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Cover Page Footnote

I would like to express my appreciation to Prof. Dr. Theresa Botts, Prof. Dr. Jonathan Gore, and Prof. Dr. Adam Lawson for their unwavering guidance and support throughout the development of my thesis.

Evaluating Shame: A Comparative Look at Sexual and Physical Abuse

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Abstract: *Shame is a potential adverse effect which can occur following a traumatic experience, such as being a survivor of sexual and physical abuse. Demonstrating the prevalence and levels of shame resulting from sexual and physical abuse can be of interest to those professionals working with survivors of trauma. The purpose of this study was to separately evaluate the prevalence of shame within sexual and physical abuse. This study tested the following hypotheses: hypothesis 1, shame will be more prevalent and demonstrate higher levels in sexual abuse survivors than in physical abuse survivors and hypothesis 2, survivors of both sexual and physical abuse will demonstrate higher prevalence and higher levels of shame than those who only experienced sexual or physical abuse. Participants completed a questionnaire that assessed any history of sexual and physical abuse and a questionnaire that assessed prevalence and levels of shame. Data was analyzed by running a Univariate ANOVA through SPSS. Mean scores for the ISS were utilized to draw comparisons between abuse types and shame prevalence. The post-hoc analysis displayed significant differences between different abuse types and the ISS mean. Both hypotheses in this study were supported by the data analysis. Shame was found to exist at higher levels for survivors of sexual abuse than survivors of other abuse types.*

Keywords: sexual abuse, physical abuse, shame, trauma

Experiences and situations that occur throughout life can have lasting effects and devastating consequences, particularly those occurrences involving trauma. Internal conflict, like feeling shameful, can be a prominent response to trauma. Shame is an adverse effect frequently reported following trauma (Amstadter & Vernon, 2008). Shame can be defined as the self-conscious moral emotion resulting from a negative appraisal of one's self-worth (Amstadter & Vernon, 2008) with the personal view of being flawed or wrong (Young, Neighbors, DeBillo, Trayler, & Tompkins, 2016); it can also be defined as "the chronic and persistent negative evaluation of self" (Feinauer, Hilton, Callahan, 2003, p.66). High levels of shame can

be associated with maladaptive cognitions and health hazards including anxiety, depression, lower self-esteem, and substance abuse (Young et al., 2016). Further, shame has been associated with a sense of worthlessness, incompetence, and a generalized feeling of contempt (Pettersen, 2012).

In past years, empirical attention has been devoted to trauma and the concerns that may arise as a result (Amstadter & Vernon, 2008). Complex trauma, a term developed to describe symptoms of extensive and/or repeated trauma, is defined as a traumatic event that is chronic and interpersonal, including child sexual and physical abuse (Wasmer-Nanney & Vandenburg, 2013). Several studies have shown a link between shame and painful experience, particularly abuse, which can be manifested through “feelings of disgrace, disrepute, dishonor, loss of self-esteem, loss of virtue, and loss of personal integrity” (Bratton, 2011, p.6). Fraizer (2000) proposed that abuse can be shaming for two reasons. One, physical and sexual abuse are violent acts that can render a person powerless to maintain personal boundaries and two, perpetrators have been known to intentionally place shameful thoughts or feelings into their victim by words and actions. The current study aims to add to the research concerning the association of shame following trauma by exploring whether shame is more prevalent in sexual abuse or physical abuse survivors. This study will be looking at sexual and physical abuse which took place in childhood and adolescence and its impact on adulthood prevalence of shame associated with the earlier abuses. The purpose of this study is to uncover whether shame is more common and occurs at higher levels in those with a history of sexual abuse or physical abuse.

Child abuse is an epidemic that has affected approximately 20% to 21% of women and 15% to 31% of men (Marshall & Leifker, 2001). It has been determined that one in four people have a history of child abuse (Ellenbogen, Trocmé, Wekerle, & McLeod, 2015). Childhood abuse, defined as sexual abuse, physical abuse, and/or neglect, has adverse outcomes for those who experience it (Rellini, Vujanovic, Gilbert, & Zvolensky, 2012). Although shame has been found to be correlated with having experienced traumatic events, delving further into which types of trauma are likely to cause it may be beneficial. Most notably, the differences between childhood sexual abuse and physical abuse may reveal a notable variance in the prevalence and level of shame experienced among survivors.

Sexual Abuse

In 2001, Child Protective Services (CPS) determined that 10% of the 903,000 children abused over the course of that year met standards for sexual abuse (Rodriguez-Srednicki & Twaite, 2004, p.316). The Child Abuse Prevention and Treatment Act (CAPTA) defined sexual abuse criteria as:

The employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or stimulation of

such conduct for the purpose of producing a visual depiction of such conduct; or the rape, statutory rape, molestation, prostitution, or other form of sexual exploitation of children; or incest with children. (Rodriguez-Srednicki & Twaite, 2004, p.318)

Nine percent of men and 19% of women have reported experiencing sexual abuse in childhood. However, these numbers may not be entirely representative of shame prevalence due to surrounding taboo and a shameful quota (Rahm, Renck, & Ringsberg, 2006; Rodriguez-Srednicki & Twaite, 2004). To be abused is to automatically be shamed (Frazier, 2000) and shame has been indicated as a barrier leading to underreported abuse (Zinzow & Thompson, 2011). In other words, shame can be viewed as negative and prohibited in terms of societal norms. Child sexual abuse (CSA) is highly associated with stigma and therefore those who experience it are deemed to have a more shameful status. This link may be the reason behind higher prevalence rates of shame within those who experience sexual abuse. Sexual abuse survivors may be more prone to receiving negative messages (e.g. it was your fault, you asked for it) that contribute to shameful appraisals (Amstader & Vernon, 2008). Research has suggested that males and females respond differently to acts of sexual abuse, noting that males are more likely to view sexual abuse survivors as more culpable (the perception that survivors are responsible for the acts committed against them) and less credible than their female counterparts (Font, 2013). Regardless of the controversial view of sexual abuse by those in society, the adversity sexual abuse brings to both males and females who experience it is clear. Functioning of both males and females following sexual abuse can be compromised; Dorahy and Clearwater (2008) conducted a study involving males who had experienced CSA and how well they functioned later as adults. Results of the study demonstrated a high degree of shame for those survivors. A separate study involving female survivors showed similar results in levels of shame following victimization experiences (Rahm, Renck, & Ringsberg, 2006). It appears that, regardless of gender, shame can inhibit personal functioning following sexual abuse.

Amstader and Vernon (2008) conducted a study that exhibited high levels of shame in reports after trauma, specifically following sexual abuse. Higher levels of shame were shown for those who experienced sexual abuse than those who experienced physical abuse. Despite the fact that shame prevalence was higher in sexual abuse, physical abuse survivors did demonstrate levels of shame. However, overall, research supports that shame is more prevalent in sexual abuse than other reoccurring traumas such as physical abuse. Although physical abuse demonstrates shame prevalence, associated levels are not as high as those seen in sexual abuse.

Physical Abuse

According to the CPS report, 19% of children met the criteria for physical abuse (Rodriguez-Srednicki & Twaite, 2004). There is no consensus of what constitutes physical abuse. Physical abuse will be defined here as any intentional harm inflicted upon a child that causes serious injury including but not limited to bruises, cuts, punctures, fractures, and/or organ damage (Rodriguez-Srednicki & Twaite, 2004).

Although physical abuse survivors experience unhealthy levels of shame in connection with feelings of not being valued, helplessness, and violation, the link between shame and physical abuse has received little research attention (Hoglund & Nicholas, 1995). Although there is limited research on physical abuse related shame, physical abuse has often been known to be enmeshed with psychological abuse where the abuser manipulates their victim with shame inducing messages (i.e. the abuser tells the victim that they are bad or deserve punishment) (Ellenbogen et al., 2015). Even so, Hoglund and Nicholas (1995) did not find a significant relationship between physical abuse and shame. The researchers proposed that the lack of association between the two variables was indicative of there not being a direct attack on the survivor's self-esteem during or following physical abuse. For this reason, the survivor may be more concerned with feeling guilty in regard to something they believe they did wrong instead of feeling shameful for who they are because of what was done to them.

Present Study

Shame is less correlated with physical abuse than sexual abuse. Per the research reviewed, shame appears to be more highly associated with the latter. Presently, there seems to be a dearth of research extensively or directly comparing sexual and physical abuse. The current study will take a comparative look at sexual abuse and physical abuse and the levels and prevalence of shame survivors may experience. Doing so will contribute to the research regarding the possible correlation between sexual and physical abuse and shame prevalence. This addition may prompt further research pertaining to differing experiences of shame following sexual and physical abuse and prove of interest to those professionals involved in the care and treatment of survivors. Hence, it is hypothesized that survivor shame will be more prevalent and demonstrate higher levels in sexual abuse survivors when compared to physical abuse survivors. Additionally, it is hypothesized that survivors of both sexual abuse and physical abuse will demonstrate higher shame prevalence and higher levels of shame than those who only experienced sexual abuse or physical abuse.

Method

Participants

The participants of this study were 368 undergraduate students from Eastern Kentucky University (EKU). As a result of extensive data loss, 225 participants were excluded from the study which left data from 143 participants. Students, both male and female, ranged from freshman to senior classification. All participants were recruited through EKU's SONA system. Prior to completion of the study, participants were provided with a consent form (see Appendix A). All students voluntarily agreed to participate.

Materials

Items on the questionnaires used in this study assessed the participants' histories of sexual abuse and physical abuse as well as participants' related prevalence of shame.

Abuse. The 38-item Sexual and Physical Abuse History Questionnaire (SPAHQ) measured history of sexual abuse and physical abuse in the participants' past (Lesserman, Li, Drossman, Toomey, Nachman, & Glogau, 1997) (see Appendix B). The SPAHQ is normally used as an interview but for purposes of this study it was adapted into a survey format. The 38 questions were divided into two types of abuses: items 1 through 24 pertained to sexual abuse and items 25 through 38 pertained to physical abuse. Participants were asked to follow each question's instructional prompt and provide answers as accurately as possible.

Shame. The prevalence of shame was measured by Cook's Internalized Shame Scale (ISS) (Cook, 1998, 2000) (see Appendix C). Participants were asked to rate 30 items using a 5-point Likert scale where 1 indicated the participants had never felt the way specified in the given item and 5 indicated the participants almost always felt the way specified in the given item. Items 4, 9, 14, 18, 21, and 28 were positively worded items. These 6 items, from Rosenberg's 12-item self-esteem scale (Vikan, Hassel, Rugset, Johansen, & Moen, 2010), were not intended to be an adequate measure of self-esteem (Cook, 1998, 2000). The 6 questions were included to counterbalance a negative response set.

Procedure

Before each stage, participants were provided with written prompts. If the participants agreed to participate in the study, a consent form was provided before the study began (see Appendix A). If the participants agreed to partake in the study they were then prompted to complete both the SPAHQ and the ISS (see Appendices B, C). Initially, the SPAHQ was given before the ISS with the idea that its completion would enable participants to better recall the levels of associated shame, however, the order of the questionnaires were switched in the middle of data collection due to data loss. Thus, some participants were presented with the SPAHQ first and

some were presented with the ISS first. Participants were allowed to withdraw participation at any point during the study even if it had not been completed. Upon completion of the study, a debriefing form was provided (see Appendix D) that contained additional information about the study, contact information, and relevant references and resources. These resources included abuse and suicide hotline numbers as well as contact information for the counseling center on EKU's campus should any student have felt the need to utilize them. Participants individually completed the study at their own pace but participation, from start to finish, never exceeded 30 minutes. Participants received one half (.5) outside credit for completion of the study.

Results

Analysis focus was on participants' mean score for the ISS. This allowed for examination of the level of shame prevalence for each participant. Positive Pearson Correlations for the sexual abuse and physical abuse variables are reported in Table 1. Significant correlations were found for both variables; sexual abuse showed significant correlation with the ISS mean ($r = .479$, $n = 142$, $p = .01$) and physical abuse showed significant correlation with the ISS mean ($r = .314$, $n = 133$, $p = .01$). Significant correlation was also shown for sexual abuse and physical abuse ($r = .267$, $n = 132$, $p = .01$). Since our main interest was looking at shame concerning different abuse types, mean scores for the ISS were created reflecting each abuse level (no abuse, sexual abuse, physical abuse, both abuses) using a univariate, or one-way, analysis of variance (ANOVA). The following was found for each abuse type: no abuse ($n = 36$, $M = 2.311$, $SE = .140$), physical abuse ($n = 37$, $M = 2.482$, $SE = .138$), sexual abuse ($n = 20$, $M = 2.805$, $SE = .188$), and both abuses ($n = 39$, $M = 3.451$, $SE = .135$); see Figure 1.

There was a significant effect of abuse on shame prevalence at the $p = .05$ level for the four abuse types [$F(3,128) = 13.543$, $p = .0005$]. A significant effect was found for those experiencing both types of abuse and those experiencing sexual abuse. Post-hoc comparisons found that participants who experienced both sexual and physical abuse had higher levels of shame ($p < .0005$) than those with sexual abuse, physical abuse, or no abuse. Sexual abuse was also shown to be significantly different from no abuse. There was no statistical significance for no abuse when compared to physical abuse or physical abuse compared to sexual abuse.

Discussion

The results of this study suggest that the more abuse history a participant has, the higher their level of shame prevalence will be. Those participants that experienced both sexual and physical abuse presented higher ISS means. Also, those participants that experienced only sexual abuse presented a higher ISS mean than those categorized within the other abuse types. Both hypotheses of this study were supported. Supporting

results seem to be indicative of sexual abuse and sexual and physical abuse experienced together having a higher presence of shame.

Findings were consistent with those found in previous studies. Dorahy and Clearwater (2008) and Rahm et al. (2006) conducted studies that linked high levels of shame prevalence to survivors of sexual abuse. Amstader and Vernon (2008) also conducted a study that led to similar findings in shame levels following trauma reports, specifically those involving sexual abuse. Although there is a dearth in research on shame prevalence and physical abuse, this study remained consistent with those findings that did indicate levels of shame in survivors of physical abuse. However, even more consistent with previous findings is the association of higher levels of shame in sexual abuse and higher levels in sexual abuse than in physical abuse.

The significance and importance of these findings lie with those professionals who work with trauma survivors. These findings have added pertinent information to existing research about complications that can arise following trauma (Amastatder & Vernon, 2008; Dorahy & Clearwater, 2012). Before, there was limited research concerning physical abuse and shame prevalence. This study was able to support levels of shame being prevalent in physical abuse. Although it remains supported that shame is found in higher levels within sexual abuse, it is worth noting the presence within physical abuse. It is worth further investigation to understand why this complex emotion shows up in abuse survivors and what clinicians can be doing to lessen potential lasting effects. It is still not evident why sexual abuse survivors report higher levels of shame—this could be a question to investigate for future research in this area.

Possible limitations of this study must be addressed. First, it quickly became evident that a lot of data early in the data collection phase from the ISS was being lost. At the beginning of data collection, the SPAHQ was given to participants before the ISS. The impact of this question order appeared to trigger and upset participants. It is likely that participants were so disgruntled by the questions that, when asked to complete the ISS, they skipped over it. Another possibility is that the SPAHQ took participants so long to finish that they did not feel like completing the ISS and instead skipped over it. When the SPAHQ and the ISS were swapped mid-study, data immediately began being collected for the ISS. Thus, this initial question order limitation caused much data loss and, therefore, participant loss. For future direction, researchers should take this into consideration and begin the study with the ISS. Another limitation of this study is the population from which the sample came. This study was strictly limited to the access of college students, thus the generalizability of the results could be potentially weak. Reaching out to a larger and more diverse population could help strengthen the generalizability of this study. A third limitation is the measures used; although they served the purpose for this study, it is recommended for future direction that a simpler questionnaire is used to measure sexual and physical abuse. This way, participants are not as likely

to become exhausted with answering so many questions in one setting.

For anonymity purposes, conducting this study online has its advantages. It assists participants with feeling more secure and therefore more willing to provide honest answers. Also, this aids in faster data collection. The disadvantage to the online aspect lies with the possibility of some participants speeding through the study and not taking it seriously or neglecting to answer questions, both being concerns that arose during this study. Aside from that, the study ran successfully with minimal issues. Those interested with future direction should be advised of the data loss complication that arose as well as the extensive, and potentially exhausting, SPAHQ.

Conclusion

The current thesis examined shame prevalence in sexual abuse and physical abuse survivors. Both hypothesis 1 and hypothesis 2 were supported by the data collected. Data analysis showed that those who experienced sexual abuse or both sexual and physical abuse had higher levels of shame than those who experienced only physical abuse or no abuse. The findings of this study added to the shortage of research concerning the correlation between physical abuse and shame. Although it remains supported through this study that shame levels are higher in those with a history of sexual abuse, it also supports those with a history of physical abuse experiencing shame to some degree. With future direction, this study can be expanded to look at explaining possible reasons as to why shame levels are different for different abuse experiences. For now, the research support provided from this study is applicable to professionals that work with trauma survivors as well as those who are involved in educating themselves or others about the adverse effects seen within cases of trauma. The more that is known and understood about trauma and its related effects, the better the treatment outcomes can become for clients.

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Figures and Tables

	ISS Mean	Sexual Abuse	Physical Abuse
ISS Mean			
Pearson Correlation	1	.479**	.314**
Sig. (2-tailed)		.000	.000
N	143	142	133
Sexual Abuse			
Pearson Correlation	.479**	1	.267**
Sig. (2-tailed)	.000		.002
N	142	142	132
Physical Abuse			
Pearson Correlation	.314**	.267**	1
Sig. (2-tailed)	.000	.002	
N	133	132	133

Table 1

**** Correlation is significant at the 0.01 level (2-tailed)**

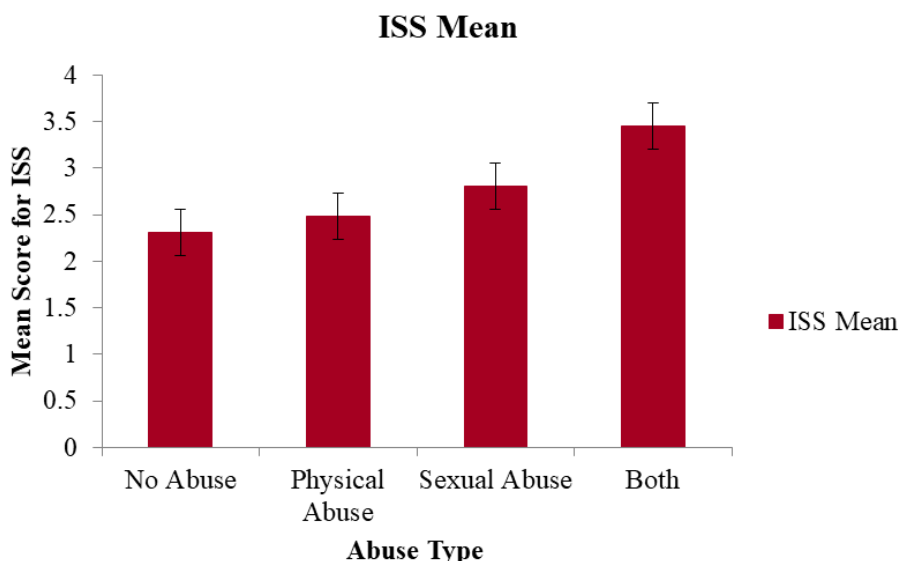


Figure 1