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The Imprint of Childhood Abuse on Trauma-Related Shame in Adulthood

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The Imprint of Childhood Abuse on Trauma-Related Shame in Adulthood

Abstract

Research has consistently linked residual trauma-related shame among child sexual abuse (CSA) survivors to sexual revictimization, health risk behaviors, and poorer response to mental health treatment. However, questions remain regarding the imprint of childhood maltreatment on trauma-related shame including which CSA characteristics or types of childhood maltreatment contribute to residual shame in adulthood. Using data drawn from a prospective study of 174 primarily African American women with histories of CSA and a matched comparison group, this study explores whether specific characteristics of CSA (familial CSA, CSA with penetration, force used by CSA perpetrator), repeat sexual victimization in adolescence, childhood physical abuse, childhood neglect, and childhood commercial sexual exploitation contribute to the level of trauma-related psychosexual shame reported during adulthood. Ordinal logistic regression revealed that the analyzed characteristics of CSA did not result in higher levels of shame. However, repeated sexual victimization during adolescence, childhood physical abuse, childhood neglect, and childhood commercial sexual exploitation resulted in higher levels of trauma-related shame reported in adulthood. For treatment providers, these findings highlight the critical need to address and treat trauma-related shame with clients who have experienced maltreatment or sexual exploitation during childhood.

Keywords

trauma-related shame, child maltreatment, commercial sexual exploitation

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THE IMPRINT OF CHILDHOOD ABUSE ON TRAUMA-RELATED SHAME IN ADULTHOOD

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ABSTRACT

Research has consistently linked residual trauma-related shame among child sexual abuse (CSA) survivors to sexual revictimization, health risk behaviors, and poorer response to mental health treatment. However, questions remain regarding the imprint of childhood maltreatment on trauma-related shame including which CSA characteristics or types of childhood maltreatment contribute to residual shame in adulthood. Using data drawn from a prospective study of 174 primarily African American women with histories of CSA and a matched comparison group, this study explores whether specific characteristics of CSA (familial CSA, CSA with penetration, force used by CSA perpetrator), repeat sexual victimization in adolescence, childhood physical abuse, childhood neglect, and childhood commercial sexual exploitation contribute to the level of trauma-related psychosexual shame reported during adulthood. Ordinal logistic regression revealed that the analyzed characteristics of CSA did not result in higher levels of shame. However, repeated sexual victimization during adolescence, childhood physical abuse, childhood neglect, and childhood commercial sexual exploitation resulted in higher levels of trauma-related shame reported in adulthood. For treatment providers, these findings highlight the critical need to address and treat trauma-related shame with clients who have experienced maltreatment or sexual exploitation during childhood.

KEYWORDS

trauma-related shame, child maltreatment, abuse, commercial sexual exploitation

TRAUMA-RELATED SHAME had been consistently linked to elevated risk for sexual revictimization¹ (Arata, 2000, 2002; Reid, 2011; Van Bruggen et al., 2006) and various health-risk behaviors² (Alix et al., 2017; Holl et al., 2017). Critical to effective provision of mental health treatment and trauma-informed care, the newest edition of *The Diagnostic and Statistical Manual of Mental*

¹ *Sexual revictimization* refers to the recurrence of sexual assault across different developmental periods of the lifespan (e.g., as a child and as an adult).

² Behaviors linked to the leading causes of death and disability are known as *health risk behaviors*. These behaviors include alcohol and other illicit drug use, tobacco use, risky sexual behaviors (e.g., having unprotected sex, having a high number of sexual partners), behaviors that result in unintentional injuries or violence (e.g., carrying a weapon, getting in fights).

Disorders (DSM-5) expanded the scope of diagnostic criteria for posttraumatic stress disorder (PTSD) to include a criterion that is evidenced by the presence of trauma-related shame, guilt, or anger (American Psychiatric Association, 2013). Moreover, researchers have observed that trauma-related shame impedes healing from trauma and posttraumatic stress regardless of the general efficacy of the selected therapy (Ironson et al., 2002).

Identifying origins of residual trauma-related shame is the purpose of this study. Using data drawn from a prospective study of 174 urban, predominantly low-income, African American women with and without histories of CSA, this study explores whether specific characteristics of CSA (e.g., familial CSA, CSA with penetration, force used by CSA perpetrator), repeat sexual victimization in adolescence, childhood physical abuse, childhood neglect, and childhood commercial sexual exploitation in prostitution contribute to the level of trauma-related psychosexual³ shame reported during adulthood. Greater understanding the formation of residual trauma-related shame, which has been consistently linked to a heightened vulnerability to revictimization, health-risk behaviors, and poor response to mental health treatment, could lead to more effective trauma-informed interventions.

Enduring Effects of Sexual Victimization and Revictimization

Childhood sexual abuse (CSA) has been consistently linked to mental health disorders and health risk behaviors, most commonly noted are PTSD, depression, suicidal ideation and behaviors, alcohol and drug problems, and eating disorders (Briere, 1992; Briere & Runtz, 1993; Campbell & Wasco, 2005; Roth & Newman, 1993; Saunders et al., 2003). Adult survivors of CSA may also experience interpersonal relationship problems, engage in high-risk sexual behaviors, and resort to extreme types of coping strategies (Briere & Runtz, 1993; Senn et al., 2007; Simons & Whitbeck, 1991; Summit, 1983).

Survivors of CSA may perceive their self-identity as contaminated, and struggle with feelings of self-loathing and shame (Phillips & Daniluk, 2004). Exposure to ongoing traumatic events (such as multiple incidents of CSA) may hinder survivors' ability to perceive future relationships as supportive or helpful and hamper the development of trust in others (Briere & Runtz, 1993). Survivors of CSA may consider themselves as undeserving of relationships with partners who are loving and supportive (Conte & Schuerman, 1987). Shame-based core beliefs⁴ may trouble CSA survivors including the belief that they are unlovable and that no one could care about them based on their own merits (Carnes, 1997). Recent neuroimaging research may provide greater understanding of these neurological basis of these difficulties. Researchers found brain-based disturbances in women with PTSD providing evidence of posttraumatic guilt and shame that prompts an altered sense of self and negative emotional response toward others (Frewen et al., 2017).

Previous sexual victimization is a strong predictor of future sexual victimization. Based on a survey of over 1000 college students, Humphrey and White (2000) suggested that vulnerability to sexual assault follows a simple linear path model.

³ *Psychosexual* is defined as relating to the mental, emotional, and behavioral aspects of sexual development or sexual activity.

⁴ *Core beliefs* are repeating patterns of thought determined by assumptions and expectations about self, others, and the world.

“Childhood victimization predicts adolescent victimization, which in turn predicts first-year collegiate victimization. First-year victimization in turn predicts further victimization in subsequent collegiate years” (Humphrey & White, 2000, p. 424). Among the many consequences stemming from sexual victimization, heightened risk for sexual revictimization⁵ is one of the most damaging (Filipas & Ullman, 2006). Trauma compounds the effects of previous trauma. When compared to survivors of one traumatic event, survivors of more than one sexual victimization more likely to suffer severe and lasting psychological damage such as experiencing severe PTSD symptoms, reporting self-blame at the time of the abuse and residual self-blame, coping by using drugs and alcohol, acting out sexually, and withdrawing from people (Filipas & Ullman, 2006). Multiple interpersonal traumas (either prolonged, repeated abuse with one perpetrator or assaults by multiple perpetrators) are more strongly associated with problems in emotional dysregulation than experiencing one traumatic event (Ford et al., 2006; Solomon & Heide, 1999; Terr, 2003).

Shame Linked to Revictimization, Health Risk Behaviors, and Reduced Efficacy of Mental Health Treatment

Numerous researchers have found that CSA survivors were at least twice as likely to be revictimized as women without a history of CSA (Classen et al., 2006; Messman-Moore & Long, 2003). Several cognitive, social learning, and psychoanalytical theories intersect as they address interpersonal deficits and challenges facing survivors of CSA that may heighten risk of revictimization (see Gleiser, 2003 for review). All theories converge by noting that a dysfunctional psychosexual belief system emerges from the experience of CSA. Perhaps the most empirically-supported theoretical model explaining how CSA may increase the odds of later abuse in life was theorized by Finkelhor and Browne (1985) (see Stockdale et al., 2002 for review of empirical support). Finkelhor and Browne’s (1985) Traumagenic Theory of Child Sexual Abuse highlights four aftereffects related to CSA including: 1) traumatic sexualization, 2) betrayal, 3) powerlessness, and 4) stigmatization. Together, these dynamics result in distortions in self-concept, worldview, and affective capacities.

Finkelhor and Browne (1985) describe traumatic sexualization as the “process in which a child’s sexuality . . . is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse” (p. 531). Effects of traumatic sexualization are the association of sex with affection or attention, thereby promoting precocious sexual behavior, increased risk for revictimization, and the use of sex for monetary gain or as a way to obtain affection. Betrayal occurs when a trusted individual in the child’s life manipulates, lies to, and abuses them. The pain of betrayal may impact future relationships and results in an inability to discern whether someone is trustworthy or not. Powerlessness occurs when the child’s efforts to avert abuse are continually prohibited and overridden. Lack of power during CSA can result in residual feelings of powerlessness with others who are manipulative, aggressive, or violent. Stigmatization describes the process by which CSA survivors develop a negative self-image that may lead to substance abuse, risky sexual behavior, or even criminal behavior. Stigmatization evokes fear and anxiety, the need to feel in control, and the lack of development of healthy

⁵ *Sexual revictimization* refers to the recurrence of sexual assault across different developmental periods of the lifespan (e.g., as a child and as an adult).

coping skills. Any combination of these factors puts an individual at risk for revictimization. For example, by combining sexual acting out (due to traumatic sexualization) with poor coping skills such as alcohol or drug use (due to stigmatization), the risk for revictimization is amplified (Gleiser, 2003).

Research studies support Finkelhor and Browne's (1985) Traumagenic Theory of Child Sexual Abuse, documenting that CSA survivors report greater sexual concerns and lower sexual self-esteem (Arata, 2000, 2002; Van Bruggen, et al., 2006). Sexual revictimization of CSA victims has been shown to be partially mediated by poor sexual self-esteem and self-blaming cognitions regarding their childhood victimization (Arata, 2000; Van Bruggen, et al., 2006). Revictimization has consistently been found to be associated with higher levels of trauma-related shame (for review, see Classen et al., 2005). In a review of 19 studies on mediators linking CSA with adult emotional distress and revictimization, Whiffen & MacIntosh (2005) found that shame or self-blame was more strongly linked to adult emotional distress and revictimization than interpersonal difficulties or family environment.

Beyond revictimization, trauma-related shame has been linked to numerous health-risk behaviors including drug and alcohol use, suicidality, self-harming behavior, and risky sexual behavior. For example, Holl and colleagues (2017) found an association between childhood abuse, intensity of shame emotions, and substance use. More specifically, the study found that the higher the intensity of the experience of shame, the more substances consumed. These findings support the theory that substance use functions as an emotion regulation strategy to cope with shame (Holl et al., 2017). Substance use has also been found to mediate the association between CSA and risky sexual behaviors (Senn et al., 2008). Roemmele and Messman-Moore (2011) found that early maladaptive schemas⁶ including disconnection and rejection, defectiveness/shame, and abandonment schemas were associated with risky sexual behavior among those with histories of CSA and childhood physical abuse. Self-hatred was strongly linked to self-harming ($\beta = .45$, $p < .001$) in a study of 782 adolescents (Xavier et al., 2016). These researchers concluded that "hatred and disgust towards the self is one reason for physically attacking the self" (Xavier et al., 2016, p. 13). Moreover, using a sample of 147 adolescent girls with histories of CSA, researchers found that shame partially mediated the links between abuse-related self-blame, PTSD, and suicidal ideation (Alix et al., 2017).

Trauma-related shame has been linked to PTSD symptoms, prognosis, and treatment effectiveness. In a study of 157 victims of violent crime, shame was the only independent predictor of PTSD symptoms at six months when controlling for predictors of PTSD symptoms at one month (Andrews et al., 2000). Trauma-related shame in response to crime victimization was higher among participants with histories of childhood maltreatment (Andrews et al., 2000). Filipas and Ullman (2006) found that residual, long-lasting self-blame for CSA significantly predicted PTSD symptom severity in CSA survivors. In longitudinal research of 118 sexually abused children over a five-year period, Feiring and Taska (2005) found that persistent shame was a complicating factor related to children's failure to process the abuse and played a key role in the maintenance of PTSD symptoms.

⁶ *Early maladaptive schema* (EMS) is a term used to describe dysfunctional schemas that develop in response to "toxic childhood experiences" (Young et al., 2003, p. 7).

Most importantly, in researching the effectiveness of various empirically-supported treatments for PTSD (i.e., EMDR and Prolonged Exposure Therapy), Ironson and colleagues (2002) found that participants who were experiencing trauma-related guilt or shame did not improve and their PTSD symptoms worsened during treatment. These researchers suggested that guilt and shame may result in PTSD becoming refractory to treatment (see also Kubany, 1998; Meadows & Foa, 1998; Pitman et al., 1991; Resick & Schnicke, 1992). Others have suggested that shame and guilt not only disrupt therapeutic effectiveness but that trauma treatment that fails to address trauma-related shame and guilt could even lead to worsening of post-trauma reactions (Lee & Scragg, 2001). Attempts to provide trauma-informed care may arouse and expose clients to overwhelming feelings of shame and guilt, which may contribute to treatment failure or early treatment drop out (Lee & Scragg, 2001, p. 464). In further support of the role of shame in PTSD treatment efficacy, researchers found that among participants who were not responding to treatment, there was a predictive, temporal relationship between shame and subsequent PTSD symptoms—in other words, alterations in the level of shame predicted PTSD symptom severity or improvement measured a few days later (Øktedalen et al., 2015). These researchers concluded that trauma-related shame and guilt “warrant a greater prominence in understanding the emotional underpinnings of PTSD symptoms” (Øktedalen et al., 2015, p. 527).

As noted, the recently published DSM-5 expanded the description of PTSD to include not only fear-based symptoms but also the presence of trauma-related shame, guilt, or anger (American Psychiatric Association, 2013). Criterion D of PTSD states the trauma-related negative alterations in cognitions and moods may be evidenced by:

Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad”, “No one can be trusted”) Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others...Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame) (“Trauma- and Stressor-Related Disorders,” DSM-5, 2013).

Substantiating the broadening of the DSM-5 PTSD criteria, some clinicians and researchers have theorized that certain types of trauma, particularly ongoing interpersonal victimizations such as child sexual abuse, are inherently shame-producing at the moment of the trauma in the same way that certain traumatic experiences are immediately fear-producing for most, if not all, individuals (Herman, 2011; Lee & Scragg, 2001). Herman (2011) states that “like fear, shame is a biologically hardwired experience” (p. 262). Supporting this notion, two strong autonomic responses—blushing and sweating—accompany shame. Feelings of panic are common with shame, flooding those experiencing shame with a powerful desire to escape. In sum, recent research suggests that trauma-related shame is not simply a correlate or outcome of PTSD symptoms; instead shame, in addition to fear, is a contributing factor to the development of PTSD symptoms in survivors of interpersonal violence (La Bash & Papa, 2014; see also Herman, 2011). If the etiology of PTSD is shame and fear rather than fear alone, then addressing shame in mental health treatment and in the provision of trauma-informed care should not be overlooked but must be a central component of trauma treatment.

Child Sexual Abuse Characteristics Theorized to Influence Trauma-Related Shame

Based on Finkelhor and Browne's (1985) theory, certain characteristics of CSA contribute to the formation of traumatic sexualization and stigmatization including the relationship of the perpetrator to the victim, the level of force used by the perpetrator during CSA, and whether CSA involved penetration. Finkelhor and Browne (1985) describe the ultimate betrayal of trust that occurs when someone whom children look up to and rely on maltreat them. Kessler and Beischler (1999) found that familial CSA was associated with the highest risk for adult victimization when compared with peer or non-familial CSA. Filipas and Ullman (2006) found that individuals who were sexually abused by someone they knew experienced more severe PTSD symptoms than those individuals abused by strangers or someone less familiar to them. Platt and Freyd (2015) found that trauma involving physical, sexual, and emotional abuse by a perpetrator in close relationship to the victim resulted in higher levels of shame and dissociation. CSA perpetrated by a relative or a person in a close relationship is thought to increase trauma-related shame due to the child's need to maintain the relationship attachment through the fabrication of self-blame (Gleiser, 2003). However, questions remain regarding the impact of child-perpetrator relationship on trauma-related shame. In a review of research on the topic, Valle and Silovsky (2002) found no specific child-perpetrator relationship consistently linked to greater self-blame.

The level of invasiveness of the sexual contact during CSA has been shown to be positively correlated with risk of revictimization (Arata, 2000, 2002; Classen et al., 2005; Humphrey & White, 2000). Fleming and colleagues (1999) found that CSA involving intercourse tripled the risk of rape in adulthood. CSA with penetration was more commonly reported by revictimized women and those with more severe PTSD symptoms (Classen et al., 2005; Koverola et al., 1996). Ullman and associates (2006) found that individuals with greater CSA severity were one and a half times more likely to blame themselves at the time the abuse occurred and more than twice as likely to blame themselves currently for the abuse. Jonzon and Lindblad (2005) found that penetration during CSA was significantly related to more psychosomatic symptoms in survivors. Du Mont and colleagues (2003) found that abuse involving intercourse was more likely to lead to feelings of self-blame and stigma resulting in greater emotional distress.

Several theorists and researchers have proposed that level of force used by the perpetrator during CSA does not follow a simple linear relationship, but a curvilinear, "u-shaped" association with PTSD and abuse-related shame (McCahill et al., 1979). Experiences in which the child is enticed to participate are more likely to be more damaging than those in which force is used. In the absence of violence, the child is more likely to be blamed for failure to resist the assault or even for trying to cover up "consensual" sexual activity. Reinforced by the accusations of others, his/her feelings of guilt or self-blame may begin to surface (McCahill et al., 1979). Greater use of physical force or coercion during CSA has been consistently associated with both children and adults having less self-blame (for review, see Valle & Silovsky, 2002). At the other end of the spectrum, a form of traumatic sexualization may result when fear becomes associated with sex in the wake of severe force (Finkelhor & Browne, 1985).

The Effects of Other Types Childhood Abuse on Shame

Higgins and McCabe (2001) found greater and more prominent adjustment problems in adults were associated with reports of having been exposed to several types of maltreatment, which illustrates the importance of including different types of abuse when studying the long-term effects of child maltreatment (Finkelhor et al., 2005; Reid & Sullivan, 2009; Saunders, 2003). Prior studies have found mixed results when researching the relationship between child physical abuse (CPA) and sexual behaviors and attitudes. Researchers have found that CPA places an individual who was sexually victimized at an increased risk for revictimization (for review, see Classen et al., 2005). CPA has been found to be associated with interpersonal aggression, low self-esteem, and depression (Van Bruggen, et al., 2006). The effects of CPA share common characteristics with CSA (powerlessness, betrayal, post-traumatic symptoms, low self-esteem). Physically abused children frequently develop disorganized insecure attachments to their caregivers and do not develop a healthy self-concept (Heide & Solomon, 2006).

Past studies have also found links between child neglect and sexual revictimization (Reid, 2011; Reid & Piquero, 2016; Reid & Sullivan, 2009). Neglected children often learn that they cannot count on others to respond to their needs and to comfort them. Compared to physically abused children, neglected children exhibit more severe cognitive deficits (Heide & Solomon, 2006) and a diminished sense of self (Solomon & Heide, 2005). A neglectful family environment that lacks nurturing and in which needs are not acknowledged may result in children viewing themselves as deserving of maltreatment and powerless to prevent violence and abuse.

Current Study

The research hypotheses of this study are based upon the Finkelhor and Browne's theory that certain dynamics of CSA result in traumatic sexualization and stigmatization (i.e., trauma-related psychosexual shame). More specifically, the study examined the effect of CSA as well as three characteristics of CSA: familial perpetrator, penetration, the use of force on the level of trauma-related psychosexual shame. Having a relative as a perpetrator and experiencing penetration during CSA were theorized to increase shame. Conversely, the use of force during CSA is theorized to decrease the level of shame as past studies have found that children who are enticed by a perpetrator rather than physically forced to participate in sexual abuse have greater levels of guilt and shame. Additionally, the study examined the impact of other types of child abuse—repeat sexual victimization during adolescence, physical abuse, neglect, commercial sexual exploitation—which were expected to result in higher levels of trauma-related psychosexual shame.

Methodology

Data Collection and Study Sample

In 1973 to 1975, 206 girls, ranging in age from 10 months to 12 years, who were victims of reported cases of sexual abuse were examined as part of a larger National Institute of Mental Health–funded study on the consequences of sexual assault (McCahill et al., 1979). In 1996 and 1997, follow-up interviews were conducted with both the original CSA victims and women in a matched comparison group. The matched comparison group was created by searching the pediatric emergency room records of the hospital where the CSA victims were seen to identify girls who were treated at the hospital during the same time period for reasons not related to

abuse (Siegel & Williams, 2001a, 2001b, 2003). Eligible girls were matched based on race, age (within 1 year), and date of hospital visit (within 1 year).

Data from the follow-up interviews conducted in 1996-1997 were analyzed in this study. Of the 238 women contacted for follow-up interviews, 174 women agreed to participate in the interviews and were paid \$35 for participating in interviews lasting approximately three hours (Siegel & Williams, 2001a). Fifty percent of the 174 women who participated in the follow-up interviews were from the original sample of CSA victims and the other 50% were from the matched comparison group (Siegel & Williams, 2003, p. 911). The race/ethnicity distribution of the study participants was 89% African American, 7% Caucasian, 2% Hispanic, 1% Native American, and 2% described their ethnicity as biracial. At the time of the follow-up interviews in 1996-1997, the average age of the sample was 31.6 years old. Based on census tract information, the average family median income at the time of the collection of the original data was categorized as lower income (Siegel & Williams, 2001a).

Measures

The child sexual abuse (CSA) measure, coded (no = 0 or yes = 1), indicated if participants reported “incidents involving genital contact (including fondling), force, or sexual contact with someone who was five years older than the respondent when she was younger than 13” (Siegel & Williams, 2003, p. 912). Dichotomous variables indicated whether CSA involved: a) a relative as a perpetrator, b) penetration, or c) force. McCahill et al. (1979) defined relative as “nuclear and/or extended family members.” Force during CSA was defined as “slapping, pushing, shoving, beating, choking, or use of weapon” during CSA. Penetration was defined as the perpetrator “inserting finger, object, or penis into mouth, vagina, or rectum or performing oral sex on you” during CSA.

Repeated sexual victimization in childhood and adolescence was coded in a manner that captured the effects of “double” sexual victimization as a minor. Participants who reported never being sexually abused or who reported either being sexually abused as a child (i.e., before the age of 13) or as an adolescent (i.e., while aged 13-17 years old) were coded “0”. Those who reported sexual victimization during both childhood and adolescence or double victims were coded “1”.

A dichotomous variable measured whether a woman reported any harsh physical discipline or abuse by either (a) her mother or other mother figure or (b) her father or other father figure. A woman was coded as having experienced such abuse if she reported that a parent or other parent figure had ever done any of the following to her: hit her with an object, beaten her up, hit her with a fist or kicked her hard, choked her, burned or scalded her on purpose, threatened her with a knife or gun, or used a knife or fired a gun at her.

The indicators of child neglect were based on participants’ responses to five questions, asking whether her parents (defined as persons that the participant considered her mother figure or her father figure while a youth) ever: (1) had to leave her home alone, even when they thought an adult should be there; (2) were unable to make sure she got the food she needed; (3) were not able to make sure she got to a doctor or hospital when she needed to; (4) were so drunk or high they had a problem taking care of her; and (5) were so caught up with their own problems that they were unable to show or tell her that they loved her. No was coded “0” and yes was coded “1.” The Cronbach’s alpha for this index was .70, showing an adequate

level of internal consistency (Nunnally, 1978). Responses to these five questions were added together and the total was used as the child neglect score with scores ranging from 0 to 5.

The indicator for commercial sexual exploitation in prostitution while a minor was based on participants in the study reporting if they “exchanged sex for money or drugs, that is, engaged in prostitution” before the age of 18. No was coded “0” and yes was coded “1.” While this measure does not reflect all possible forms of commercial sexual exploitation, these data and this measure have been used in previous studies exploring risk factors related to commercial sexual exploitation (Reid, 2014) and pathways to commercial sexual exploitation (Reid, 2011).

Siegel and Williams (2001a, 2001b, 2003) utilized items from Jelu’s (1998) Belief Inventory to assess two concepts from Finkelhor and Browne’s (1985) Traumagenic Theory of Child Sexual Abuse—traumatic sexualization and stigmatization. Full or partial versions of the Belief Inventory have been regularly used as research instruments to measure dysfunctional beliefs resultant of CSA (for review, see Reid & Sullivan, 2009). For this measure, participants were asked whether the following statements were true or false for them *all or most of the time*: (1) in your opinion, no man would care for you without a sexual relationship; (2) in your opinion, only bad, worthless guys would be interested in you; (3) you use sex to get something you want or need; (4) you find yourself in awkward sexual situations; (5) you get into trouble because of your sexual behavior; (6) you control others through the use of sex. Items 1-3 assessed the level of stigmatization (i.e., negative self-concept, typified by feelings of shame and worthlessness) and items 4-6 measured the level of traumatic sexualization (i.e., a dysfunctional linking of sex with love or the inappropriate use of sex to obtain approval or control). A scale with values ranging from 0 to 6 was created by summing participant responses to all items (true = 1, false = 0). Cronbach’s alpha for this scale was .79 (Siegel & Williams, 2000), demonstrating adequate level of internal consistency (Nunnally, 1978).

Data Analysis

The analytic strategy of this study involved several steps. Descriptive statistics and bivariate associations of characteristics of CSA and additional forms of child maltreatment with the trauma-related shame measure were explored. Following the bivariate analyses, ordinal logistic regression (OLR) was utilized to estimate the influence of the predictor variables on the outcome variable (trauma-related shame) while controlling for all other predictors in the model. OLR was chosen to analyze this model due to the ordinal dependent variable. Long (1997) recommends the use of OLR as an alternative to linear regression, as it is designed explicitly for ordinal outcomes. Diagnostic testing was conducted to test that the parallel regression assumption, critical to OLR, was not violated. Results of the OLR are presented in estimates given in units of ordered log odds and as proportional odds ratios.

Results

Descriptive statistics of the study variables are displayed in Table 1. Descriptive analysis of the CSA characteristics revealed that 66% of participants reported CSA, with 37% of participants reporting familial CSA, 41% reporting CSA involving force, and 44% reporting CSA involving penetration. Double sexual victimization across childhood and adolescence was reported by 18% of participants. Eighty-four

percent of the participants reported that at least one parent physically abused them and 12% reported commercial sexual exploitation in prostitution occurred before they were 18 years old. Fifty-seven percent of the participants reported some form of child neglect ($M = 1.07$, $SD = 1.29$). Forty-four percent of participants reported some level of trauma-related shame ($M = 1.16$, $SD = 1.65$).

Table 1. Descriptive statistics of All Study Variables (N= 174)

	Percent	M	SD	Range
CSA	66			
Familial CSA perpetrator	36			
CSA with force	41			
CSA involved penetration	44			
Double sexual victimization in childhood and adolescence	18			
Physically abused by at least one parent	84			
Commercial sexual exploitation in prostitution as a minor	12			
Child neglect		1.07	1.29	0-5
Trauma-related shame		1.16	1.65	0-6

Note: CSA = Child sexual abuse.

Bivariate statistical analyses are summarized on Table 2, which identifies the variables significantly related to trauma-related shame. CSA was not significantly associated with higher trauma-related shame. Having a relative as a perpetrator was associated with higher levels of trauma-related shame; however, the use of force and penetration during CSA were not related to the dependent variable. As hypothesized, all types childhood abuse or exploitation were found to be significantly related to the dependent variable. For example, when examining differences in those with and without a history of commercial sexual exploitation in prostitution as a minor, those with no history of such exploitation were much more likely to score zero on the trauma-related shame scale than those with history of exploitation (61% vs. 24%). Additionally, only 1% of those with no history of this type of exploitation scored six on the trauma-related shame scale (the most extreme score), while 10% of those with a history of CSEC scored six on the scale. Scores on the child neglect scale were moderately correlated with the scores on the scale assessing trauma-related shame.

Table 2. Results of Bivariate Analysis of Predictor Variables and Trauma-Related Shame (N= 174)

Predictor Variables	<i>M</i>	<i>SD</i>	<i>t</i> -statistic/ <i>r</i>
CSA			0.89 NS
YES	1.24	1.71	
NO	1.00	1.53	
CSA relative perpetrator			2.20*
YES	1.52	1.70	
NO	0.94	1.59	
CSA using force			0.98 NS
YES	1.31	1.84	
NO	1.05	1.49	
CSA with penetration			1.46 NS
YES	1.37	1.87	
NO	0.99	1.44	
Double sexual victimization			3.70***
YES	2.22	1.86	
NO	0.91	1.50	
Child physical abuse			6.89**
YES	1.35	1.73	
NO	0.18	0.48	
Commercial sexual exploitation			3.14**
YES	2.43	2.04	
NO	0.98	1.51	
Child neglect			.36***

Note: CSA = Child sexual abuse. * $p < 0.05$, ** $p < 0.01$, two-tailed.

The results of the ordinal regression analysis are shown on Table 3. The data fit the model well, ($\chi^2_{(8)} = 52.23, p < .001$). A significant chi-square means that the null hypothesis that the model without predictors is as good as the model with predictors is rejected. Collinearity statistics of tolerance and the Variance Inflation Factor (VIF) were evaluated for all model predictors. Results indicated that the model did not have high multicollinearity among the predictor variables. Diagnostic testing revealed that the assumption of parallel regressions was non-significant ($\chi^2_{(40)} = 5.31, p = 1.00$), indicating that the coefficients can be assumed to be the same across all levels of the dependent variable.

Table 3. Summary of Ordinal Logistic Regression

Predictor Variables	<i>B</i>	<i>SE B</i>	Odds Ratio [95% CI]
CSA	-1.04	0.55	0.35 [0.12, 1.03]
CSA relative perpetrator	0.77	0.42	2.17 [0.95, 4.97]
CSA using force	-0.46	0.46	0.63 [0.26, 1.55]
CSA with penetration	0.01	0.46	1.00 [0.41, 2.49]
Double sexual victimization	1.38**	0.45	3.98 [1.65, 9.54]
Child physical abuse	1.58**	0.59	4.85 [1.52, 15.53]
Child neglect	0.35**	0.14	1.42 [1.08, 1.85]
Commercial sexual exploitation	1.52**	0.48	4.59 [1.78 11.85]

Note: CSA = Child sexual abuse. * $p < .05$. ** $p < .01$. *** $p < .001$, two-tailed test.

Controlling for other predictors in the model, neither CSA nor the analyzed characteristics of CSA had significant effects on the level of trauma-related shame. Apart from CSA, all other analyzed types of child maltreatment had significant effects of the level of trauma-related shame. Controlling for the other variables in the model, double sexual victimization in childhood and adolescence significantly increased the likelihood of higher levels of trauma-related shame ($b = 1.38$, $p < .01$). For those reporting double victimization, there was 3.98 (298%) greater odds of having higher levels of trauma-related shame. Being physically abused as a child significantly increased the likelihood of higher levels of trauma-related shame ($b = 1.58$, $p < .01$) when compared to those who were not physically abused. Participants reporting child physical abuse showed 4.85 times (385%) greater odds of having higher levels of trauma-related shame relative than those who were not physically abused. Additionally, being neglected as a child significantly increases the likelihood of higher levels of trauma-related shame ($b = 0.35$, $p < .01$), with each unit increase in the child neglect score there was 1.42 times (42%) greater odds of having higher levels of shaming beliefs and behaviors. Controlling for the other predictors in the model, being sexually exploited in prostitution while a minor significantly increased the likelihood of higher levels of trauma-related shame ($b = 1.52$, $p < .01$) when compared to those who were not exploited. Participants who reported commercial sexual exploited in prostitution while a minor sustained 4.59 time (359%) greater odds of having higher levels of trauma-related shame compared to those who were not exploited in prostitution.

Discussion

The purpose of this study was to examine the impact of certain characteristics of CSA and the impact of various forms of child maltreatment on the level of trauma-related psychosexual shame reported in adulthood. The study findings indicate that childhood experiences of repeat sexual victimization across two developmental stages—childhood and adolescence—significantly increased trauma-related psychosexual shame reported in adulthood. This finding confirms previous research regarding the detrimental impact of sexual revictimization (Filipas &

Ullman, 2006) and substantiates concerns regarding the lasting impact of sexual victimization during childhood and adolescence (Phillips & Daniluk, 2004).

Additionally, child physical abuse, child neglect, and commercial sexual exploitation in prostitution while a minor each individually contributed (i.e., while controlling for other types of child maltreatment) to trauma-related psychosexual shame with effects lasting into adulthood. This important finding highlights that each type of child maltreatment may lead to trauma-related psychosexual shame reported in adulthood. CSA has long been considered unique in producing psychosexual shame or traumatic sexualization. However, these findings indicate that each type of child maltreatment can have lasting negative impact on feelings of worthiness, create doubts about the prospect of healthy relationships and whether others could care about them based on their own merits, particularly in the context of sexual or romantic relationships (Carnes, 1997).

Several implications emerge from the strong association between trauma-related shame and commercial sexual exploitation in prostitution as a minor even when accounting for other the negative impact of other types of child maltreatment. The association of commercial sexual exploitation with higher levels of shame draws attention to the importance of addressing trauma-related shame with those who have been exploited in prostitution. Trauma-related shame is an irrational and biological response that is connected the specific reactions of denial, hiding, and running away (Lewis, 1971). People in the state of shame can experience something akin to panic that drives them to escape intolerable emotions (Lewis, 1988). Strong emotional reactions to shame may contribute to the high rate of chronic running away that has been reported among adolescents who have experienced commercial sexual exploitation (Reid, 2010, 2011).

While the findings of this study are useful in understanding the etiology of trauma-based shame, the generalizability of the study findings is limited due to the sample selection process and the lack of cultural diversity in the study sample. The prevalence of CSA in the study sample and other forms of child maltreatment are not representative of their prevalence in the general population. The participants in the study were predominantly African-American and therefore the results may not be applicable to men or women from other racial or ethnic backgrounds. Despite this limitation, it should be noted that African American women from low-income families living in an urban area are at high risk for victimization (Goldmann et al., 2011; Walsh et al., 2014) and therefore research on this particularly vulnerable group is critically important. Additionally, the study sample is not a nationally representative sample and as such the findings are not generalizable to all women who have experienced child maltreatment. However, prospective longitudinal data from survivors of sexual victimization and commercial sexual exploitation in prostitution during adolescence are not commonly available. The availability of the data utilized in this study make it possible to identify adverse childhood experiences associated with trauma-related shame in adulthood. Future studies with male participants and female participants from other racial and ethnic could be useful in understanding the development in trauma-based shame in the other populations.

Additionally, future research is critically needed to investigate treatment effectiveness in reducing trauma-related shame. To date, there have only been a few studies that have evaluated interventions purposefully targeting trauma-related shame (for review, see Au et al., 2017). Researchers recently evaluated the

usefulness of brief compassion-based therapy (designed to increase self-compassion) for reducing shame and PTSD symptoms in a small sample ($N = 10$) of trauma-exposed adults with promising results (Au et al., 2017). Based on the study results, the researchers recommended that brief compassion-based therapy be used either as a stand-alone treatment for trauma-related shame or in conjunction with other types of trauma-informed treatment models.

In closing, there has been a positive shift in the legal status of minors exploited in prostitution in the United States (from juvenile delinquent to crime victim), including limited protection from prosecution provided by legislation such as The Trafficking Victims Protection Act of 2000. However, it is important to note that numerous researchers have raised concerns regarding the “victim” or “victimhood” label being linked to those involved in commercial sexual exploitation (Dodsworth, 2014; McMahon-Howard, 2017). In this context, the colloquial term victim with its largely derogatory connotation has been confused with the strictly legal distinction of the term victim (i.e., a crime victim as opposed to a criminal). Concerns have also arisen regarding the requirement, in certain circumstances, for youth to acknowledge some level of “exploitation” in order to receive treatment or services (Dodsworth, 2014) or to avoid prosecution for prostitution (Reid & Jones, 2011). The notion of victimhood or being exploited may demoralize adolescents with histories of trauma exposure, while also diminishing their feelings of self-efficacy and resilience (Dodsworth, 2014). Appropriately responding to these concerns is vital for those providing trauma-informed care to survivors of commercial sexual exploitation or other types of child maltreatment. Herman (2011) acknowledges the difficulty of this challenge facing professionals engaged in treating individuals with histories of interpersonal trauma (i.e., the very fact of acknowledging victimization or exploitation may evoke shame, as clients may view being labeled a victim as a sign of weakness and failure) (p. 267). Herman (2011) recommends educating clients regarding the normative effects of trauma so that they gain understanding that shame is a normal, autonomic, biological response to trauma and betrayal. Greater understanding of normative responses to trauma – including shame- and fear-based responses – facilitate clients’ ability to escape from the toxic cycle of feeling ashamed of being ashamed.

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