The Impact of Traumatic Symptoms on Intimacy Among Sexually Abused Women, Mediated by Shame

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The Impact of Traumatic Symptoms on Intimacy Among Sexually Abused Women,

Mediated by Shame

Stacy Hamilton

A dissertation submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

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ABSTRACT

The Impact of Traumatic Symptoms on Intimacy Among Sexually Abused Women, Mediated by Shame

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Traumatic symptoms are common for survivors of childhood sexual abuse (CSA), and such symptoms are often compounded by the presence of shame. While much is known regarding the negative impact of Posttraumatic Stress Disorder (PTSD) on CSA survivors, less is known regarding the relationship between PTSD and shame and little to no research has investigated the impact of PTSD on intimacy mediated by shame for CSA survivors. The current study sought to fill this gap in the literature by exploring this phenomenon.

Data was randomly collected from households in the following cities: Chicago, IL; New York City, NY; Salt Lake City, UT; and San Francisco, as well as the Utah State Penitentiary. Those who had completed the Trauma Symptom Checklist-33 (TSC-33), the Personal Assessment of Intimacy in Relationships scale (PAIR), and Internalized Shame Scale (ISS) were included in the dataset. Exclusionary criteria included females under 18, males, those who had not experienced sexual abuse, and those who had not completed the requisite scales. In all, 318 participants met criteria for the current study.

The current study hypothesized that: (1) trauma symptoms would be negatively related to intimacy, (2) internalized shame will be negatively related to intimacy, and (3) internalized shame will significantly mediate the relationship between trauma symptoms and intimacy. The hypotheses were analyzed utilizing Structural Equation Modeling (SEM) and the associated AMOS 19 and MPlus software.

Results found that trauma symptoms negatively impact intimacy and that shame has a mediating impact on this phenomenon. Further, shame was found to be a full mediator. While results of the current study illustrate the mediating role of shame on trauma symptoms, this mediation is within a relational rather than an individual context. Consequently, the current study fills an important gap in the literature regarding the interplay between shame and trauma for CSA victims within a relational context. Results of the current study give direction regarding the treatment of trauma and point to the importance of addressing shame in survivors of sexual abuse.

Keywords: PTSD, shame, sexual abuse, intimacy, mediation
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# TABLE OF CONTENTS

List of Tables ......................................................................................... vii
List of Figures......................................................................................... viii

CHAPTER ONE..................................................................................... 1
  Introduction........................................................................................ 1

CHAPTER TWO..................................................................................... 2
  Review of Literature........................................................................... 2
    Sexual Abuse: Prevalence Rates and Symptoms............................ 2
    Posttraumatic Stress Disorder....................................................... 5
    Shame and Sexual Abuse............................................................... 6
      Shame and PTSD........................................................................ 8
      Shame and PTSD for CSA survivors........................................ 9
    Intimacy........................................................................................... 10
      Intimacy and PTSD..................................................................... 12
      Intimacy and PTSD for CSA couples....................................... 13
    Shame and intimacy for CSA survivors...................................... 14
      Shame, PTSD, and intimacy for CSA survivors....................... 15
  Co-Occurring Physical and Sexual Abuse...................................... 15
  Summary of Literature..................................................................... 16
  Significance of Study...................................................................... 16
  Statement of Purpose...................................................................... 17
  Hypotheses....................................................................................... 17

CHAPTER THREE .................................................................................. 19
Methods

Sample Development Procedures

Subject Demographics

Measures

Design and Statistical Analysis

CHAPTER FOUR

Results

Preliminary Analyses

Variable Statistics and Correlations

Hypothesis 1. The effect of trauma symptoms on intimacy

Hypothesis 2. The effect of internalized shame on intimacy

Hypothesis 3. The effect of trauma symptoms on intimacy, mediated by shame

Additional Findings

CHAPTER FIVE

Discussion

Results and Previous Research

Clinical Implications

Strengths and Limitations

Conclusion

REFERENCES

APPENDICES

Appendix A
 LIST OF TABLES

Table 1. Demographic variables for all participants in the study including age, gender, relationship variables, education, ethnicity, and age at which abuse began ................... 21

Table 2. Zero-order correlations of main study variables along with means and standard deviations .......................................................... 28

Table 3. Zero-order correlations of latent and control variables ....................... 29
LIST OF FIGURES

Figure 1. Theoretical model indicating relationships among PTSD, sexual abuse, and physical abuse with shame as a mediator………………………………………………………………………………… 17

Figure 2. Structural equation model for intimacy predicted by trauma symptomology, mediated by shame with standardized regression coefficients………………………………………..30

Figure 3. Structural equation model for intimacy predicted by trauma symptomology without shame as a mediator with standardized regression coefficients……………………………………….31
CHAPTER ONE

Introduction

Sexual abuse is perhaps one of society’s most disconcerting problems, creating difficulties that can take survivors years to overcome. Left in its wake, survivors face the challenge of dealing not only with harrowing memories but with their reactions to them, resulting in individual psychopathology and difficulties with intimate relationships. PTSD is a common experience for survivors of CSA and is often compounded by the presence of shame. Although the negative impact of PTSD has been well studied and a few studies have examined the relationship between shame and PTSD, little to no research has investigated the impact of PTSD on intimacy, mediated by shame. The current study seeks to fill this gap in the literature by exploring the effects of trauma symptoms on intimacy for women with CSA histories, mediated by shame. Throughout the following literature review, studies included participants of various ages, both male and female.
CHAPTER TWO

Review of Literature

Sexual Abuse: Prevalence Rates and Symptoms

Estimates on the prevalence rates for sexual abuse vary by gender, with an average of 19.7% of women, and 7.9% of men having experienced some type of sexual abuse before eighteen (Pereda, Guilera, Forns, & Gomez-Benito, 2009). Actual occurrence rates may be higher due to either lack of or discrepant reporting (e.g., Tyler & Melander, 2009). Discrepant reporting occurs when individuals deny being a victim in general, but report experiences of specific types of maltreatment and occurs most frequently for experiences related to “minor physical assault” and “noncontact sexual abuse” (Tyler & Melander, 2009, p.513). Meta-analytic results indicate that specific risk factors associated with sexual victimization include being female, black, adolescent, and residing in unsafe communities (Black, Heyman, & Slep, 2001). Lower levels of intelligence, academic performance, and previous experiences of sexual victimization also serve as risk factors (Black et al., 2001). Family factors associated with risk include lower professional status, lower income, membership in a single-parent or stepfamily, and psychiatric symptoms in mothers and fathers (Black et al., 2001).

The effects of sexual abuse are encompassing, impacting for survivors levels of psychopathology in forms of both externalizing and internalizing behaviors. Externalizing behaviors associated with CSA may include increased sexual activity (Black, Oberlander, Lewis, Knight, Zolotor, Litrownik et al., 2009), association with deviant peer groups (Hawke, Jainchill, & De Leon, 2000), aggression (Deb, Mukherjee, & Mathews, 2011), and substance use (Guy, 2005; Hawke et al., 2000). Internalizing behaviors may include depression (Maniglio, 2010), anxiety, obsessive-compulsive symptomology (Carter, Bewell, Blackmore, & Woodside, 2006),
eating disorders (Moyer, DiPietro, Berkowitz, & Stunkard, 1997), suicidal ideation (Spokas, Wenzel, Stirman, Brown, & Beck, 2009), and low self-esteem (Carter et al., 2006).

The experience of sexual abuse not only influences the way in which survivors interact with others but also how survivors interact with themselves. This self-interaction comes in the form of internalizing behaviors and also through the experience of shame (a more comprehensive discussion of shame will occur in later sections). Indeed, this assault on the sense of self may be one of the most damaging aspects of CSA, as survivors are left not only to struggle in effectively coping with the abuse but to determine who is at fault and why. Research has consistently shown that shame (Feinauer, Hilton, & Callahan, 2003) or the assumed sense of responsibility regarding CSA (Feiring, Simon, & Cleland, 2009) is persistent and has a negative impact on resolution of the trauma (Feiring & Taska, 2005).

A seminal study on the effects of sexual abuse was conducted by Finkelor and Brown (1985), in which four main “traumagenic dynamics” are argued to account for the majority of trauma experiences by CSA survivors. These “dynamics” include “traumatic sexualization, betrayal, powerlessness, and stigmatization” (p.530). The authors purport that although aspects of these different dynamics may occur in other traumatic situations, the combination of the four work to make the experience of sexual abuse unique (Finkelhor & Browne, 1985). They further argue that these dynamics not only work to change the child’s emotional and cognitive orientation to his/her surroundings, but can also create trauma through distortion of the child’s sense of self, their worldview, and “affective capacities” (p.531). Each dynamic appears to play a unique role in this distortion or shift of senses and beliefs.

“Traumatic sexualization” occurs when the survivor’s sexuality (sexual attitudes and feelings) does not form in a developmentally appropriate or interpersonally healthy way due to
the sexual abuse. Traumatic sexualization can occur in a number of ways including: (a) when the child learns to use sexual behavior as a way of manipulation or the means of fulfilling needs that are developmentally appropriate, (2) when the child is consistently rewarded for performing sexual behaviors that are outside of developmental appropriateness, (3) when specific anatomical features are “fetishized” or given levels of meaning and importance that are distorted, (4) through misconstrued and confusing messages about sexuality received by the child from the perpetrator, and (5) through the association of fear-laden memories with sexuality (Finkelhor & Browne, 1985). Though a number of factors influence both the type and level of sexual traumatization, those experiencing traumatic sexualization develop “inappropriate repertoires” of sexualized behaviors, confusion regarding their sexual selves, and atypical “emotional associations” regarding sexual activity (Finkelhor & Browne, 1985).

Betrayal refers to the process in which the child realizes that an individual on whom they were dependent harmed them. This realization may occur during or after the abuse experiences. Further, the survivor may experience a sense of betrayal not only from the perpetrator but from family members who perhaps knew about the abuse but did not stop it, who were unwilling to believe the abuse, or who appear to have a “changed attitude” towards the survivor following disclosure (Finkelhor & Browne, 1985).

“Powerlessness” occurs when the child’s desire, efficacy, and will are repeatedly breached. For instance, within sexual abuse, the child’s “territory and body space” are consistently violated thus creating a sense of powerlessness. The use of coercion or manipulation can then increase the sense of powerlessness as well as the child’s experiences of attempting and failing to divert the abuse. Fear and being unable to make other adults believe or understand the
abuse also increases a sense of powerlessness, as does the realization of the child that they are dependent on the abuser and hence trapped in the situation (Finkelhor & Browne, 1985).

Lastly, stigmatization refers to the process in which “negative connotations” (i.e. shame, badness, guilt) around the abuse are communicated to the child and incorporated into the survivor’s sense of self-image (Finkelhor & Browne, 1985). Such messages may actively come from the perpetrator, from pressures to keep things secret, from societal attitudes regarding sexuality and taboos, or from negative attributes given to the victim by others following disclosure. Finkelhor and Brown (1985) hypothesize that these four dynamics account for the bulk of trauma experiences by CSA survivors. While it is recognized that these dynamics are not “pure” or “narrowly defined,” it is suggested these dynamics be utilized as “broad categories” that are helpful in organizing an understanding of the effects of CSA (Finkelhor & Browne, 1985, p.533).

**Posttraumatic Stress Disorder**

Another condition associated with CSA are PTSD symptoms (Brand, King, Olson, Ghaziuddin, & Naylor, 1996). According to the DSM-IV, PTSD is characterized as feelings of intrusive thoughts and images, recurrent experiences of the event, emotional and cognitive numbing or avoidance around the event, and hyperarousal including hyper-vigilance (American Psychiatric Association, 2000). Prevalence rates of PTSD for CSA survivors are above 30% (Giaconia, Reinherz, Silverman, Pakiz, Frost, & Cohen, 1995; Masho & Ahmed, 2007), with some studies reporting entire samples that meet diagnostic criteria (Bonugli, Brackley, Williams, & Lesser, 2010). Gender also plays a role in PTSD following CSA, with girls and women consistently showing higher rates of symptoms (Walker, Carey, Mohr, Stein, & Seedat, 2004).
Those dealing with PTSD symptoms may experience recurrent thoughts or images of the event, including nightmares and flashback or a sense that the event is occurring in the moment (APA, 2000). In addition, efforts to avoid reminders of the event, such as thoughts and feelings, along with restricted memory and affect (APA, 2000) may psychologically isolate the individual. Difficulties with sleep and concentration, along with experienced “startle” responses (APA, 2000) may hinder levels of function and productivity. Correlates for general PTSD have been found to include problem drinking (McDevitt-Murphy, Wiliams, Bracken, Fields, Monahan, & Murphy, 2010), substance use disorders (McDevitt-Murphy, Parra, Shea, Yen, Grilo, & Sanislow, et al., 2009), reported health difficulties (Calhoun, Wiley, Dennis, & Beckham, 2009), and suicide (Bullman & Kang, 1994). Correlates to CSA-specific PTSD have been found to include levels of high-risk behaviors, substance use (O’Hare, Shen, & Sherrer, 2010), depression, and delinquency (Danielson, Macdonald, Amstadter, Hanson, de Arellano, Saunders, et al., 2010). A reciprocal feedback relationship also appears to occur for some correlates. For instance, O’Hare et al. (2010) found that while levels of abuse may increase high-risk and substance using behaviors in reaction to PTSD symptoms, that these same behaviors (high-risk and substance using) may conversely increase levels of PTSD symptoms. As such, PTSD may not only be a sequel of CSA experiences but may also in itself be a cause of enhanced psychopathology in survivors.

**Shame and Sexual Abuse**

The presence of shame in survivors of sexual abuse has been well-documented (Feiring et al., 2009; Feiring & Taska, 2005; Ginzburg, Butler, Giese-Davis, Cavanaugh, Neri, Koopman, Classen, & Spiegel, 2009; Rahm, Renck, & Ringsberg, 2006) and several theories exist as to its development in survivors. According to Finkelhor and Browne (1985), stigmatization occurs
when negative messages around the abuse (i.e. shame, guilt, “badness”) are communicated and then integrated into the survivor’s sense of self. These messages can be directly communicated by the perpetrator or come in the form of blaming and demeaning, secrecy implicated around abuse, and be reinforced through societal taboos associated with CSA (Finkelhor & Browne, 1985). According to Feinaure et al (2003), CSA survivors may form a sense of being internally defective due to disregard of their needs (accountability, intimacy, dependency, safety), explicit and implicit blaming for undesired experiences, and the tendency of the survivor to assume responsibility for the actions of the perpetrator. Lee, Scragg, and Turner (2001) found that trauma may create feelings of both internal and external shame in that survivors may feel as if they are to blame for the traumatic event, and that others may view them in a negative light as a result of the trauma. Internalized shame is conceptualized as a state in which an individual senses that they are internally flawed and possess a certain “badness” that is unchangeable despite their actions (Harper, 2011). Internalized shame is conceptualized to be connected to a lack of three family processes, termed the “the affirmation triangle” (Harper & Hoopes, 1990 as cited in Harper, 2011, p.190). These processes include accountability, appropriate dependency, and intimacy (Harper, 2011) of which apparently diminish in the context of sexual abuse.

The experience of shame can be persistent (Feiring & Taska, 2005) continuing on even when the abusive experiences have ended (Williamson, 2009) and compounding difficulties around healing. Feiring and Taska (2005) found that those who had high levels of shame at one point in time were also likely to have high levels six years later, and that levels of shame were correlated with levels of intrusive thoughts around the abuse. The authors purported that shame may serve as a motivator for victims to avoid thinking about the trauma experiences, which over time may lead to unsuccessful suppression and associated increases of intrusive abuse memories (Feiring
As such, shame decreases the survivor’s ability to accurately integrate abuse memories and move towards resolution of the trauma (Feiring & Taska, 2005). In this way, CSA survivors dealing with shame may be stuck within the trauma, being unable to effectively process it or come to an accurate understanding of their lack of responsibility for the abuse.

**Shame and PTSD.** Several models have explored the unique relationship between shame and PTSD. As a whole, PTSD appears to influence levels of shame while shame likewise influences treatment gains for PTSD symptoms. Harman & Lee (2009) found that shame was positively correlated with self-criticism and negatively correlated with self-reassurance for those dealing with PTSD in connection with war-related trauma. According to the authors, those who struggle with self-reassurance may find it difficult to create within themselves a sense of safety (Harman & Lee, 2009). Shame may then perpetuate in individuals the sense of threat that is central to the experience of PTSD (Harman & Lee, 2009). Perhaps this process creates in survivors a continual sense of being in danger, making treatment gains for PTSD symptoms difficult to obtain.

Outcome research indicates that those who blame themselves for traumatic events have greater PTSD symptoms and lower self-perceived recovery (Najdowski & Ullman, 2009), and that effects of treatment on PTSD symptoms are mediated or influenced by level of changes in shame (Ginzburg et al., 2009). Within the model tested by Najdowski & Ullman (2009) coping (both adaptive and maladaptive) served as a partial mediator to the impact of shame on PTSD symptoms. Maladaptive coping was conceptualized to include tendencies to self-distract, deny, and behaviorally disengage while adaptive coping was conceptualized to include tendencies to use active coping strategies, support, venting, reframing, planning, humor, acceptance, and religion (Najdowski & Ullman, 2009). While the authors do not fully explain this mediating
impact, perhaps those who blame themselves for trauma experiences engage in fewer positive coping strategies, thus perpetuating PTSD symptoms.

**Shame and PSTD for CSA survivors.** Few studies examine the mediating impact of shame on PTSD symptoms specifically for CSA survivors. The studies that do exist reiterate the powerful role that shame plays in the trajectory of PTSD symptoms. Andrews and colleagues examined the impact of a history of abuse (including sexual abuse) on PTSD symptoms developed from crime-related experiences (Andrews, Brewin, Rose, & Kirk, 2000). They found that shame was a factor that independently predicted symptoms of PTSD at 1 month post-evaluation and was the only factor that independently predicted PTSD symptoms at 6 months (Andrews et al., 2000). They conclude that the impact of shame is “unique” in regards to the trajectory of PTSD symptoms and that their results further illustrate the mediating role of shame between abuse experiences and psychopathology in adulthood (Andrews et al., 2000).

In another study, Ginzburg and colleagues explored the impact of shame on PTSD for survivors of sexual abuse and similarly found that changes in PTSD symptoms were mediated by changes in shame (Ginzburg et al., 2009). As such, Ginzburg et al (2009) hypothesized that treating shame in trauma survivors may indicate a pathway to treating symptoms related to PTSD. Results from this study also indicate a differential impact of the effect of guilt and shame on PTSD symptoms in that shame was found to be a mediator of PTSD changes while guilt was not (Ginzburg et al., 2009). The authors explain that while guilt denotes a greater level of “self-criticism” shame involves a “greater social dimension” (Ginzburg et al., 2009, p. 541). Hence, while blame may consist of internal evaluations, those who experience shame may sense disapproval from others (Ginzburg et al., 2009). Such differences may inform treatment
decisions given that group treatment may be helpful for survivors experiencing a sense of shame (Ginzburg et al, 2009).

**Intimacy**

In addition to increased levels or propensity for individual dysfunction, CSA has also been associated with relational difficulties. While individual survivors deal uniquely with symptoms, consistent relational patterns have been identified and include decreases in sexual health, emotional intimacy, relational stability, and relational satisfaction.

In terms of sexuality, CSA not only thwarts the development of healthy sexuality but also skews the experience of sexual intimacy. For some survivors, CSA may be correlated with hyper sexuality while others experience a sexual decrease. More specifically, some CSA survivors may engage in sex at younger ages, have greater frequencies of teen pregnancy (Noll, Trickett, & Putnam, 2003), have higher numbers of intimate partners, and be at greater risk for contracting sexually transmitted infections (Testa, VanZile-Tamsen, & Livingston, 2005). CSA victims may also be more preoccupied with thoughts around sexuality (Noll et al., 2003) and exhibit inconsistent use of preventative measures, including condoms (Brown, Lourie, Zlotnick, & Cohn, 2000). On the other hand, some CSA survivors experience a sexual aversion (Noll et al., 2003) which may include a perceived lack of sexual desire as well as anger and shut-down around sexuality (Bacon & Lein, 1996). Survivors may also experience fewer orgasms, be less sexually responsive, and experience lower satisfaction in their sexual relationships (Tsai, Feldman-Summers, & Edgar, 1979).

Specific reactions to abuse experiences may help explain why some survivors appear to lean towards hyper sexuality while others appear to stray from it. Simon and Feiring (2008) found that erotic reactions to abuse experiences were associated with hyper-sexuality including
higher sexual-risk taking behaviors. However, sexually anxious reactions to abuse experiences were associated with lower numbers of sexual partners and avoidant perspectives of sexuality. Independent of whether survivors lean towards or away from sexuality, it is clear that CSA has a deleterious impact on sexual functioning as victims are robbed of the chance to experience sexual development in a healthy environment.

In addition to sexual development, connection and attachment may also be difficult for CSA survivors. Inherent to the experience of abuse is betrayal (Finkelhor & Browne, 1985) and a discounting of the child’s needs (Feinauer et al., 2003). This sense of betrayal may not only come from experiences with the abuser but from non-abusing family members who may disbelieve or fail to protect the victim (Finkelhor & Browne, 1985). Given such betrayal, survivors may have difficulty trusting others (DiLillo & Long, 1999), thus negatively influencing connection and attachment. Survivors may also struggle with emotional expression and closeness (Pistorello & Follette, 1998) similarly making connection to others difficult, particularly given that trust and security are pivotal to the development of secure attachments (Johnson & Williams-Keeler, 1998).

Difficulties with attachment may also spring from a sense of powerlessness. Such powerlessness is developed when the abused child’s efficacy, will, and desires are consistently violated (Finkelor and Browne, 1985). Not only is the child’s “territory” and “body space” consistently violated, but this violation may be enhanced by levels of manipulation and coercion utilized by the perpetrator (Finkelor & Browne, 1985, p.532). Failed attempts to stop the abuse reinforces this sense of powerlessness along with feelings of fear and the inability to create in safe others understanding and belief about the abuse experiences (Finkelor & Browne, 1985). Consequently, survivors may feel unable to prevent others from harming or manipulating them
(Finkelor & Browne, 1985) perhaps contributing to the fear of intimacy so consistently found in CSA survivors (Barry, 2010). Indeed, vigilance around closeness may lead to difficulties in attainment of “intimate connection” within adult relationships (Pistorello & Follette, 1998, p. 479).

In addition to difficulties with sexual health, attachment, and intimacy, research documents levels of aggression in CSA relationships (DiLillo, Giuffre, Tremblay, & Peterson, 2001; Friesen, Woodward, Horwood, & Fergusson, 2010). Finkelor and Browne (1985) purport that levels of aggression may stem in response to a sense of powerlessness and a connected need to dominate or control others. Further, CSA victims may not only be more likely to engage in relational violence (Friesen et al., 2010) but may also choose partners that are likewise physically aggressive (Testa et al., 2005). Indeed, given decreased sexual health and intimacy, attachment, and relational aggression, it is no wonder that CSA couples experience lower levels of relationship satisfaction (Friesen et al., 2010).

**Intimacy and PTSD.** Research indicates that a history of PTSD is also consistent with relational difficulties. Trauma survivors with PTSD may experience a sense of emotional disconnection from others, difficulty in experiencing feelings of love, and avoid those that remind them of the traumatic event (APA, 2000). According to McFarlane & Bookless (2001), those dealing with PTSD may struggle in effectively managing irritability, fears of trauma reoccurrence, and emotional numbing. Individuals with PTSD may vacillate between increased agitation or anxiety and a seeming detachment from others (McFarlane & Bookless, 2001). The stress caused by this pattern of vacillation may be further exacerbated by social withdrawal (McFarlane & Bookless, 2001). Given this breakdown in relational connection, relationships that could have served as mediators to the impact of PTSD are lost further compounding a lack
of “homeostasis within the family” (McFarlane & Bookless, 2001, p. 263). Additional factors that serve to break down intimacy include difficulties with communication (Cook, Riggs, Thompson, Coyne, & Sheikh, 2004; DiLillo, & Long, 1999), intimacy (Cook et al., 2004; Riggs, Byrne, Weathers, & Litz, 1998), physical aggression (Carroll, Rueger, Foy, & Donahoe, 1985), and difficulties with trust (DiLillo, & Long, 1999). Consequently, PTSD couples may experience lower relationship satisfaction (DiLillo, & Long, 1999) and higher rates of separation or divorce (Riggs et al., 1998).

**Intimacy and PTSD for CSA couples.** Having a history of either CSA or PTSD can be challenging to healthy relational functioning, but dealing with a combination of the two may present compounding difficulties. It has been purported that CSA-related trauma may have a more deleterious impact on the couple relationship than other types of trauma (Pistorello & Follette, 1998). This may be due to the contextual nature of the trauma in that CSA occurs during a time in which the survivor is undergoing pivotal development and may be centered within a primary relationship for the victim (Pistorello & Follette, 1998; Cole & Putnam, 1992). As stated by Milwood (2003), “it makes sense to conclude that the effect of CSA trauma on couples differs from, and is probably more intense or pervasive than, the effect of other traumas that do not contain such a strong interpersonal element” (p.27). However, surprisingly little research has examined the unique impact of CSA-related PTSD on relational functioning. The few studies that do exist have found correlates with trauma symptomology and levels of dating aggression (Wekerle, Wolfe, Hawkins, Pittman, Glickman, & Lovald, 2001; Wolfe, Wekerle, Scott, Straatman, & Grasley, 2004), avoidance of sex, and “sex history guilt” (Pistorello & Follette, 1998, p.478).
In sum, CSA survivors dealing with PTSD face significant challenges both individually and interpersonally. Not only may survivors struggle with various diagnostic features, but such features may create an environment in which sexual health, connection, and satisfaction is difficult to obtain. Indeed, CSA is an inherently harrowing experience and the aftereffects continue to create pain. Another factor that contributes to this cocktail of misery is the presence of shame in CSA survivors.

**Shame and intimacy for CSA survivors.** Shame has a deleterious effect on both individual and interpersonal functioning for CSA survivors. Individually, shame has an impact on dissociation (Feiring et al., 2010; Talbot, Talbot, & Tu, 2004), psychopathology related to bulimia (Murray & Waller, 2002), and self-harm (Milligan & Andrews, 2005). Interpersonally, shame is associated with dating aggression, difficulties with sexuality (Feiring et al., 2009) family conflict (i.e. verbal and physical aggression with partners) (Kim, Talbot, & Cicchetti, 2009), and poorer sense of acceptance from peers (Feiring, Rosenthal, & Taska, 2000). Shame may also influence survivors to sexually reject their partners (Traeen & Sorensen, 2008). Traeen and Sorensen (2008) purport that abuse survivors may cope with feelings of shame or lack of “self-appreciation” by sexually rejecting a partner before their partner rejects them. Survivors may also deny feelings of sexual interest towards the partner (Traeen & Sorensen, 2008). Perhaps such actions provide the survivor with a sense of felt safety from the familiar rejection so inherent to CSA. Shame has also been correlated with increased aggression in intimate relationships, including those categorized as “self-verbal” and “partner-physical” (Kim et al., 2009, p. 362). “Self-verbal” refers to the victim’s use of verbal aggression towards their partner, while “partner-physical” refers to the partner’s use of physical aggression towards the victim (Kim et al., 2009).
Shame, PTSD, and intimacy for CSA survivors. While much is known regarding the relational impact of trauma symptoms for CSA survivors, and the role that shame plays in mediating trauma, little is known regarding the relational impact of this mediating role. Indeed, while it is known that both shame and PTSD influence intimacy, and that these influences occur for CSA couples, the author was unable to find any published articles that explicitly examine the ways in which trauma symptoms influence intimacy for CSA women, mediated by shame. The current study seeks to fill this gap in the literature by exploring this phenomenon.

Co-Occurring Physical and Sexual Abuse

Perhaps one of the greatest tragedies associated with abuse is that many survivors are subject to multiple abuse types. Co-occurrence rates of multiple forms of abuse have been found to range from 3 to 55% (Edwards, Holden, Felitti & Anda, 2003). However, relatively few studies in the literature have explicitly explored symptomology patterns for victims of multiple abuse types. Those studies that do exist report poorer outcomes (Mullen, Martin, Anderson, Romans, & Herbison, 1995), lower levels of mental health (Edwards et al., 2003) and higher levels of dysfunction (Davis, Petretic-Jackson, & Ting, 2001) for survivors.

Research on PTSD and multiple abuse types indicate higher rates for victims of both physical and sexual abuse in comparison to those who experienced physical abuse only (Hetzel & McCanne, 2004). Multiple abuse survivors may also differ in their trauma symptomology, reporting higher scores for factors related to “dysfunctional sexual behavior” and “intrusive experiences” (Davis et al., 2001 p. 71). In terms of impact on relational functioning, research indicates that survivors of physical and sexual abuse experience more fear of intimacy than victims of either physical or sexual abuse only (Davis et al., 2001). Given the high occurrence
rates of co-occurring types of abuse and the impact this has on relational functioning, physical abuse was controlled for in the preceding analyses.

**Summary of Literature**

CSA survivors suffer both individually and interpersonally. Individually, survivors may experience a myriad of symptomatic behaviors that include internalizing and externalizing behaviors. Interpersonally, survivors struggle with sexual health, connection, and relationship satisfaction. PTSD is a common experience for CSA survivors and is often compounded by the presence of shame. Although much is understood regarding the negative impact of PTSD and the relationship between shame and PTSD, little is known regarding the impact of CSA-related PTSD on intimacy, mediated by shame. The current study seeks to fill this gap in the literature by exploring the impact of trauma symptoms on intimacy, mediated by shame in a sample of adult women survivors of CSA.

**Significance of Study**

Perhaps one of the most damaging aspects of sexual abuse is the tendency of the experiences to be perpetuated over time, possibly through a lack of healing and the development of relationship patterns that are reminiscent of the abuse. As victims are stuck within the throws of PTSD and held back by the self-stigma of shame, survivors continue to suffer as do their relationships. Little is known regarding the unique mediating role of shame on the effects of CSA-related PTSD on intimacy. However, given existing literature on the effects of shame and PTSD individually on relational functioning, one may assume shame enhances the negative impact of PTSD on intimacy and complicates healing for survivors. Given its intimate nature, the couple relationship may have the capacity to be a source of comfort and healing for survivors of
CSA. As such, understanding the mediating role of shame and how to effectively address it in treatment is essential in aiding survivors on the path of healing.

**Statement of Purpose**

The purpose of the current study was to explore the effects of trauma symptoms on intimacy for women with CSA histories, mediated by shame. The following model was developed to identify the interaction of study variables:

![Diagram](image)

*Figure 1.* Theoretical model indicating relationships among trauma symptoms, sexual abuse, and physical abuse with shame as a mediator. This figure illustrates the models conceptualized by the hypotheses.
Hypotheses

The following hypotheses were tested:

H1: Trauma symptoms will be negatively related to intimacy for CSA woman.

H2: Internalized shame will be negatively related to intimacy in CSA women.

H3: Internalized shame will significantly mediate the relationship between trauma symptoms and intimacy for CSA woman. Specifically, higher levels of shame will be associated with a greater effect of trauma symptoms on intimacy for CSA women.
CHAPTER THREE

Methods

Sample Development Procedures

Data for this study were gathered as part of the Hardiness and Childhood Trauma Project headed by Dr. Leslie L. Feinauer, Brigham Young University. Data was randomly collected from households in the following cities: Chicago, IL; New York City, NY; Salt Lake City (SLC), UT; and San Francisco, CA. Surveys were sent to participants who were randomly selected from lists generated from voter registries, clearing house lists, and phone books. Roughly 28,000 surveys were sent to both men and women in these cities over a period of four years. No follow-up mailings occurred. In 1991, 4,000 surveys were sent to residents in the SLC area of which 158 were returned resulting in a 4% response rate. In 1992, 4,000 surveys were again sent to residents in the SLC area, with 227 being returned resulting in a 5.7% response rate. In 1993, 10,000 surveys were sent to individuals in San Francisco of which 355 were returned for a 3.6% response rate. The last installment of 10,000 surveys was sent conjointly to Chicago and New York City, with 334 surveys returned (3.3% response rate). In total, 28,000 surveys were sent and 1054 were returned for 3.8% total response rate.

Prevalence rates for the CSA experiences within the general population may give context regarding the response rate of the current study. Specifically, of the participants studied it was expected that only a fraction would have experienced sexual abuse. Studies on prevalence rates in generalized samples (i.e. community, student, etc.) have found that 19.7% (19.7% for women, 7.9% for men) (Pereda et al., 2009) and 12% (Finkelhor, Ormrod, Turner, & Hamby, 2005) experience some form of sexual abuse. Such prevalence rates shed light on to actual expected response rates for the current study.
Though the response rate for the current study was low, it is considered adequate for the population being studied (Finkelhor, 1984). Others have speculated as to the reasons for such low response rates in studies utilizing victims of sexual abuse. Perhaps the sensitive nature of sexual abuse makes it difficult for some to admit occurrence of the abuse due to feelings of shame, embarrassment, or experienced difficulties as of the abuse (Finkelhor, 1984). In addition, aspects of the questionnaires such as wording and length may have a negative impact on response rates (Finkelhor, Araji, Baron, Browne, Peters, & Wyatt, 1986). Educational levels of survivors may also play into the response rate in that survivors with lower levels of education may not have been assessed given the particular design of the study (Bagley, 1991).

**Subject Demographics**

Participants who had completed the Trauma Symptom Checklist-33 (TSC-33), the Personal Assessment of Intimacy in Relationships scale (PAIR), and Internalized Shame Scale (ISS) were included in the dataset. Given the focus of the study on women, females under the age of 18, males, those who had not experienced sexual abuse, and those who had not completed the requisite scales were excluded from this study. As such, of the original 1054 surveys that were utilized in creating the original dataset, only 318 participants met criteria for the current study and were utilized in creating the associated dataset.

As indicated in Table 1, a total of 318 women were included in the study ranging in age from 17 to 72 with a mean age of 36.56 and a standard deviation of 7.82. In terms of ethnicity, 89.3% of the women were Caucasian, 3.1% Hispanic, 3.8% Oriental, and 3.4% reported being black, American Indian, or “other.” As shown in Table 1, education ranged from high school to MD or PhD. The majority indicated that they had completed some college with either an associate degree or a Bachelors degree. The average length of relationship was 13 years for a
marriage partner and 12 years for those living with a significant other. For more detailed information, please see Table 1. Forty seven point five percent of the sample scored above the clinical cut-off of 61 for internalized shame. Thirty two point seven percent of the sample scored below 39, which is considered a mild shame score; nineteen point eight percent scored between fifty and sixty which is considered moderately high (Cook, 1994).

Table 1

**Demographic Variables for all Participants in the Study Including Age, Gender, Relationship Variables, Education, Ethnicity, and Age at Which Abuse Began.**

<table>
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<th>Variable</th>
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<th>N</th>
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<th>Percent</th>
<th>Standard Deviation</th>
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<td>N/A</td>
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**Measures**

While the subjects completed a number of measurements, those requisite to inclusion in this study included completion of the Trauma Symptom Checklist-33 (TSC-33), the Personal
Assessment of Intimacy in Relationships scale (PAIR), and Internalized Shame Scale (ISS). The individual items for these scales can be found in Appendix A of this paper.

Internalized Shame Scale (ISS). The ISS measures the degree to which individuals have internalized shame (Cook, 1994). The scale contains a total of 30 items, 24 of which comprise the shame portion of the scale, and 6 of which comprise the self-esteem portion of the scale. The shame items are negatively worded and scored using a Likert scale with scores ranging from “never” (0) to “almost always” (4). Possible summed scores range from 0 to 96 with higher scores indicating higher levels of shame. Scores greater than 50 indicate clinically internalized shame (Cook, 1994).

del Rosario and White (2006) performed factor analysis and found that the scale factors into the following three subscales: empty/lonely, inferiority, and fragility/exposed. The empty/lonely subscale contains four questions and accounted for 5.66% of the variance with the study conducted by del Rosario and White (2006). An example question includes “I feel empty and unfulfilled.” The inferiority subscale contains twelve questions and was the dominate factor accounting for 47.82% of the variance (Del Rosario & White, 2006). An example question includes “I think that people look down on me.” Lastly, the fragility/exposed subscale contains eight questions accounting for 8.29% of the variance (Del Rosario & White, 2006). An example question from this scale includes “I have an overpowering dread that my faults will be revealed in front of others.” Alpha reliability for the entire shame scale is .96, with a nine-week test-retest coefficient of .84. The ISS is considered a reliable measure. In addition, it has been correlated with self-concept measures such as the Tennessee Self Concept Scale with a correlation of -.66 (Cook, 1994). Other studies have likewise found strong correlations between the ISS and anger, depression, anxiety, and eating disorders thereby further indicating the ISS as a valid measure.
(Cook, 1994). Chronbach’s alpha for the each of the subscales for the current study were found to include the following: empty/lonely (.93), fragile/exposed (.90), and inadequate (.95). For a copy of the measure, see Appendix A.

The Personal Assessment of Intimacy in Relationships (PAIR). The Personal Assessment of Intimacy in Relationships (PAIR) (Schaefer & Olson, 1981) contains 36 items, all scored using the Likert scale, with scores ranging from 0 (strongly disagree) to 4 (strongly agree). The measure truncates into the following subscales of intimacy: social, intellectual, sexual, recreational, and emotional. The sixth and final subscale of “conventionality” is utilized and scored separately in order to determine the extent to which individuals are trying to “create a good impression” (Schaefer & Olson, 1981, p. 52). The scale measures both expected and perceived intimacy with scores ranging from 0 to 96.

Psychometric testing indicates split-half reliability greater than 0.70. Specific alpha coefficients for the individual subscales included the following: social intimacy (0.78), intellectual intimacy (.80), sexual intimacy (0.77), recreational intimacy (0.81), and emotional intimacy (0.83). The validity of PAIRS was determined by correlating the subscale scores with the Lock-Wallace Marital Adjustment Scale. All subscales were found to have correlation coefficients higher than 0.30 and the majority were significant at p < .001 while the remainder held significance at the p < .01 level (Schaefer & Olson, 1981). Chronbach’s alpha for the each of the subscales for the current study were found to be the following: intellectual (.75), sexual (.78), recreational (.74), and emotional (.81). Due to a lack of significance, the social intimacy subscale was dropped from the current study. For a copy of the measure, see Appendix B.

Trauma Symptom Checklist-33 (TSC-33). The TSC-33 contains 33 items which make up the following five subscales: depression, dissociation, anxiety, sleep disturbances, and post-
sexual abuse trauma. Each item is rated on a Likert scale with scores ranging from ranging from one (“never”) to three (“very often”). Total scores range from 0 to 99 and indicate the level of emotional adjustment with higher scores indicating more symptoms and poorer adjustment. For the current study, only the post-sexual abuse trauma subscale was utilized to determine PTSD symptoms. The score for this subscale is obtained by summing the following six items: “nightmares,” “flashbacks,” “sexual problems,” “fear of men,” “feelings that things are ‘unreal,’” and “memory problems.”

Psychometric research yielded internal consistency alphas of 0.89 for the entire assessment and an average alpha of 0.71 for the five subscales (Briere & Runtz, 1989). Discriminant statistics indicate the subscale scores were effective predictors in that 79% of all participants were correctly categorized in regards to sexual abuse histories (Briere & Runtz, 1989). Concurrent validity of the TSC-33 was established via correlations with the following measures: the Middlesex Hospital Questionnaire, the Coopersmith’s Self-esteem Inventory, and the Center for Epidemiology Studies Depression Scale (CESD) (e.g., Bagley, 1989 as cited in Briere & Runtz, 1989). Results indicated that not only was the TSC-33 more effective in detecting survivors of sexual abuse, but that there was a “pattern of correlations” between the TSC-33 and the other measures thereby indicating concurrent validity of the TSC-33 (Briere & Runtz, 1989, p.158). Chronbach’s alpha of the post-sexual abuse trauma subscale for the current study was found to be .65. For a copy of the measure, see Appendix C.

Control variables were measured via a series of questioning techniques. Specifically, age, relationship length, and age at abuse were determined through open-ended self-report; education was determined through self-report on an item scale that ranged from less than high school to have a graduate or professional degree; relationship length was determined; and income was
determined through self-report on an item scale that ranged from under $5,000 to over $45,000 per year. Physical abuse was measured using one item self-report scale that ranged from 1 (never) to 4 (often) in terms of physical abuse experiences.

**Design and Statistical Analysis**

The hypotheses of the current study were analyzed utilizing Structural Equation Modeling (SEM) (Arbuckle, 2010) and the associated AMOS 19 and MPlus software. The statistical steps in building the current model included determining the loading of the indicators on the associated latent variables and calculation of descriptive statistics including means, standard deviations, and ranges for all variables. The possibility of multicollinearity was addressed through the creation of a correlation matrix for all model variables. Lastly, SEM was used to determine model fit and significance of regression coefficients for each path in the model.
CHAPTER FOUR

Results

Preliminary Analyses

Structural equation modeling (SEM) was used to test the hypotheses and determine the extent to which shame mediated the effects of PTSD on intimacy for this population. Preliminary analysis of the hypothesized model indicated lack of appropriate fit. Confirmatory factor analysis showed that the factor loading for the measured variable social intimacy was only .49. Dropping this variable from the indicators of the latent variable intimacy improved overall model fit. In addition, control variables which were not statistically significant predictors were dropped from the model. These included education level ($\beta = -.04$, $p = .40$, ), age ($\beta = -.02$, $p = .60$) household income ($\beta = .07$, $p = .19$) and age at which abuse began ($\beta = -.02$, $p = .70$).

Variable Statistics and Correlations

The means and standard deviations for all variables included in the full model are illustrated in Table 2. For purposes of simplicity, correlations for all variables are not shown in subsequent figures. The average length of relationship with significant others was 12.13 years ($M = 12.13$, $SD = 8.6$). Of the items measuring PTSD, participants scored highest on average in memory problems ($M = 1.06$, $SD = 1.01$) followed by sexual problems ($M = 0.96$, $SD = 1.08$) and nightmares ($M = 0.87$, $SD = 0.91$). Participants also scored highest on average in the inadequacy subscale of shame and indicated higher levels of recreational intimacy on average.

In order to address the issue of multicollinearity, a correlation matrix was created for all variables in the full model. As expected, Table 2 shows that the subscales of the ISS were highly correlated with one another as were the subscales of shame. The TSC items were likewise positively correlated with one another, although these correlations are weaker in comparison.
a whole, intimacy and shame items were inversely correlated, and this correlation is statistically significant. The TSC items were positively correlated with the shame items and negatively correlated with intimacy items with the majority of these correlations being statistically significant.
Table 2

Zero-order Correlations of Main Study Variables Along with Means and Standard Deviations.

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<th>Categories</th>
<th>Measure</th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
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<tr>
<td></td>
<td>2. Flashbacks</td>
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<tr>
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<td>3. Sexual Problems</td>
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<tr>
<td>9. Physical abuse</td>
<td>.35</td>
<td>.38</td>
<td>-.54</td>
<td>.06</td>
<td>-.32</td>
<td>-.10</td>
<td>-.15</td>
<td>.07</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3

Zero-Order Correlations of Latent and Control Variables.
The full model of the study is illustrated in Figure 2 and was found to have appropriate fit as indicated by the following model fit indices: $X^2 = 106.4$, df = 92, p = .15, CFI = .99, RMSEA = .02 (see Figure 2). While not shown in Figure 2, all control variables were run during analysis of the final model. However, results are not reported here because they were not significant.

*Figure 2. Structural equation model for intimacy predicted by trauma symptomology, mediated by shame with standardized regression coefficients*

**Hypothesis 1. The effect of trauma symptoms on intimacy**

The first hypothesis assumed that trauma symptoms would have a negative impact on relationship intimacy. As illustrated by the full model, the first hypothesis of the study was not supported in that trauma symptoms did not have a direct significant negative impact on intimacy for woman. While a negative relationship is indicated by the beta coefficient of -.07, this standardized regression weight was not significant. As such, hypothesis 1 is rejected.

One could question whether this finding would hold true if shame was not included in the model as a mediating variable. SEM results showed that trauma symptoms were significantly
negatively related to intimacy ($\beta=-.53$, $p<.001$) when shame was not included in the model ($X^2 = 27.91$, $df=24$, $p=.26$, $CFI=.998$, $RMSEA=.02$) (see Figure 3). As such, hypothesis 1 is confirmed when shame is not included in the model.

**Figure 3.** Structural equation model for intimacy predicted by trauma symptomology without shame as a mediator with standardized regression coefficients

**Hypothesis 2. The effect of internalized shame on intimacy**

The second hypothesis of the study assumed that shame would negatively impact intimacy for women who had experienced sexual abuse. As illustrated by Figure 2, this hypothesis was supported in that internalized shame was significantly negatively related to intimacy ($\beta=-.61$, $p<.001$).

**Hypothesis 3. The effect of trauma symptoms on intimacy, mediated by shame**

The third hypothesis of the study assumed that shame would mediate the negative relationship between trauma symptoms and intimacy. To assess for this mediation, a separate model was created in which shame was dropped thereby allowing the examination of the impact of trauma symptoms on intimacy in the absence of shame.
The path from trauma symptoms to shame was statistically significant ($\beta=.69$, $p<.001$) meaning that as trauma symptoms increase, internalized shame increases. Shame was negatively related to intimacy ($\beta=-.53$, $p<.001$) so it appeared that shame might fully mediate the relationship between trauma symptoms and intimacy. In order to test the significance of this mediation path, a Sobel test was conducted. Results indicated that shame served as a full mediator of the relationship between trauma symptoms and intimacy ($-4.44$, $p < .001$).

Because it is also theoretically possible to conceptualize shame as a moderator of the relationship between trauma symptoms and intimacy, MPlus was utilized to test a moderating SEM. According to Hoopwood (2007), moderation refers to a “third variable (or set of variables) that acts as a controlling condition for the effects of variables (or sets of variables) on other variables (or sets of variables)” (p. 263). In contrast, “mediation consists of a case in which a third variable is a pathway for the effect of a predictor on an outcome” (Hopwood, 2007, p.265). Using MPlus, a model was tested in which trauma symptoms were a predictor of intimacy, shame was a predictor of intimacy, and the interaction term (trauma symptoms times shame) was a predictor. As was true in the mediation model, the relationship between trauma symptoms and intimacy was not statistically significant when shame was included as a predictor of intimacy in the model. Further, the relationship between the interaction term (trauma symptoms times shame) was also not significant. The relationship between shame and intimacy was statistically significant ($\beta=-.62$, $p<.001$). The model fit for treating shame as a moderating variable was poor ($\chi^2=103.21$, $df=52$, CFI=.92, RMSEA=.08), making the mediation model a better fit to the data.
Additional Findings

It is interesting to note that of all the control variables originally examined in the model (education level, age, household income, age at which abuse began, length of relationship with current partner) that only the relationship variable was significant. The beta coefficient for the relationship variable of -.17 (p<.001) indicated that as the length of relationship increases the level of intimacy decreases. Co-occurring physical abuse was also found to have a negative impact on intimacy (β=−.01) although this effect was not statistically significant.
CHAPTER FIVE

Discussion

The purpose of the current study was to explore the effects of trauma symptoms on intimacy for women with CSA histories, mediated by shame. Results utilizing SEM indicate that as hypothesized, shame has a mediating impact of trauma symptoms on intimacy. In addition, shame was found to be a full mediator in that the influence of trauma symptoms on intimacy lost all statistical significance when shame was included in the model. Additional statistical analysis through the use of the Sobel test further verified the significance of the mediating role of shame in the model. As such, results of the study indicate that shame is the primary vehicle through which sexual abuse related trauma symptoms negatively impact intimacy for women in the study. Further analyses utilizing Mplus verify that this relationship is mediating rather than moderating in nature.

Results and Previous Research

The results of the current study are consistent with previous research that illustrates the negative impact of shame on interpersonal functioning. Not only has shame been associated with dating aggression, sexuality difficulties (Feiring et al., 2009), family conflict (Kim et al., 2009), purported sexual rejection of partners (Traeen & Sorensen, 2008), and aggression within intimate partnerships (Kim et al., 2009), results of the current study illustrate its negative impact on intimacy as a whole.

Results of the current study are also consistent with previous research focused on the mediating relationship of shame to trauma symptoms for sexual abuse victims. Previous studies have found that shame not only predicts the trajectory of PTSD symptoms in adults with sexual abuse experiences (Andrews et al., 2000) but also mediates changes in PTSD symptoms
(Ginzburg et al., 2009). However, contextual limitations exist in making comparisons between the current study and results of previous research. Specifically, previous research examining the impact of shame on PTSD symptoms for CSA survivors has focused on symptoms within an individual context (Andrews et al., 2000; Ginzburg et al., 2009). While results of the current study similarly illustrate the mediating role of shame on trauma symptoms, this mediation is within a relational rather than an individual context. Consequently, the current study fills an important gap in the literature regarding the interplay between shame and trauma for CSA victims within a relational context.

Research regarding the etiology of the shame/PTSD connection have focused not only on the mediating role of shame to PTSD symptoms (Ginzburg et al., 2009; Andrews et al., 2000), but also the possibility of a parallel process. For instance, Wilson, Drozdeck, and Turkovic (2010) compare posttraumatic shame and guilt and assert that shame is more complex in that it involves “processes concerning attributes about the core dimensions of the self, identity, ego processes, and personality” (p. 123). As such, posttraumatic shame involves evaluation of self-virtue and goodness as well as a sense of dishonor, disgrace, “disrepute,” and loss of self-esteem, virtue, and integrity (Wilson et al., 2010, p.123). Consequently, posttraumatic shame centers on the core of the individual, seemingly searing trauma experiences within the flesh of the soul. Wilson et al., (2010) purports that posttraumatic shame may be “coupled with a broad range of affects…to form complex states of intrapsychic tension as part of PTSD” (p. 124). In some instances, “states of posttraumatic shame and guilt form the pathological nucleus of simple and complex PTSD (Wilson, 2004c as cited in Wilson et al., 2010, p.124). Consequently, not only does shame mediate PTSD symptoms, but it may also be at the heart of traumatic symptomology. As emphasized by Wilson et al (2010), “unresolved posttraumatic shame” has
the ability to “generate fuel for trauma complexes, PTSD, and self-destructive patterns of coping” (p. 139).

Results of the current study also shed light on the impact of co-occurring physical and sexual abuse on intimacy. Previous research exploring this phenomenon found that survivors of physical and sexual abuse experience more fear of intimacy than victims of either physical or sexual abuse alone (Davis et al., 2001). Results of the current study parallel results of Davis et al (2001) in that co-occurring sexual and physical abuse was found to negatively impact intimacy, although this effect was not statistically significant.

**Clinical Implications**

Results of the current study give direction regarding the treatment of trauma and point to the importance of addressing shame in survivors of sexual abuse. As indicated by Ginzberg et al (2009), the significance of understanding the mediating relationship between trauma and PTSD symptoms is that in addition to the inherent value of reducing shame in clients, efforts to do so may also represent options for treating PTSD (p.539). In other words, not only is treating shame inherently valuable but it also represents a way in which PTSD symptoms may be effectively treated. While previous research denotes the importance of addressing the shame/PTSD connection within an individual setting (i.e., Andrews et al., 2000; Ginzburg et al., 2009), results of the current study illustrate this need within a relational context.

Indeed, a relational setting may provide unique opportunities to address the shame and associated trauma symptomology often inherent within abuse experiences. As indicated by Wilson et al (2010), those with shame may not only experience lost innocence, decreased self-virtue, and a sense of being dirty, but may also feel they have lost the respect of others due to what has happened to them (p. 129). In fact, of the eight “dimensions of posttraumatic shame”
developed by Wilson et al (2010), four focus on evaluation by others, including the loss of “self-continuity” in upholding cultural values or norms, perceptions of shame in the perspective of others (i.e. condemnation or failure), self-consciousness about having disappointed others, and decreased self-respect within roles and status defined by culture (p. 125). Others similarly purport that shame has a societal component that involves “implied devaluation by others” (Ginzburg et al., 2009, p.541). Hence, it would appear that treating shame within a relational context would allow unique opportunities to address potential feelings victims may have regarding being alienated, inherently different, and isolated from others. Consequently, it is essential that clinicians working within relational settings be equipped with the tools necessary to effectively address the shame of CSA victims dealing with PTSD symptoms.

As a whole, treatments geared for couples in which one partner is a survivor of childhood sexual abuse have been inadequately researched. Previous research in this area has historically focused on theoretical underpinnings or case study, resulting in a dearth of clinical studies examining treatment effectiveness for this population (MacIntosh, 2005). One study aimed at filling this gap in the literature examined the effectiveness of Emotionally Focused Therapy (EFT) in reducing interpersonal distress for couples who had at least one partner with a history of CSA (MacIntosh & Johnson, 2008). Results indicated that half of the couples reported significant improvements in both relationship satisfaction and trauma symptomology (MacIntosh & Johnson, 2008). Consequently, it may be purported that EFT is an effective treatment for couples dealing with the negative interpersonal sequel of CSA.

Perhaps one of the greatest difficulties in addressing shame is gaining clinical access to it. The mere presence of shame within victims may increase their tendencies to emotionally avoid, placate others, and play down their traumatic experiences. Shame seems to have a tendency to
distract and then take hold of the client, leading them further from sources of healing but ever closer to sources of pain (dangerous people, places, self-beliefs, etc.). As such, when shame does surface within clinical work, clients may seek to distract the clinician by being overly pleasing, masking symptoms, and denying felt pain. Hence, when clinically drawing near the burrow of shame, specific clinical tools may be especially useful including a powerful therapeutic alliance, gentleness, unconditional positive regard, genuineness, and patience with the process. Given that shame most often occurs within a relational context, healing most likely occurs in such contexts as well.

**Strengths and Limitations**

In addition to filling a specified gap within the current literature, an additional strength of the current study is the sample size. With 318 participants, the current study exceeds in sample size many of the other studies addressing the impact of shame on relational functioning (e.g., Feiring et al., 2009 [n=160], Kim et al., 2009 [n=129] as well as the mediating impact of shame on PTSD symptoms (e.g., Ginzberg et al, 2009 [n=129], Andrews et al., 2000 [n=157]). Indeed, with a sample size of 318, the current study is nearly double the sample size of similar studies. In addition, methodology of the current study may make results more generalizable given that participants were gathered from the general public (i.e. phone book census) in comparison to studies focused on more specific populations, such as children and adolescents involved in child protective services (e.g., Feiring et al., 2009) and financially disadvantaged mothers of at-risk children (e.g. Kim et al., 2009). Further, the current study recruited participants from multiple regions of the country whereas the majority of similar studies focused on participants in one central location (e.g., Andrews et al., 2000; Feiring et al., 2009; Ginzburg et al., 2009; Kim et al., 2009).
While a large, non-clinical, and geographically diverse sample population may lend to
greater generalizability of the results, several factors serve as limitations of the current study.
One demographic feature that particularly decreases generalizability of findings is the ethnic
homogenous nature of the sample. Within the current study over 89% of participants are
Caucasian and represents a higher level of ethnic homogeneity when compared to similar studies
(e.g. Feiring et al., 2009 [31% White], Ginzburg et al, 2009 [36%, 33%, 35% White/European
American], Kim et al., 2009 [34% European American]). Consequently, caution must be made
when making generalizations of the current findings to that of other similar with more ethnically
diverse populations.

An additional limitation of the current study is the relatively low response rate of 3.8%.
Several factors may have contributed to this low rate including the length of the questionnaire
and sensitive nature of questionnaire material. However, projected prevalence rates of
populations as a whole provide context regarding the response rate.

Given the methodology of the study, it was also difficult to control for certain variables.
Due to the length of the questionnaire it may be possible that those self-selecting to complete it
were different than those who opted to disregard it, including higher levels of psychological
functioning, self-regulatory abilities, and comfortability in reflecting on abuse history. Given the
retrospective nature of the study it is also important to note that the data gathered was dependent
on accuracy of participant memory and contingent on conceptualization of abuse experiences.
Further, given limitations inherent within quantitative data, it should be noted that richness of
experience may not be fully captured.

In addition, given the emphasis of the study on ways in which trauma and shame
influence intimacy, an additional limitation is the lack of partner data. Given that partner views
are highly valuable and provide insight the victim may not possess, it should be noted that results of the current study represent one perspective of the influence of trauma and shame on intimacy. Additional studies focused on partner as well as survivor perspectives would give context to the findings of the current study and provide greater insight into the complete impact of trauma on intimacy in couples, moderated by shame.

Likewise, research indicates that family of origin experiences play a role in the development of shame (Harper & Hoopes, 1990). Harper and Hoopes (1990) explain in detail the continuum of the types of shame-based families, common characteristics of those families, and the role that the “negative affirmation triangle” plays in the development of shame within individuals (p.73). While a full account of their work is not within the scope of this paper, their findings shed light on the importance of considering family of origin factors when addressing shame. Given the design of the current study, the influence of family of origin factors on the internalized shame experienced by participants was not fully explored. As such, this should be considered another limitation to the present study.

**Conclusion**

The current study explored the effects of trauma symptoms on intimacy for women with CSA histories, mediated by shame. While previous studies had likewise determined the mediating influence of shame on PTSD symptoms, the current study fills a literature gap addressing this phenomenon within a relational sphere. Results of the current study point to the importance of addressing shame when treating trauma in sexual abuse survivors. Consequently, it is essential that clinicians are familiar with therapeutic modalities geared towards treating shame that are well-suited for relational contexts.
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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.
17. I could beat myself over the head with a club when I make a mistake.
18. On the whole, I am satisfied with myself.
19. I would like to shrink away when I make a mistake.
20. I replay painful events over and over in my mind until I am overwhelmed.
21. I feel I am a person of worth at least on an equal plane with others.
22. At times I feel like I will break into a thousand pieces.
23. I feel as if I have lost control over my body functions and my feelings.
24. Sometimes I feel no bigger than a pea.
25. At times I feel so exposed that I wish the earth would open up and swallow me.
26. I have this painful gap within me that I have not been able to fill.
27. I feel empty and unfulfilled.
28. I take a positive attitude toward myself.
29. My loneliness is more like emptiness.
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.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Somewhat Disagree</th>
<th>Neutral</th>
<th>Somewhat Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

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.
### Trauma Symptom Checklist 33

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

<table>
<thead>
<tr>
<th>1 = Never</th>
<th>2 = Occasionally</th>
<th>3 = Fairly Often</th>
<th>4 = Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Insomnia (trouble getting to sleep)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Restless sleep</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Nightmares</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Waking up early in the morning and can’t get back to sleep</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Weight loss (without dieting)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling isolated from others</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Loneliness</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Low sex drive</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Sadness</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. “Flashbacks” (sudden, vivid, distracting memories)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. “Spacing out” (going away in your mind)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Headaches</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Stomach problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Uncontrollable crying</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Anxiety attacks</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Trouble controlling your temper</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Trouble getting along with others</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. Dizziness</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. Passing out</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. Desire to hurt yourself physically</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
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<tr>
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</tr>
<tr>
<td>21.</td>
<td>Desire to hurt others physically</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>Sexual problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>Sexual overactivity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>Fear of men</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Fear of women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>Unnecessary or very frequent washing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>Feelings of inferiority</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>Feelings of guilt</td>
<td></td>
<td></td>
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<tr>
<td>29.</td>
<td>Feelings that things are “unreal”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>Memory problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31.</td>
<td>Feeling of not always being in your body</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.</td>
<td>Feeling tense all the time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33.</td>
<td>Trouble breathing</td>
<td></td>
<td></td>
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</tbody>
</table>