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Tabitha Nicole Webster
Brigham Young University - Provo

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Shame Not the Same for Different Styles of Blame: Shame as a Mediating Variable
for Severity of Childhood Sexual Abuse and Trauma Symptoms in
Three Attribution of Blame Groups

Tabitha N. Webster

A thesis submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of
Masters of Science

James M. Harper, Chair
Jonathan Sandberg
Mark H. Butler

School of Family Life
Brigham Young University

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ABSTRACT

Shame Not the Same for Different Styles of Blame: Shame as a Mediating Variable for Severity of Childhood Sexual Abuse and Trauma Symptoms in Three Attribution of Blame Groups

Tabitha N. Webster
School of Family Life, BYU
Master of Science

This study examined the role of internalized shame in mediating the relationship between severity of childhood sexual abuse and adult symptoms in three groups based on attribution of blame. The random community sample of 318 female survivors completed the Trauma Symptom Checklist-40 (Briere, 1996), Internalized Shame Scale (Cook, 2001), questions about frequency of abuse, duration, and specific characteristics (no physical contact to vaginal/anal intercourse with force) and the degree to which they blamed self, fate, or perpetrator.

It was hypothesized that severity (measured by abuse characteristics, frequency, and duration) would predict symptoms (measured by subscales of dissociation, anxiety, sexual problems, depression, and sleep disturbance from TSC-40) and that Internalized shame would be a potential mediator in all three groups (blame self, blame fate, or blame perpetrator).

Multiple group analysis in Structural Equation Modeling showed that severity and shame were related for all groups and that the relationship was strongest when survivors blamed themselves and weakest when they blamed perpetrators. Shame was a significant predictor of symptoms for all three groups with no significant differences between groups. Severity was a significant predictor of symptoms for the blame self and blame fate groups but not for the blame perpetrator group, with symptoms being the strongest in the blame self-group. Sobel tests showed that shame was a significant mediator for all three groups.

Given these findings, therapists treating adult survivors who blame fate or the perpetrator for the abuse should consider addressing the underlying shame. When treating adult survivors that blame themselves, therapists should consider addressing this attribution of blame and its meaning in addition to focusing on shame.

Keywords: childhood sexual abuse, shame, blame, trauma, post-traumatic stress disorder, symptoms

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Introduction

According to the US Census there are 157.2 million females in the United States (U.S. Bureau, 2012). Estimated prevalence rates of Childhood Sexual Abuse (called CSA hereafter) vary from 2% to 46% (Bolen & Scannapieco, 1999), much of the variance due to under reporting. According to the U.S. Department of Justice, 65% of rapes and sexual assaults for ages 12 or older go unreported (Berzofsky, Krebs, Langton, & Smiley-McDonald, 2012). There is little data on under reporting in children under age 12. When retrospective self reporting of incidents of sexual abuse is used, 64% of sexual abuse occurs before the age of twelve (Finkelhor, Hotaling, Lewis, & Smith, 1990). In a global meta-analysis, Stoltenborough, van IJzendoorn, Euser and Bakermans-Kranenburg (2011) estimated the prevalence of adults who experienced childhood sexual abuse as 11% to 21%, depending on the continent. The under reporting is likely explained by two predominate issues: “(a) Most sexual abuse reports, unlike other forms of child maltreatment, start from children's own disclosures, which are more difficult for younger children to make, (b) Much sexual abuse goes on for extended periods of time before being disclosed, and the data is based on age at the time of report, not age at onset (Finkelhor & Dziuba-Leatherman, 1994).” The current study acknowledges the significance and severity of childhood sexual abuse of males; however, due to only seven male respondents in the data sample, only females responses were used in this study.

The effects of being sexually abused as a child last long into adulthood. Some long term effects include depression, anxiety, eating disorders, substance abuse, self-harm, post-traumatic stress disorder (PTSD), marital discord, sexual disorders and interpersonal problems (Hunter, 2006; Mullen, Martin, Anderson, Romans, & Herbison, 1996, Williamson, 2009). Many studies

have shown that the more intense or severe the abuse, the more negative and intense the outcomes in adult survivors (Coffey, Leitenberg, Henning, Turner, & Bennett, 1996; Dube et al., 2005.) Prominent emotional disturbances associated with childhood sexual abuses are feelings of guilt and shame, the latter (Davis & Perietic-Jackson, 2000; Zlotnick, Zakriski, Shea, & Costello; Williamson, 2009), generally described as the person feeling defective or flawed. Others (Stuart, 1994; Finkelhor, 1990; Conte, 1985; Roth & Newman, 1991) have found that the survivor's attribution of blame for the abuse is related to the severity and intensity of negative outcomes and symptomology for the survivor (Stuart, 1994; Finkelhor, 1990; Conte, 1985; Roth & Newman, 1991).

With such high prevalence rates, in context of both the United States and globally, clearly a mental health provider will inevitably encounter clients presenting with CSA. Unfortunately, clinicians vary in their conceptualization and treatment of CSA. Harvey and Taylor (2010) and Kindall-Tackett, Willams and Finkelhor, (1993) conducted meta-analyses of treatment studies, which documented this lack of consistent definition, operationalization, conceptualization and treatment of CSA which in turn produces a variety of research outcomes.

Kindall-Tackett, Willams and Finkelhor (1993) conducted a meta-analysis of 45 studies about the impact of sexual abuse and found that in 6 out of 10 of these studies, severity of sexual abuse was highly correlated with higher levels of trauma symptoms. However, researchers in the remaining four studies found no such correlation. One reason for this inconsistency is that there is an abundance of variance in how researchers define and operationalize severity, age of onset, penetration, frequency, duration, perpetrator identity, force, etc. leading to this in part still being an important realm to investigate.

Similarly, the role of abuse-related shame has been shown to have a longitudinal effect on PTSD symptoms and poor adjustment (Finkelhor & Browne, 1985; Feiring, Taska, & Chen, 2002). As severity increases in intensity, severity of symptoms increases. In an attempt to make cognitive meaning of the abuse, survivors often internalize the blame (blame themselves) with increased amounts of shame, viewing the abuse as their predestined “fate”, or blaming the perpetrator. While it is possible that the source (self, fate, perpetrator) toward which survivors direct blame may be related to how much their shame is internalized, there have been no studies that look at the possibility that the degree of internalization of shame might be related to who or what a survivor blames for the abuse in adult females. In 2002, Fiering, Taska and Chen looked at attribution for abuse event, shame for the abuse, symptoms of depression and PTSD variables in a small study of 80 children and 57 adolescents where she explored survivors' personal processing of sexual abuse. She defined shame as a dejected, humiliation-based emotional state in which the self desires to shrink and hide the exposed self (Lewis, 1971; Lewis, 1992) and attribution of blame as the possible reason one was targeted for the abuse. She indicated that shame and blame may play a significant role in understanding how individuals made meaning of abuse; however, she did not link these variables together or to occurrence of symptoms or severity of abuse.

Williamson (2009) found that severity of abuse was directly related to survivor’s experience of internalized shame. Other studies (Stuart, 1994; Barker-Collo, 2001) have shown that survivors’ attributions of blame for the abuse may be related to the long term symptoms of low self-esteem, depression, anxiety, and possibly suicidal behaviors. Survivors often have to understand the abuse through blaming, whether it is from an internal (self) or external (perp)

source. It is important for clinicians to be able to help survivors learn to form appropriate and healthy attributions of blame for the abuse (Murtagh, 2010).

Knowing that both internalized shame and attribution of blame may be key in understanding the levels of adjustment and symptomology based on level of abuse severity, it seems that these two elements may play a key role in being able to treat survivors. If the relationship between severity of abuse, shame and attribution of blame is supported by a large study of sexually abused women, it will demonstrate that internalized shame must be addressed in therapy for healing to take place. It will also provide further support to Murtagh's (2010) postulation that clinicians should help survivors learn to form appropriate and healthy attribution of blame for the abuse. If the relationship between shame and blame are strong, the results of this study would support the supposition that as the survivor is able to decrease her internalized shame (defective) for the events, she is able to appropriate blame the perpetrator for the abuse. It seems likely that survivors' shame from being abused is possibly one process through which severity of abuse has its effects long into adulthood, and the relationship between these variables might differ based on attribution of blame, whether toward self, fate, or perpetrator.

The purpose of this study was to examine the potential of internalized shame as a mediator of the relationship between severity of CSA and adult trauma symptoms among three groups of CSA survivors, those who primarily blame themselves, blame fate, or blame the perpetrator for the abuse. Definitions of variables will first be identified before examining empirical literature related to these topics.

Definitions

For the purpose of this study the following are the conceptual definitions of the key terms:

Childhood sexual abuse (CSA). This will be defined as a female individual under the age of 17 who has been involved with sexual activities which she does not or cannot fully comprehend and give consent to (Feinauer, 1989) as measured by her self-report as an adult.

Severity of abuse event. This will be defined as the frequency, duration in terms of the child's years, and the degree to which the abuse involved intrusive physical contact and force.

Internalized shame. Shame, measured by Cook's Internalized Shame Scale (2001), is defined as a self-conscious emotion that requires the cognitive ability to evaluate one's own behavior and internal experiences as persistently flawed or inadequate (Lewis, 2000; Harper, 2012; Harper & Hoopes, 1990).

Attribution of blame. This is defined in part by the way in which a survivor makes meaning of the abuse (Foresterling, 1992) whether through blaming or holding responsible one's self, the perpetrator, or fate for the CSA. This was measured using the Williams Coping scale.

Trauma symptoms. These are defined as common symptoms related to trauma which are supported by several studies of long-term effects related to sexual abuse, including symptoms of depression, dissociation, anxiety, post-traumatic stress, and somatization (e.g., Bryer et al., 1987; Lindberg & DiStad, 1985; Pribor, Yutzy, Dean, & Wetzel, 1993; Surrey, Swett, Michaels, & Levin, 1990). These were measured using subscales from The Trauma symptom checklist.

Literature Review

In the following review of literature, a brief review of sexual abuse and trauma symptoms will be followed by a careful review of research studies focused on the relationship of sexual abuse, attribution of blame, and internalized shame. This will be followed by a summary of the findings.

Childhood Sexual Abuse and Negative Outcomes

Research has repeatedly shown that childhood sexual abuse leads to marked distress and adjustment difficulties even long into adulthood. Studies have shown the more severe the act, the more severe the negative symptom outcomes (Browne & Finkelhor, 1985; Finkelhor, 1990). For example, Browne and Finkelhor (1985) found that penetration as a sexual abuse act was related to an increase in trauma symptoms. Kendall-Tackett et al. (1993) found the same. Dube et al. (2005) and Barker-Collo (2001) found that those who encountered higher levels (based on frequency, duration, abuse type, and relationship to perpetrator) of abuse had a greater risk of substance use, increased suicidality and attempts, greater chances of marrying an alcoholic partner and more marital and/or family problems. Similarly, Coffey et al. (1996) found that intensity of abuse was related to increased negative self-perceptions, self-blame, and experience of stigma.

CSA and Trauma Symptoms

Orr et al. (1998) compared 18 year old or older female survivors with histories of penetration sexual abuse experienced between the ages of 5 and 13 who had full PTSD, partial PTSD, and no PTSD. All three groups reacted to the “30-scripts portraying five past personal experiences, including the two most stressful childhood sexual abuse experiences,” however

women with full PTSD showed significantly greater increases in heart rate and forehead muscle tension than did those without PTSD. Similarly, Metzger et al. (1999) found that, when reminded about their CSA, survivors with current PTSD or lifetime PTSD had greater heart rate responses than CSA survivors without PTSD. These findings suggested that women with PTSD–CSA exhibit patterns of psycho-physiological responses similar to those observed in male combat veterans with PTSD. They concluded that these negative outcomes ranged from physiological effects, trauma and PTSD symptomology, relational struggles and self-concept maladjustments.

Much of the literature categorizes severity of abuse in terms of the intrusiveness of the perpetrators' behaviors. Generally studies have operationalized severity as ranging from no abuse to genital contact and penetration (Mullen et al., 1996; Dube et al., 2005). For this study, categories were further broken down based on assumptions that visual experience (e.g. someone exposing his genitals) is not as intrusive as touch contact. Penetration or sexual intercourse is usually on the extreme end of intrusiveness, but use of force or threat of weapons to coerce intercourse or as a part of ritual ceremony is even more intrusive, since factors of lack of safety and emotional threat can be abusive acts in and of themselves but are even more abusive when added to sexual abuse (Fienauer, Mitchell, Harper, & Danes, 1996). Kendall-Tackett et al. (1993) have added characteristics of the abuse such as duration and frequency to the list of what makes sexual abuse more severe.

CSA and Internalized Shame

According to Finkelhor and Browne (1985), the stigma associated with CSA may adversely affect later psychological wellbeing. Talbot (1996) stated shame was a core emotion in CSA survivors. Similarly, studies have shown that shame and guilt are associated with the

emotional distress of abuse. Higher levels of both shame (e.g., Feinauer, Hilton, & Callahan, 2003) and guilt (e.g., Sheldon & Bannister, 1998) have been found in CSA survivors.

In general, literature on CSA uses guilt and shame interchangeably as a negative reaction to trauma (Feiring, Taska, & Lewis, 1996). Both guilt and shame focus on the meaning of self and are seen as negative feelings, but the nuances of guilt versus shame focuses on specific aspects of the self. Guilt defined by Fiering and Taska (2005, p. 338), is where the self is perceived as causing the failure, whereas shame focuses on the whole self. “Guilt concerns one’s actions. Shame concerns one’s entire being.” Abuse-related shame would be expected to cause the individual to feel shame in response to everyday negative events, to a much higher degree (Fiering & Taska, 2005). This coincides with earlier concepts of Erikson (1950) who suggested shame was the product of the child not developing autonomy. Furthermore, where others studies have added to shame helplessness and powerlessness, these definitional and theoretical foundations of shame make it likely that survivors develop a high levels of shame-proneness (Williamson, 2009; Feinauer et al., 2003).

In a longitudinal study, Fiering and Taska (2005) showed that children who remained high in abuse-related shame one year following the abuse experienced the highest levels of PTSD symptoms. Finkelhor and Browne (1985) and Negrao, Bonanno, Noll, Putnam, and Trickett (2005) have shown similar results implying that shame related to CSA is core to the development of poor adjustment in adult survivors. Negrao et al. (2005) concluded that shame in non-disclosing CSA survivor’s likely results in higher levels of PTSD symptoms. Many studies provide evidence for clinical observations that shame is imperative for understanding the negative outcomes of CSA (Andrews, 1995; Ferguson, Stegge, Miller, & Olsen, 1999). Fiering

and Taska (2005) stated that CSA-related shame is essential in understanding of long term consequences for the experience of PTSD symptoms.

CSA and Attributions of Blame

According to the learned helplessness model, attribution styles are categorized into three types: internal-external, stable-unstable and global-specific (Abramson, Seligman, & Teasdale, 1978). A self-blaming style incorporates negative events attribution to internal, stable and global causes, which have been shown to be related to negative affect. Positive events are more likely to be attributed to external, unstable, and specific causes (Celano, 1992). These studies conclude that blaming a sexual abuse experience in an external way may be more adaptive than attributing the experience to internal causes, (i.e., blaming other vs. blaming self; Brickman et al., 1982).

Morrow (1991) found higher rates of depression and negative self-esteem in adolescent survivors of sexual abuse who attributed blame to themselves. Another study (Shapiro, Leifer, Martone, & Kassem, 1992; Barker-Collo, 2001) similarly found a positive relationship between self-blame for the abuse and internalized dysfunction that are exhibited as trauma symptoms. Conte and Schuerman (1987) and Cantón-cortés, Cantón, and Cortés (2012) found self-blame to be among a number of predictors of symptomatology for survivors of sexual abuse.

According to DiLillo, Long and Russell (1994), who studied the experiences of 66 college females, those who were sexually abused by family members as children had higher self-blame and higher trauma symptomology than those abused by strangers. Ullman (1997) studied 155 women who were abused in either childhood or adulthood and found that the women who self-blamed for the abuse were more likely to have a poorer recovery than those who externalized the blame. Other researchers (Feinauer & Stuart, 1997) found that those who blame

themselves for the abuse have higher trauma symptom checklist scores than those who did not. Those who blamed fate for the abuse had significantly lower trauma symptoms scores than those who blamed themselves. Those who blamed the perpetrator, not fate or self, for the abuse had significantly lower trauma symptom scores than those who blamed fate or themselves. Feinauer and Stuart (1997) concluded that externalization of the abuse allows women to adapt in better ways (Feinauer & Stuart, 1997).

CSA, Shame and Blame

It appears that survivors of sexual abuse continue to experience blame and shame for the abuse. Herman (2000) found that survivors of incest at some point found pleasure with the experience, whether it be physical, emotional or being singled out as “special.” These women were not only ashamed of the occurrence of abuse, but they were likely to blame themselves for feeling “special” in being selected as the object of abuse.

Kellog and Hoffman (1997) found that survivors who had multiple experiences with abuse by more than one perpetrator had higher levels of shame and self-blame and were more likely to delay disclosure of the abuse. Delayed disclosure has been found to be related to greater psychological trauma, mistrust, fear (Somer & Szwarcberg, 2001).

Fiering et al. (2002) investigated the phenomena of blame for the abuse within 8 weeks of discovery of the abuse and then one year later in 80 children ages 8 to 11 and in 57 adolescents ages 12 to 15. They found that internal (self-blaming) attributions consistently led to higher levels of psychopathology and were predictive of higher levels and development of PTSD symptomology. Shame was also found to be positively associated with symptomology levels and mediated the self-blaming style and PTSD symptoms. The current study postulates that

because of these factors, shame is present in the majority of CSA survivors, regardless of how they make meaning of the abuse in their attribution of blame style, and so it is hypothesized that shame will be a mediating factor between severity and trauma symptomology.

Summary

CSA is a global problem which affects persons of every culture, gender, and age. There is a large body of literature documenting the long term negative effects of CSA. Severity consistently is identified as the most important variable related to negative outcomes.

Symptoms which occur as a consequence of abuse include personal and interpersonal distress including depression, PTSD, anxiety, sexual dysfunction, intimacy/attachment disorders, and marital distress. The studies reviewed indicate that the shame may mediate the relationship between severity of the abusive event and adult symptoms differently, depending on whether a survivor blames self, blames fate, or blames the perpetrator.

Statement of Purpose

The purpose of this study was twofold: 1) to examine the potential role of internalized shame in mediating the relationship between severity of childhood sexual abuse and adult symptoms, and 2) to examine differences in the relationship between severity of abuse, shame, and adult trauma symptoms among three groups of survivors, including those who blame themselves, those who blame fate, and those who blame their perpetrator. Figure 1 shows the hypothesized model with paths between variables representing the hypotheses below.

Hypotheses

The following hypotheses were tested in this study.

1. Severity of abuse event will be positively related to adult trauma symptoms for all three groups.
2. Severity of abuse event will be positively related to internalized shame for all three groups.
3. Internalized shame will be positively related to adult symptoms of trauma for all three groups.
4. The standardized coefficients for the structural paths in the model shown in Figure 1 will be significantly stronger for the “Blame Self” group than the other two groups.
5. Internalized shame will mediate the relationship between severity of abuse event and adult trauma symptoms for all three groups.

Method

Sample and Data Collection

The data used in this study comes from a data set that was part of the Hardiness and Childhood trauma project (Feinauer, Callhan, & Hilton, 1996.) Data was collected in the following locations: Salt Lake City, UT; Salt Lake City Prison; Brigham Young University Comprehensive Clinic; San Francisco, CA Bay area; Chicago, IL and New York City, NY Metropolitan area. All data were collected during the years 1991 to 1994. Households were randomly selected from phonebook, voter registrations and clearing house lists, and approximately 28,000 questionnaires were sent out to male and females between the ages of 16 and 85.

Finkelhor et al. (2005) estimated that the prevalence rate of childhood sexual abuse in the general population is about 8%, though arguably higher. Using this estimate of 8%, 2,240 of the 28,000 questionnaires mailed out would reach households where a person had experienced childhood sexual abuse. One thousand, five hundred and eighty surveys were returned. Of these 1580 who returned the questionnaires, 473 individuals reported that they had never been abused so they did not qualify for this study. Meaning 1,107 fell in the targeted population resulting in a 49% response rate of the 2,240 based on prevalence estimates. Seven hundred eighty nine individuals returned surveys but did not answer the questions about whether they blamed themselves, fate, or the perpetrator, which left 318 women whose answers were complete enough to be used in this study. Dillman's (2008) suggestion that letters be followed by reminder cards was not implemented in gathering this archival data set, which may be one reason more individuals did not respond.

The demographic characteristics of the women in this sample are shown in Table 1. All participants in this sample were female with the average age of 35.56 years ($SD = 7.82$). Each CSA survivor had been in their current relationship 12.23 years ($SD = 8.16$). The majority of participants had achieved at least a high school education and self identified as being Caucasian. Income ranged from under 15,000 to over 45,000 with the 41% reporting they have income over 45,000.

Measures

Severity of abuse. A latent variable called *Severity of the Abuse Event* was created from three indicators, a summed score from The Severity of Abuse Scale (SAS) (Wilkins, 1992), survivor's report of the frequency of the abuse, and survivor's report of the duration of the abuse.

The SAS was adapted by Wilkins from Wyatt et al.'s (1992) measure. The SAS consists of 16 items with respondents indicating whether or not the given event had happened to them before the age of 16. The items were rescored with 0 representing no reported sexual abuse, 1 representing no contact abuse (made sexual comments to me; forced me to view pornography); 2 indicating contact only abuse (fondled me through my clothes; forced me to masturbate them with my hand); 3 indicating penetration and intercourse (put their finger into my vagina or rectum); and 4 indicating use of force or bizarre ritual (forced me to have intercourse, did strange things to me like rituals or black magic; threatened me with a gun or knife to participate). Wilkins (1992) showed that this measure has high inter-item reliability. Cronbach's alpha for this sample was .77. The second indicator called frequency of abuse was taken from the self-reported answer to the question, "How often did they have sexual experience with you?" Answers ranged on a scale from 1 (*only occurred once*) to 7 (*more than once a week*). The third indicator called duration was calculated from two questions: Participants were asked at what age the abuse began and at what age the abuse ended? The age at which abuse began was subtracted from the age at which it ended to create this indicator. The factor loadings for The Severity of Abuse Scale, its frequency items and the duration items were .58, .67, and .56 respectively.

Shame scale. A latent variable called *Internalized Shame* was created using the summed scores of the three subscales of the Internalized Shame Scale (Cook, 2001). This assessment contains 24 items that are categorized into three subscales: inadequate/deficient, empty/lonely and exposed/fragile. Using a Likert-type scale ranging from 1 (*never*) to 5 (*almost always*), participants responded to each item based on the extent to which that feeling or thought occurs. The inadequate subscale has 12 items, with summed scores ranging from 1 to 48 (I think people

look down at me; I scold myself and put myself down). The empty scale has five items, with possible scores ranging from a 0 to 20 (I feel somehow left out; I feel empty and unfulfilled).

The exposed subscale has 8 items, with possible summed scores ranging from 0 to 32 (At times I feel like it will break into a thousand pieces; I think other can only see my defaults).

The ISS has an alpha reliability of .96 and test/retest reliability of .84 (Cook, 1991). Studies (Kim, Thibodeau, & Jorgensen, 2011; Ashby, Rice, & Martin, 2006) have shown correlations between shame and depression ranging from .44 to .79. In terms of predictive validity, scores on the Internalized Shame Scale were significantly predictive of eating disorders, anxiety and anger (Cook, 1991). Factor loadings for this study were .93 for the inadequate subscale, .87 for the empty subscale, and .91 for the exposed subscale.

Blame scale. A scale was created using questions from William McPearl Belief Scale and the Williams Coping Scale requiring the participants to indicate how much they blamed “fate” (2 items; “It is part of my karma”), “self” (2 items; “I am to blame for my abuse as a child and as an adult”) and “perpetrator” (2 items; “I blame the person that abused me”) for the abuse. Responses varied from 1 (*never*) to 5 (*always*). The scores for each scale were summed, and participants were classified into each group based on the highest of the three scores.

Trauma Symptom CheckList-33. The TSC-33 is a revised version of Briere’s Crisis Symptom Checklist. The TSC-33 has been designed to assess symptoms of trauma (Briere & Runtz, 1989). The assessed symptoms are related to five areas of adult functioning. The subscales are Chronic Dissociation (“spacing out”), Anxiety (fear of men), Depression (uncontrollable crying), Sexual symptomatology (sexual over-activity) and Sleep Disturbance (nightmares). Participants respond to a Likert-type scale ranging from 0 (*never*) to 3 (*very often*). The reliability

coefficients ranged .66 to .77 on subscales, with alphas for the full scale being .90 (Briere, 1996). Test-retest reliability was shown to be .88 for the full scale. Concurrent validity of the TSC-33 has shown that the items are highly correlated with scores from the Symptom Checklist (SCL-90) (Derogatis & Coons, 1993), and the Hopkins Symptom Checklist (HSCL; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974). The subscales and total scores gained from the TSC-33 have been previously reported as having good discriminant validity (Briere & Runtz, 1989). The alpha reliabilities in this sample were .69 for dissociation, .74 for anxiety, .86 for depression, .79 for sexual problems, and .87 for sleep disturbance. The loadings on the latent variable were .78 for dissociation, .79 for anxiety, .96 for depression, .69 for sexual problems, and .77 for sleep disturbance.

Statistical Analyses

Structural equation modeling using AMOS 20 (Muthen & Muthen, 2012) was used to analyze both measurement error and the structural relationships between the variables in Figure 1. First, factor analysis was used to determine that all of the proposed indicators loaded at least at a .50 level on each latent variable. Means and standard deviations for all measured variables were calculated, and a correlation matrix for all measured variables was created both to better understand the relationships among the measured variables and ensure that there were no multicollinearity problems, which there were not.

Multiple group comparison in AMOS 20 was used to compare the strengths of paths in the model among three groups, “Blame Self,” “Blame Fate,” and “Blame Perpetrator.” To test hypothesis five regarding the potential of shame to either partially or fully mediate the

relationship between severity of sexual abuse event and trauma symptoms as an adult, Sobel tests were calculated separately for each group.

Results

Table 2 shows the means and standard deviations for the abused sample for all the variables in the present study. The mean score for severity of abuse was 1.96 (SD=.92) where higher score indicate more intrusiveness. The average frequency of abuse was 2.48 (SD = 2.16). Participants scores ranged from 1 (*Only once*) to 7 (*More than once a week*). On this scale a score of 2 indicates being approached weekly, and a score of 3 indicates several times a month. The average duration of abuse was 2.95 years (SD = 3.39) with a range of less than one year to 21 years. Of these survivors, 25.2% reported being abused by immediate family member, 12.9% by extended family member, 37.1% by non-family, 24.8% had missing data on this question. The averages for this study show that this sample consisted of a highly abused group, suffering high frequency and over a substantially long period of time.

Table 2 shows the correlations among all variables in the study. The three subcategories in the shame scale: inadequacy, emptiness and feeling exposed were all highly correlated ($p < .001$) with the subscales of the TSC-40: dissociation (.57, .60, .62), anxiety (.57, .57, .59), depression (.70, .71, .71), sexual problems (.41, .47, .40), and sleep disturbances (.45, .50, .50). Additionally, Table 2 indicates that trauma symptomology of sleep disturbances (.23) correlated less significantly ($p < .01$) with duration of abuse and dissociation (.21, .21) was also correlated at this level with duration of abuse and frequency. Sexual problems (.14, .18, .16) were significant correlated with all subscales of severity as were the shame subscales and duration of abuse (.14, .17, .12).

Structural Path Results

Hypothesis one. As can be seen in Figure 2, standardized Beta coefficients for the blame self, blame fate, and blame perpetrator groups are shown on each structural path in the model. The first hypothesis that severity of abuse event would be positively related to symptoms of trauma was confirmed for the “blame self” group ($\beta = .17, p < .05$) but not for the “blame fate” ($\beta = .14$) or “blame perpetrator” ($\beta = .05$) groups, when the mediating variable, shame, was included in the model.

Since a later hypothesis was related to shame as a potential mediating variable, the model shown in Figure 3 was analyzed to determine if the direct effects changed for the “blame fate” and “blame perpetrator” group when shame was not in the model. As can be seen in Figure 3, the first hypothesis that severity of the abuse event would be positively related to symptoms as adult was statistically significant for all three groups (“Blame self” group: $\beta = .46, p < .001$; “Blame fate” group: $\beta = .43, p < .001$; “Blame perpetrator” group: $\beta = .36, p < .001$) when shame was not in the model, so the first hypothesis was confirmed for all three groups.

Hypothesis two. As shown in Figure 2, the second hypothesis that severity of the abuse event would be positively related to internalized shame was confirmed for all three groups (“Blame self” group: $\beta = .36, p < .001$; “Blame fate” group: $\beta = .25, p < .01$; “Blame perpetrator” group: $\beta = .17, p < .05$).

Hypothesis three. The third hypothesis that internalized shame would be positively related to trauma symptoms as adult was also confirmed for all three groups. (“Blame self” group: $\beta = .76, p < .001$; “Blame fate” group: $\beta = .75, p < .001$; “Blame perpetrator” group: $\beta = .68, p < .001$).

Hypothesis four. Hypothesis four stated that the coefficients in the Structural Equation Model would be significantly stronger for the “blame self” group than for the “blame fate” and “blame perpetrator” groups. To test this hypothesis, a fully constrained model in which all paths were constrained to be equal was compared to a fully unconstrained model in which the paths were not constrained. The X^2 difference test showed that the two models were significantly different from each other ($62.80-36.33=26.14$, $df: 55-39 = 14$, $p < .05$). Successive analyses were performed in which each path in the model was constrained separately in sequential steps until the model with the best fit was determined. In the model with the best fit, the relationship between severity of sexual abuse events and trauma symptoms as an adult was stronger for the “Blame Self” group than the other two groups. The relationship between severity of sexual abuse event and internalized shame showed the highest significance level for the “Blame Self” group, next for the “Blame Fate” group, and least for the “Blame Perpetrator” Group. The path from internalized shame to trauma symptoms as adult was weaker for the “Blame Perpetrator” group than it was for the other two groups. Hypothesis four was partially confirmed in that all paths in the model were significantly weaker for the “Blame Perpetrator” group.

Hypothesis five. To test hypothesis five which stated that internalized shame would significantly mediate the relationship between severity of sexual abuse event and trauma symptoms as adults for all three groups, Sobel tests were calculated separately for all three groups. Results showed that internalized shame partially mediated the relationship between severity of sexual abuse event and trauma symptoms as adults for the “Blame Self” group ($Sobel = 6.91$, $p < .001$). Internalized shame was also a significant mediator for the “Blame Fate” group ($Sobel = 5.50$, $p < .001$) and for the “Blame Perpetrator” group ($Sobel = 7.92$, $p < .001$). Because

the relationship between severity and trauma without shame in the model was statistically significant for these last two groups, but the significance dropped out when shame was included in the model, it appears that internalized shame fully mediated the relationship between severity of sexual abuse event and trauma symptoms as adult for both the “Blame Fate” and “Blame Perpetrator” groups.

Discussion

The purpose of this study was to identify the potential of internalized shame as a mediating variable between the severity of childhood sexual abuse and its association with adult trauma symptomology among three groups of adult female survivors, those who reported they blame themselves for the abuse, those who reported they blame fate, and those who reported they blame their perpetrator. Findings of this study indicated shame fully mediated the relationship between severity of abuse and adult trauma symptoms for those who blame fate or their perpetrator. When attribution of blame is taken into account, only those who blame themselves have any significant correlation with trauma symptoms as adults when explained through the lens of shame. Shame mediates this relationship less than in those groups with other attributions of blame. This further suggests that there is an additional and unknown piece that is further mediating this relationship outside of shame and the shame subscales used in this study. Clearly there are elements of shame and self blame that are overlapping and similar; however, through this study there is a suggestion that they are inherently different, and there may be pieces that need further exploration to understand their relationship to each other as well as to distress of the individual. Understanding who or what a survivor blames for the abuse and dealing with internalized shame appear to be associated with the experience of adult trauma symptoms. Some

clinical suggestions for working with these attribution groups can be found in the clinical implication section.

The finding that severity of abuse event was positively related to adult trauma symptoms for all three groups is similar to findings in previous studies. Hagedaars, Fisch, and Minnen (2011) investigated how incidents of trauma (of any kind) lead to symptomology, specifically PTSD. They found single versus multiple trauma and childhood versus adulthood trauma groups did not differ in depressive symptom and co-morbidity. However, those who had experienced multiple, child trauma events reported anger that was more directed towards themselves than their counter parts, leading to more intense PTSD symptoms. Fiering and Cleland (2007) found in her study of attribution of blame over a six year period that there was no correlation to symptomology if the survivor blamed the perpetrator.

It may be that severity of abuse is not the sole factor that is related to adult symptoms. The way the survivor makes meaning of the event in terms of who or what to blame may have an equal, if not greater, association with trauma symptomology. As Feinauer and Stuart (1997) postulated, blaming self is not really a way of making sense of the abuse that contributes to recovery, but is rather a hindrance in the recovery process and has debilitating effects on functionality of adult survivors. They further suggest that the separation of blame for the event and from the responsibility for recovery is a vital element in the recovery process. The findings of this study fill a gap since there has been little research that has examined looks at the role of self blame in the trauma symptomology.

Severity of Abuse

The finding that severity of the abuse was positively associated with internalized shame for all three groups is similar to findings in other published studies (e.g., Feiring & Taska, 2005; Feiring, Taska, & Chen, 2002; Williamson, 2009). Some have postulated that shame related to CSA is due to a sense of the survivor feeling like they are “spoiled goods” (Kim, Thibodeau, & Jorgenson, 2011; Williamson, 2009; Talbot, 1996; Finkelhor & Browne, 1985). The finding that the relationship between severity and shame was stronger for the group who “blamed self” may mean that it is important to understand the interactional process around blame between a perpetrator and a child. Processes in which a perpetrator tells the child it is her fault because she is “too beautiful or too sexy” or in which a perpetrator “grooms a vulnerable child” where the child feels connection and may experience erotic sensations and feelings may be more likely to contribute to the victim blaming herself. Frequent flashbacks and cognitive rehearsal of the event and these blame patterns may then entrench a belief that the victim is to blame that lasts even into adulthood.

The finding that internalized shame was positively related to adult symptoms of trauma for all three groups is also consistent with conclusions from other empirical studies that have used other mental health outcomes.

In a meta-analysis of shame on depressive symptoms, Kim, Thibodeau, and Jorgenson (2011) concluded that shame is a much more significant factor in the emotional undertones of depressive symptoms. Williamson (2009) found that shame has a negative relationship with perceptions of intimacy and sexual functioning. Feiring and Taska (2005) postulated that the

persistence of shame may explain a CSA survivor's failure to process the abuse, leading to the perpetual distress of PTSD symptoms (Fiering & Taska, 2005).

All three paths, severity of abuse to trauma symptoms, severity to shame, and shame to trauma symptoms were stronger for the "Blame Self" group than for the other two groups. This is consistent with studies that have found that those who blame themselves for the abuse, regardless of severity, score higher on the TSC-40, indicating that they experience more distress and dysfunction as adults (Johnson & Shannon, 2013; Fiering & Cleland, 2007; Fincham, 2002; Barker-Collo, 2001; Feinauer & Stuart, 1996; Lamb, 1986; Finkelhor & Browne, 1985; Conte, 1985; Courtois, 1979). Those who blamed fate similarly had high TSC-40 scores, though only somewhat lower than those that blames themselves. In a study of incarcerated women that examined maladaptive coping mechanisms of CSA survivors, Johnson and Lynch (2013) found that the relationship between emotional regulation and PTSD symptomology was mediated by self-blame (Johnson & Lynch, 2013).

The finding that internalized shame partially mediated the relationship between severity of abuse and adult symptoms and fully mediated this relationship for the "blame fate" and "blame perpetrator" groups highlights the importance of shame as a response to traumatic events. Whether a victim discloses the abuse at the time and, if they do, how the family responds may be factors that are related to whether a victim blames herself and more intensely internalizes shame. Family processes of denial or blame (e.g., when denial is a response of family members, when they may turn on the victim for creating problems in the family, when a family member may go to prison for the abuse) may contribute to a victim's likelihood of blaming herself and incorporating more shame as part of her identity.

Implications for Family Therapists and Treatment Protocol for Survivors

These findings have several implications for assessment and intervention in working with childhood sexual abuse survivors. First, it is important to address shame as part of the treatment process. Second, when abuse is disclosed when the person is a child, family therapy, not just individual child therapy, should be part of the treatment. Family therapists can help family members to avoid behaviors and attitudes that further shame the child or that implicitly convey a message that the child is to blame (Cummings, Berkowitz, & Scribano, 2012). For work with adults, therapists should be mindful of not only how, as a child, the person internalized shame but also how the person may have adopted behaviors and attitudes that made them vulnerable to further shaming events in their lives.

For those who blame themselves for the abuse, addressing the shame is important in the healing process, but the meaning of the abuse and the process of blaming self must also be addressed. For those who blame fate and/or the perpetrator, addressing the shame in therapy will likely lead to symptom relief.

There is some evidence that group therapy is a good resource to use in the treatment of childhood sexual abuse (Boakes, 1997; Lundqvist, Svedin, Hansson, & Broman, 2006). Group members would likely be able to support the survivor in changing their attribution of blame and in exploring internalized shame. Some (Gershen, 1996) have begun to look at theory and treatment for shame-based presenting concerns in therapy, which too could lead to helpful ideas and intervention of this specific shame mediated concern. One case study (Jung & Steil, 2012) explored cognitive restructuring and imagery modification with two CSA survivors whose shame manifested as feelings of “being contaminated.” Interventions for addressing shame include art

therapy, creating an abuse narrative book, strength based restoring of the shame, sharing within trusted relationships, and sandtray. Findings from this study suggest that once shame is managed for those who blame fate and perpetrator, much of the trauma symptoms should decrease. For those whose primary attribution of blame is on self, addressing the need and meaning in blaming self would be the first treatment goal, possibly working toward redirecting the blame to the perpetrator, where helpful intervention would likely include empty chair work, letter writing, art therapy, reauthoring the abuse event(s). Secondly, addressing associated shame, as described above would be the next step in the treatment goals.

Limitations

There are some limitations to the findings of this study. Being that the sample used in this study was all adult female survivors, these findings should not be generalized to how male CSA survivors attribute, internalize shame, or experience the trauma symptomology. Secondly, the participants who responded to this survey were mostly self identified Caucasian (90%), and as such, generalizability to other races or ethnicities is not suggested. In addition, whether the response rate meets a solid standard was difficult to judge. Only estimates of the prevalence of sexual abuse in a general community population have been made. When questionnaires are randomly sent to households, as was done in this study, it is difficult to determine who may have been sexually abused. Furthermore, it is difficult to determine how those who responded were different from those who had been sexually abused and did not respond. It may be that some of those have never admitted to anyone that they were abused as children. It may be that those who did not respond carried more internalized shame than those who did, and they could not cope with answering questions about the abuse. It may be that those who didn't respond were more

likely to blame themselves for the abuse. Factors including time, cultural acceptance, fear of repercussions could also explain unresponsiveness. If any of these suppositions are true, it is likely that internalized shame plays an even more important role in the non-respondents. However, for a resilient some, they may have healed and moved forward, finding responding not as relevant to them. Lastly, this study categorized CSA survivors by their primary attribution to self, to fate, or to perpetrator. In reality, many CSA survivors may have attributed blame to more than one category, ascribing different percentages of blame to each of these, and their attributions may vary over time.

Future Research

The findings of this study also raise several questions. What is the missing mediator in the blame self group between severity and symptomology? How can measurement of attribution of blame be improved? For women who are likely to equally blame themselves and their perpetrator, how do the relationships among these variables change? How might the relationships between severity, adult symptoms, and shame be different in a clinical population of survivors who have sought therapy? Have they sought out therapy because their symptoms are more severe including the possibility that shame may be more intense for them?

Directions for future research include identifying how attribution of blame and internalized shame operate within males who were sexually abused as children. More research is needed about whether the variables in this study operate in the same way in different minority populations. Evaluation of specific interventions designed to shift blame from self to perpetrator and to reduce internalized shame is much needed. How would adding specific assessment and treatment of blame and shame to current trauma treatment models improve the clinical

outcomes? Unfortunately, there appears to be a lack of research on specific interventions and modalities treating childhood sexual abuse, and it is even more limited when the survivor is an adult. An intervention study implementing the findings of this study is also a needed next step.

Conclusion

This study explored the relationship between severity of abuse and trauma symptomology through the lens of attribution of blame for the abuse event(s), and how shame mediates this relationship. This study found that for those whose primary attribution of blame was that of fate or fault of the perpetrator, shame significantly mediated that relationship, highlighting that addressing shame should be the number one treatment goal. However, for those who blame themselves for the abuse, shame does not fully explain the relationship to distress. More research needs to be conducted to find what this missing piece may be. However, this study identified the potential importance of adjusting the attribution of blame for those who blame self, shifting it toward fate or the perpetrator. Addressing shame after this task would likely be more therapeutic.

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Appendix A

Table 1

Demographic Characteristics of Sample

Variable	Mean (S.D.)
Age	36.56 (7.82)
Length of Relationship	12.23 (8.16)
	Percentages
Education	
Less than High School	2.2%
High School	28.5%
Some College	28.1%
Bachelor's degree	25.3%
Professional or Graduate Degree	12.4%
Other	3.5%
Race	
African American	.3%
Caucasian	89.6%
Native American	.6%
Latino	3.2%
Asian	3.8%
Other	2.5%
Income	
Under \$15,000	15.6%
\$15,001-\$29,999	20.9%
\$30,000-\$44,999	22.5%
\$45,000 or more	41.1%

Table 2

Correlation Values

Variable	1	2	3	4	5	6	7	8	9	10	11
Severity											
1. Severity	1.00										
2. Frequency	.27***	1.00									
3. Duration	.27***	.38***	1.00								
Shame											
4. Inadequate	.24***	.18*	.14*	1.00							
5. Empty	.24***	.25***	.17*	.75***	1.00						
6. Exposed	.29***	.24***	.12*	.85***	.77***	1.00					
Trauma Symptoms											
7. Dissociation	.27***	.21**	.21**	.57***	.60***	.62***	1.00				
8. Anxiety	.30***	.24***	.30***	.57***	.57***	.59***	.76***	1.00			
9. Depression	.29***	.27***	.26***	.70***	.71***	.71***	.76***	.77***	1.00		
10. Sexual Problems	.14*	.18*	.16*	.41***	.47***	.40***	.48***	.48***	.59***	1.00	
11. Sleep Disturb	.26***	.24***	.23**	.45***	.50***	.50***	.56***	.55***	.78***	.35***	1.00
Mean	1.96	2.48	2.95	33.93	9.96	19.06	4.60	6.23	9.35	7.15	8.32
Standard Deviation	0.92	2.16	3.39	11.07	4.90	7.26	3.92	4.55	5.36	2.25	3.00

Appendix B

Figure 1

Conceptual Model

Conceptual Model with Severity of Sexual Abuse Event Predicting Trauma Symptoms with Internalized Shame and Attribution of Blame as Potential Mediating Variables.

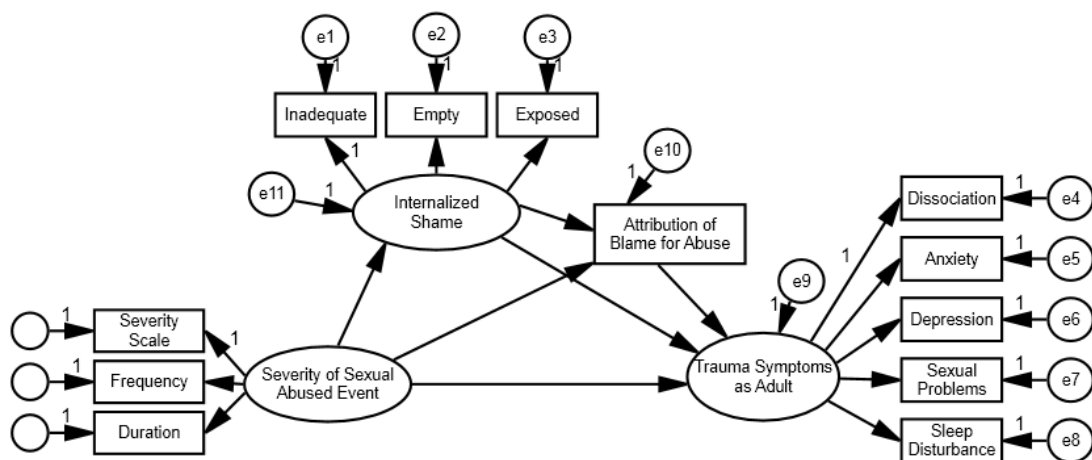
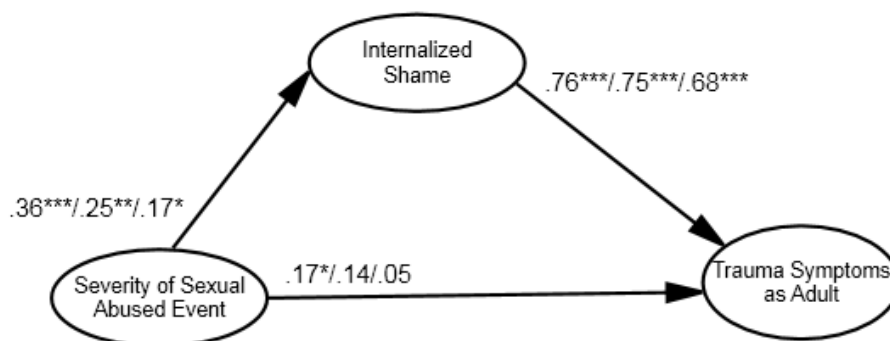


Figure 2

SEM: Multiple Group Comparison



$$X^2=120.36, df=102, p=.10$$

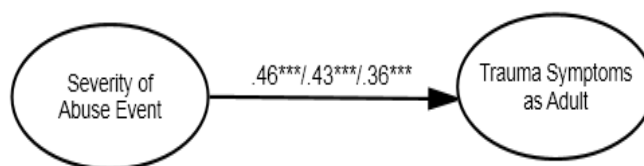
$$CFI=.98, RMSEA=.03, SRMR=.05$$

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

NOTE: “Blame self” is the first coefficient; “Blame fate” is the second coefficient; “Blame perpetrator” is the third coefficient. Age, education, and income were control variables, but since they were not significant, they are not included in this model.

Figure 3

SEM: Without Mediator



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

$$X^2=196.40, df=84, p=.58$$

$CFI=.991$, $RMSEA=.022$, $SRMR=.031$

NOTE: “Blame self” is the first coefficient; “Blame fate” is the second coefficient; “Blame perpetrator” is the third coefficient. Age, education, and income were control variables, but since they were not significant, they are not included in this model.