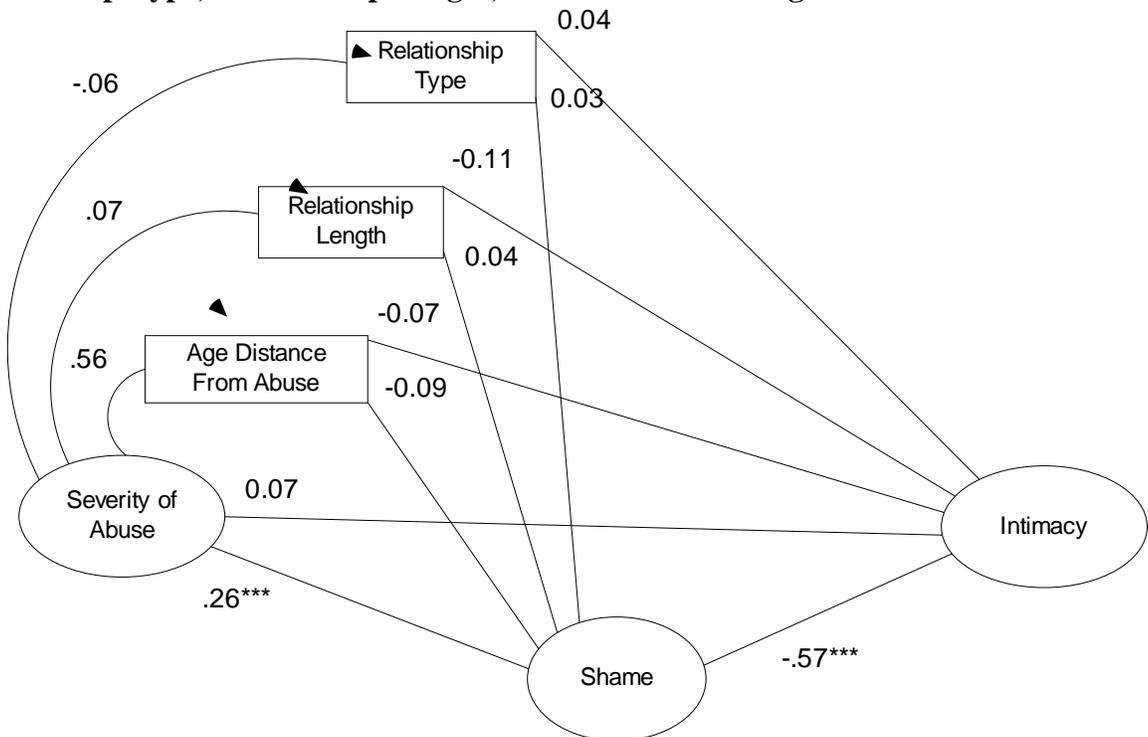
Key

- | | | | |
|-----------------------------|--------------------|----------------------------------|---------------------------|
| 1. Type of relationship | 5. Duration | 9. Shame – empty/lonely | 13. Social intimacy |
| 2. Length of relationship | 6. Frequency | 10. Shame – fragile/exposed | 14. Sexual intimacy |
| 3. Age distance from abuse | 7. Age abuse began | 11. Shame – inadequate/deficient | 15. Intellectual intimacy |
| 4. Characteristics of abuse | 8. Force used | 12. Emotional intimacy | 16. Recreational intimacy |

the second hypothesis that shame would be inversely related to intimacy was accepted, however this relationship changes when shame is incorporated into the model.

The standardized beta coefficient for the path from severity of abuse to shame was .26 ($p < .001$). It appears that more severe abuse is associated with higher levels of internalized shame, thus leading to the acceptance of hypothesis three. When including shame in the model, it was found to be a complete statistically mediator between severity of abuse and perception of intimacy ($\beta = -.57$, $p < .001$), meaning the relationship between severity of abuse and perception of intimacy was rendered nonsignificant when shame was included in the model, meaning the third hypothesis is accepted when shame is not included in the model, but rejected when shame is included in the model. Given the

Figure 2. Standardized Betas for Structural Model with Shame Mediating the Relationship Between Severity of Sexual Abuse and Intimacy, Controlling for Relationship Type, Relationship Length, and Distance from Age of Abuse.



$\chi^2 = 91.43$, $df = 77$, $p = .125$
 $CFI = .994$, $RMSEA = .024$

complete mediation effect shame has on the relationship between severity of abuse and intimacy, hypothesis four is also accepted. None of the paths from control variables to shame or intimacy were significant. The comparative fit index (CFI) for the overall model was .994 and the RMSEA was .024. These fit indices indicate the hypothesized model is a very good fit for the structure of the data.

CHAPTER FIVE

Discussion

The purpose of this study was to identify how severity of childhood sexual abuse is related to adult intimacy and how internalized shame mediates that relationship. Using Structural Equation Modeling, results indicated that though severity of abuse has a direct positive relationship with perception of intimacy when shame is not in the model, internalized shame acts as a complete mediator between severity of abuse and the perception of intimacy. Severity of abuse has a significant positive relationship with internalized shame, and shame has a significant negative relationship with perception of intimacy.

Findings of this study indicate that shame is the primary mechanism through which CSA negatively impacts perceptions of intimacy. Internal processes, such as building a shame-prone identity, mediate between CSA itself and intimacy problems. If survivors internalize the experience to mean they are insufficient, flawed, or damaged as a person (Harper & Hoopes, 1990), the more likely it is they will perceive their adult romantic relationships as much less intimate when compared to women who do not have a history of CSA.

Findings Consistent with Previous Research

The finding that severity of abuse, as measured by characteristics of abuse, duration, frequency, age abuse began, and force used during the abuse, has a positive association with internalized shame of adult survivors of childhood sexual abuse is consistent with previous research. Feiring and Taska (2005), Feiring, Taska, and Chen (2002), and Pisoni (1994) all found that shame is associated with severity of abuse.

Finkelhor and Browne (1986) also conceptualized shame as being a result of CSA because of the sense of being “spoiled goods” that can come from the perpetrator or society in general.

Much of the literature on CSA and intimacy focuses on what appeared to be a direct path between these two variables. In attempting to explain the reason many women with a history of CSA experience their committed romantic relationships as less intimate, shame seemed to have theoretical validity, but it had never been tested. Interestingly, the results of this study show shame to be a complete mediator of the relationship between the severity of childhood sexual abuse and how the adult survivor perceives the intimacy of her romantic relationships.

As mentioned in the review of literature, women with high levels of internalized shame see themselves as flawed or damaged, blameworthy or tainted, and unworthy of having their needs met. They may refer to themselves in derogatory terms or endorse statements such as, “something is wrong with me.” Given these beliefs, survivors may devalue themselves and overvalue others (Davis & Petretic-Jackson, 2000), meaning that even in long-term committed relationships, survivors may not attempt to get their needs met. This relationship pattern could clearly contribute to lower levels of marital satisfaction as well as lower levels of perceived intimacy. As women with high levels of internalized shame are also likely to see themselves as unworthy, they may also choose partners who are less capable of intimate connection, which would also lower the survivor’s perception of the intimacy in the relationship.

Clinical Implications

This research has several implications for marriage and family therapists who are working with clients who have experienced sexual abuse during childhood. As couples often come to therapy with presenting problems of “not connecting” or having some sort of intimacy problem, it is important to realize that underneath the relationship problems internalized shame is likely a major contributor to the problem. Although working specifically on the relationship may be helpful, it is also vital the therapist assess the extent to which the survivor has developed a shame-prone or shame-based identity. If she sees herself as unlovable or unworthy, her hesitation to share herself with someone else will obviously affect the level of intimacy the couple can reach. Until she has been able to process and work through her beliefs that she is irreparably flawed or damaged as a human being, just working on improving intimacy will not be helpful. (For resources on treating shame and trauma see Balcom, Lee, & Tager, 1995; Elison, Lennon, & Pulos, 2006; Johnson & Williams-Keeler, 1998; Harper & Hoopes, 1990).

As the partners of CSA survivors are often confused by the survivor’s behavior, it is extremely important for the partner to be included in the therapeutic process. Helping partners gain an understanding of how painful shame is for the survivor can help them develop patience as the survivor learns to readjust her self-perceptions and eventually how she functions in the relationship. This also gives the survivor’s partner an opportunity to get support through the therapeutic process. Additionally, recognizing that shame-prone CSA survivors tend to choose partners with less than desirable characteristics, it is important to identify and treat those issues independent of the CSA survivors’. Some partners may be capable of taking a supporting role for their spouse without needing much individual attention, which would allow the therapist to focus

more individually on the CSA survivor, however, partners who may have their own issues that keep them from understanding and interacting positively with the survivor, may require a different therapeutic approach. When both partners need individual attention, therapy may need to be shifted to focus on both individuals' issues as well as helping each partner support the other with the hope that as both partners grow, they grow closer together and intimacy increases.

Clinicians should also be aware that individuals who experience sexual abuse as children may interact in ways between the time of abuse and becoming adults that involve more shaming experiences than individuals who were not sexually abused. Some scholars propose that cycles of shame can become part of couple patterns with shame in one partner provoking shame in the other (Balcom et al., 1995). When formulating treatment plans, clinicians should be open to identifying and working through past shaming experiences that appear unrelated to the abuse, as well as how a survivor's shame affect her partner.

Though it has been well documented that survivors may choose less desirable partners (Testa et al., 2005), there is also the possibility that CSA survivors with high levels of internalized shame may attract partners who are inappropriate caretakers. In some cases the chosen partner may be emotionally, physically, or sexually abusive. Many survivors do not recognize these characteristics initially. In other cases, the survivors attract partners who are believe themselves capable of providing any amount of caregiving required. For a time their partners may enjoy being such a strong character in the marriage, but they may eventually come to resent the amount of care the survivor requires. Along this same vein, some survivors with high amounts of internalized shame

may feel so needy they expect others to take care of them, which could be very overwhelming for the partner. These processes can interfere with intimacy and if present, should be addressed in a therapeutic setting.

According to Schaefer and Olson (1981), intimacy occurs in a relationship when individuals share bonding experiences in several domains. Generally couples expect to connect emotionally, physically, intellectually, and socially. This, however, requires partners to be vulnerable with each other, especially physically and emotionally. CSA survivors who experience high levels of internalized shame may not be able to tolerate the vulnerability that is inherently connected to intimacy. Waring, Schaefer, and Fry (1994) found that deeper self-disclosure helps couples to feel more intimate, but survivors with high levels of shame may shy away from deep levels of disclosure for fear of being rejected. In order to combat this fear and low tolerance for vulnerability, clinicians should focus on the increasing the safety of the relationship.

Strengths and Limitations of Study

Strengths of this study include the sample size, 581 women, 263 who were not sexually abused during their childhood and 318 who were sexually abused during their childhood. This is a large sample in comparison to much of the previous research. It also includes both an abused and non-abused sample, which was helpful in comparing the variables of shame and intimacy. The participants were also drawn from a community sample, whereas much of the past research has used solely clinical populations. Given these strengths, the findings of this research contribute significantly to the current literature.

Despite the strengths of the study, there are also several limitations. One of the biggest limitations is that the overall response rate was fairly low, which could have been due to the length of the questionnaire. This means that the participants who chose to take the time to fill out an extremely long questionnaire may present some systematic bias in terms of functioning, time investment, or their interest in furthering research on CSA.

Some researchers have found that family environment significantly contributes to the outcomes often seen in CSA survivors (Fassler, et al., 2005) and found that in some cases, CSA is no longer a significant predictor of outcomes when family environment is taken into account. Others have found specific household dynamics (mental illness, substance abuse, parental separation or divorce) are significantly associated with CSA, making it difficult to tease out the impact of family environment and CSA itself on outcomes (Dong et al., 2003). Though this is valuable information, controlling for these factors was beyond the scope of this study.

Another limitation in the study is the lack of partner information on the intimacy scale. From the results it was clear abused and non-abused women differed in their perceptions of intimacy, but because there was not information from partners regarding intimacy, there was no way to draw conclusions regarding whether the survivors differed from their partners in their perception of the relationship. That being noted, this gives direction for future research.

Future Research

The involvement of partners would be extremely beneficial to include in future research. It would be valuable to explore how couples' views of quality of intimacy compare. Given that past research has suggested survivors of CSA are more likely to

choose less desirable partners, it would also be helpful to compare abused and non-abused couple dyads. It would be interesting to discover if women who choose partners similar to the partners chosen by their non-abused counterparts still experience the same intimacy problems as other CSA survivors.

Another direction for future research is to recreate a similar study using longitudinal research. It would be valuable to know if the perceptions of intimacy change over time or through certain events. At this point it is unknown if perceptions of intimacy change from the fifth, to tenth, to twentieth year of the relationship. It is also unknown whether certain events such as having children or children leaving home affect CSA survivor's perceptions of intimacy the same way these same events affect non-abused women. Longitudinal analysis would also be helpful in exploring the impact of shaming experiences that occur between the abuse and survey response.

A third area of research that could be explored is outcomes of couples who come to therapy and the therapy focuses on shame as well as intimacy problems. Given the results of this study, it follows that when a survivor's shame-prone identity is shifted, perceptions of intimacy will also shift.

Conclusions

Based on the current study, it is clear there is a strong relationship between severity of childhood sexual abuse, internalized shame, and perceptions of intimacy in adult relationships. Past research has focused on the direct path between severity of abuse and intimacy problems; however, from this study it is evident that the relationship is actually indirect. Severity of childhood sexual abuse affects the level of internalized

shame the survivor experiences. Internalized shame, in turn, affects the survivor's perception of intimacy.

The major implication for this study is that the severity of CSA directly affects the level of shame survivor's experience and indirectly affects perception of intimacy.

Women who experienced CSA often see themselves as irreparably flawed or damaged and hence unlovable, which becomes a barrier to forming truly intimate, connected relationships. Because shame acts as a mediator between severity of abuse and perceptions of intimacy, shame must be addressed in therapy in order to improve the survivors' perceptions of herself as unlovable, deserving of commitment, and capable of experiencing intimacy. If the shame-prone or shame-based identity of CSA survivors is not dealt with, targeting intimacy issues alone in therapy will not be nearly as successful.

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APPENDICES

Appendix A

Internalized Shame Scale

DIRECTIONS: Read each statement carefully and circle the number to the left of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below.

- | 1=Never | 2=Seldom | 3=Sometimes | 4=Frequently | 5=Almost
Always | |
|-----------|----------|-------------|--------------|--------------------|---|
| 1 2 3 4 5 | | | | | 1. I feel like I am never quite good enough. |
| 1 2 3 4 5 | | | | | 2. I feel somehow left out |
| 1 2 3 4 5 | | | | | 3. I think that people look down on me. |
| 1 2 3 4 5 | | | | | 4. All in all, I am inclined to feel that I am a success. |
| 1 2 3 4 5 | | | | | 5. I scold myself and put myself down. |
| 1 2 3 4 5 | | | | | 6. I feel insecure about others' opinions of me. |
| 1 2 3 4 5 | | | | | 7. compared to other people, I feel like I somehow never measure up. |
| 1 2 3 4 5 | | | | | 8. I see myself as being very small and insignificant. |
| 1 2 3 4 5 | | | | | 9. I feel 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 as if I am somehow defective as a person, like there is something basically wrong with me. |
| 1 2 3 4 5 | | | | | 12. When I compare myself to others I am just not as important. |
| 1 2 3 4 5 | | | | | 13. I have an overpowering dread that my faults will be revealed in front of others. |
| 1 2 3 4 5 | | | | | 14. I feel I have a number of good qualities. |
| 1 2 3 4 5 | | | | | 15. I see myself striving for perfection only to continually fall short. |
| 1 2 3 4 5 | | | | | 16. I think others are able to see my defects. |

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

Appendix B

Personal Assessment of Intimacy in Relationships

INSTRUCTIONS: These items are used to measure different kinds of “intimacy” in your relationships. You are to indicate your response to each statement by using the following five point scale. If you are not married, some of the items may not be appropriate for the significant other you have selected for this questionnaire. If this is true put NA by that item.

| | | | | |
|----------------------|----------------------|---------|-------------------|-------------------|
| 0 | 1 | 2 | 3 | 4 |
| Strongly Disagree | Somewhat Disagree | Neutral | Somewhat Agree | Strongly Agree |

First respond in the way you feel about the item at present. Place your response in the “How it is Now” column. Then respond to each item according to the way you would like it to be, that is, if you could have your relationship be any way that you may want it to be. Place your response in the “How I would like it to be.” There are no right or wrong answers.

| How it is Now | How I would like it to Be | |
|------------------|------------------------------|--|
| _____ | _____ | 1. My partner listens to me when I need someone to talk to. |
| _____ | _____ | 2. We enjoy spending time with other couples. |
| _____ | _____ | 3. I am satisfied with our sex life. |
| _____ | _____ | 4. My partner helps me clarify my thoughts. |
| _____ | _____ | 5. We enjoy the same recreational activities. |
| _____ | _____ | 6. My partner has all of the qualities I’ve always wanted in a mate. |
| _____ | _____ | 7. I can state my feelings without him/her getting defensive. |
| _____ | _____ | 8. We usually “keep to ourselves.” |
| _____ | _____ | 9. I feel our sexual activity is just routine. |
| _____ | _____ | 10. When it comes to having a serious discussion, it seems we have little in common. |

- ___ ___ 11. I share in few of my partner's interests.
- ___ ___ 12. There are times when I do not feel a great deal of love and affection for my partner.
- ___ ___ 13. I often feel distant from my partner.
- ___ ___ 14. We have few friends in common.
- ___ ___ 15. I am able to tell my partner when I want sexual intercourse.
- ___ ___ 16. I feel "put-down" in a serious conversation with my partner.
- ___ ___ 17. We like playing together.
- ___ ___ 18. Every new think I have learned about my partner has please me.
- ___ ___ 19. My partner can really understand my hurts and joys.
- ___ ___ 20. Having time together with friends is an important part of our shared activities.
- ___ ___ 21. I "hold back" my sexual interest because my partner makes me feel uncomfortable.
- ___ ___ 22. I feel it is useless to discuss some things with my partner.
- ___ ___ 23. We enjoy the out-of-doors together.
- ___ ___ 24. My partner and I understand each other completely.
- ___ ___ 25. I feel neglected at times by my partner.
- ___ ___ 26. Many of my partner's closest friends are also my closest friends.
- ___ ___ 27. Sexual expression is an essential part of our relationship.
- ___ ___ 28. My partner frequently tries to change my ideas.
- ___ ___ 29. We seldom find time to do fun things together.
- ___ ___ 30. I don't think anyone could possibly be happier than my partner and I when we are with one another.
- ___ ___ 31. I sometimes feel lonely when we're together.
- ___ ___ 32. My partner disapproves of some of my friends.
- ___ ___ 33. My partner seems disinterested in sex.

- _____ 34. We have an endless number of things to talk about.
- _____ 35. I feel we share some of the same interests.
- _____ 36. I have some needs that are not being met by my relationship.