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## The Relationship Among Adult Attachment Styles, Shame, Dissociation, and Abuse Characteristics in Women Survivors of Intrafamilial Child Sexual Abuse Perpetrated by a Parental-Figure

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LOYOLA UNIVERSITY CHICAGO

THE RELATIONSHIP AMONG ADULT ATTACHMENT STYLES, SHAME,  
DISSOCIATION, AND ABUSE CHARACTERISTICS IN WOMEN SURVIVORS OF  
INTRAFAMILIAL CHILD SEXUAL ABUSE PERPETRATED BY A PARENTAL-  
FIGURE

A DISSERTATION SUBMITTED TO  
THE FACULTY OF THE GRADUATE SCHOOL  
IN CANDIDACY FOR THE DEGREE OF  
DOCTOR OF PHILOSOPHY

PROGRAM IN SOCIAL WORK

BY  
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CHICAGO, ILLINOIS

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tremendously valued her reassurance and confidence in me accomplishing this goal. Finally, Dr. James Marley has been truly gracious in being a member of this committee and my previous committee. He provided valuable insights and clear directions in seeing through the completion of this project. I very much look forward to maintaining collegial relationships with my committee in the coming years.

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## ABSTRACT

The consequences of intrafamilial child sexual abuse (CSA) often evolve beyond the termination of abuse and pervade into adulthood, posing complex and enduring consequences for survivors (Courtois, 1999; Briere, 1992; Herman, 1981, 1991; van der Kolk & Kadish, 1987; Chu & Dill, 1990). The concepts of attachment, shame, and dissociation—in the context of childhood sexual abuse—are significant areas of study when working with adult survivors. The present study included 49 women with a history of childhood sexual abuse perpetrated by a parental-figure. The purpose of the study was to identify the relationships among adult attachment styles, shame, dissociation, and specific CSA characteristics (age at onset, relationship to the perpetrator, duration of abuse, experience of other types of abuse). Participants voluntarily and anonymously participated in completing 4 self-administered measures on demographics, adult attachment styles, levels of shame, and levels of dissociation. Treatment variables were also investigated including type of treatment currently being received at the agency, frequency of this treatment, and overall duration of treatment to assess their possible relationships to adult attachment styles, levels of shame and dissociation, and CSA characteristics.

The major findings suggest that the experience of earlier age at onset, having a father as the perpetrator, longer duration of abuse, and experience of other types of abuse lends to a greater likelihood towards fearful attachment style; adult survivors with fearful

attachment styles are more likely to have high level of shame; and adult survivors with high level of shame have high level of dissociation. Additional findings of importance are that the experience of earlier age at onset, having a father as the perpetrator, longer duration of abuse, and experience of other types of abuse leads to a greater likelihood towards both high levels of shame and high levels of dissociation which in turn were related to more frequent treatment. The finding also suggests that adult survivors with a high level of dissociation stay longer in treatment.

## CHAPTER ONE

### INTRODUCTION

#### *Statement of Problem*

The present study focused on adult women survivors of childhood sexual abuse: their attachment styles, and their experience of shame and dissociation, all in relation to the abuse characteristics. Literature on child sexual abuse (CSA), attachment, shame, and dissociation are expectedly vast. The present study has critically utilized existing literature in postulating relationships among these variables. It was hoped that the findings provide valuable information for both future clinical work and research.

The consequences of intrafamilial CSA often evolve beyond the termination of abuse and pervade into adulthood, posing complex and enduring consequences for survivors (Courtois, 1999; Briere, 1992; Herman, 1981, 1991; van der Kolk & Kadish, 1987; Chu & Dill, 1990). Traumatic experiences result in an array of psychological, emotional, and relational difficulties in life (Courtois, 1988, 1999; Briere, 1992; Herman, 1981). In many cases, CSA survivors present themselves in different treatment settings with problems such as post-traumatic stress disorders (Courtois, 1999; Briere, 1992); depression (Boudewyn & Liem, 1995; Hill, et al., 2001; Courtois, 1988); anxiety (Maynes & Feinauer, 1994; Peleikis, Mykletun, & Dahl, 2004); dissociative disorders (van der Kolk & Kadish, 1987; Chu & Dill, 1990); substance abuse (Evans & Sullivan, 1995; Herman, 1981); eating disorders (Miller, McCluskey-Fawcett, & Irving, 1993;

Everill, Waller, & McDonald, 1995; Mallinckrodt, McCreary, & Robertson, 1995); self-injurious behavior (Rodriguez-Srednicki, 2001; Turell & Armsworth, 2000); and relational difficulties (McLean & Gallop, 2003; Gold, Hill, Swingle, & Elfant, 1999).

The researcher's experiences in working with adult survivors of childhood sexual abuse have led to a growing curiosity about the long-term sequelae of CSA, particularly in the areas of affective regulation and the phenomenon of dissociation. Perspectives on attachment have also been a focus of further inquiry both in clinical work and research.

Therapeutic work with adult survivors requires comprehension of the complex dynamics of abuse. Continuing efforts to understand the effects of intrafamilial CSA experiences on the development of attachment, the affects produced, and the emergence of adaptive mechanisms, are essential when working with adult survivors. Thus, the concepts of attachment, shame, and dissociation—in the context of CSA—are significant areas of study.

An adult survivor's attachment pattern is influenced by the experiences of childhood sexual abuse (Alexander, 1992; Berlinger & Elliot, 2002; Liem & Boudewyn, 1999). In turn, an attachment style influences the meanings adult survivors carry about themselves and their experiences of the sexual abuse. Adult attachment styles reflect patterns of engagement and relating that are inevitably manifested in relationships, including the therapy relationship. Examining these relationships give way to an increased understanding of adult survivors' patterns of coping and relating to themselves and others.

The meanings tied to the CSA experience are reflected on the personality structures and defenses, and further determine which affects are produced and how these affects are dealt with. Each attachment style represents a unique structure with the purpose of ridding overwhelming affects and preventing retraumatization. Thus, the attachment system is essentially built around the process of survival and consists of mechanisms that essentially prevent further trauma (Main & Solomon, 1986, 1990; Main & Weston, 1982; Blizzard, 2003; Lyons-Ruth, 2001; Siegel, 1999).

The affect of shame associated with the experience of childhood sexual abuse can be overwhelming and typically calls for defensive strategies (Herman, 1991; Chu & Dill, 1990). Understanding ways of coping with shame is critical when working with adult survivors—it calls for recognition of the manner that a particular attachment style is related to the emergence of shame, and the manner shame is dealt with. Without an understanding of how attachment styles relate to the manner that adult survivors use to deal with their shame, shame will continue to be unattended, concealed, and at times, dissociated. The work requires an understanding of the attack of shame on the self and recognition of strategies utilized to deal with this affect. Furthermore, without an understanding of the interplay between adult attachment styles and CSA experiences, affects produced in the context of childhood sexual abuse will continue to reinforce meanings about the trauma. With this notion, it is essential that shame is understood in the context of adult attachment styles.

CSA becomes a precursor to the development of self-protective mechanisms (van der Kolk & Kadish, 1987; Chu & Dill, 1990; Herman, 1991). In the employment of self-protective mechanisms, one of the major attempts is to compensate for the sense of shame. Overwhelming shame from CSA experiences is one of the driving forces in the emergence of adaptive mechanisms (Howell, 2003). The self utilizes an array of defenses to deflect, project, or minimize the intensity of shame experienced (Herman, 1991). Because of this, as one feels intense shame, defenses become activated to protect the self, with dissociation being one of the primary defenses (Howell, 2003; Chu & Dill, 1990).

Dissociation is as a defensive strategy in the experience of trauma and has been known to manifest in adult survivors—especially in severe cases of childhood abuse (Chu & Dill, 1990; Terr, 1991). The self attempts to cope with the abuse experience by maintaining an understanding of the event that inevitably requires a fragmentation of the psyche (Chu & Dill, 1990; van der Kolk & Kadish, 1987; Herman, 1991; Gold, Hill, Swingle, & Elfant, 1999; Kluft, 1990). Shame has been related to the emergence of dissociated states in the experience of CSA (Kessler & Bieschke, 1999). Furthermore, shame can be expected to follow dissociative re-experiencing or the physical reenactment of traumatic events (Kessler & Bieschke, 1999).

This chapter includes an overview of CSA with foci on prevalence, intrafamilial CSA, trauma, and long-term sequelae for adult survivors of childhood sexual abuse. The latter part of the chapter includes discussions on the purpose of the research, research questions, and hypotheses. The primary constructs for understanding the adult survivor of

CSA (attachment, shame, dissociation, and CSA characteristics) are discussed in detail in the literature review section of the dissertation (see Chapter II).

### *Overview of CSA*

#### Prevalence of CSA

The prevalence of CSA has been increasingly recognized in the recent decades (Courtois, 1988; Briere & Conte, 1993; Briere & Runtz, 1988; Browne & Finkelhor, 1986). Sgroi (1982) writes:

Public and professional acknowledgement that significant numbers of children are sexually abused by their relatives and caretakers did not really begin to emerge until the mid-70s (p. 6).

A number of prevalence studies carried out since 1979 have included both clinical and general populations (Finkelhor, 1979; Finkelhor, 1984; Fromuth, 1986; Bagley & Ramsay, 1986). The National Center for Child Abuse and Neglect commissioned a comprehensive study in 1979 that estimated that 44,700 cases of CSA were known to professionals in the United States—almost twice as many as were known to official reporting agencies (Finkelhor, 1982). Sarafino (1979) estimated there were 336,200 annual incidents in the United States, however, this was still considered a drastic undercount in light of beginning prevalence studies (Finkelhor, 1984). Furthermore, Finkelhor (1979) writes that intrafamilial abuse tends to be reported more to child protection agencies while abuse by strangers tends to be reported more to legal authorities.

Between 1986 and 1993, reported cases of childhood sexual abuse indicated an increase of 125% (Snyder & Sickmund, 1999; U.S. Department of Justice, 2000). Children under age 12 accounted for one-third of all sexual offense victims reported to authorities (Langan & Harlow, 1994; Snyder & Sickmund, 1999; U.S. Department of Justice, 2000). Furthermore, it is estimated that at least half of all serious childhood victimizations, sexual assault included, are not reported to any authority (Snyder & Sickmund, 1999; U.S. Department of Justice, 2000).

Between 1991 and 2002, the National Incident-Based Reporting System (NIBRS) provided reports from law enforcement agencies of 21 states and specific highlights from 2000 include the following, as reported to law enforcement: 67% of sexual assault victims were juveniles under age 18; 34% of sexual assault victims were under age 12; 1 of every 7 victims of sexual assault was under age 6; 4% of offenders who victimized children under age 6 were juveniles under age 18 (U.S. Department of Justice and the Federal Bureau of Investigation, 2000).

The National Child Abuse and Neglect Data System (NCANDS) estimates both intrafamilial and extrafamilial child sexual abuse. In 1998, estimates reported over 2.5 million referrals of child abuse or neglect to relevant state or local agencies. These referrals resulted in over 900,000 confirmed victims of maltreatment at a rate of 12.9 per 1,000 children nationwide. Of these, 11.5% suffered sexual abuse (U.S. Department of Health & Human Services, 1998). In 2000, 10% of almost 900,000 children who were victims of child maltreatment experienced sexual abuse (U.S. Department of Health &

Human Services, 2000). In 2003, 9.9% were sexually abused as opposed to 9.7% in 2004 (U.S. Department of Health & Human Services, 2003, 2004). The most recent report from 2005 indicates almost 900,000 children were found to be victims of child abuse or neglect. Of these, 9.3% were sexually abused (U.S. Department of Health & Human Services, 2005).

The above reports indicate that victims of CSA comprise an average of 10% of the accounted cases of child maltreatment. The true incidence of CSA is difficult to determine. Despite the growing awareness of its serious consequences, the problem of CSA, specifically intrafamilial CSA, continues to involve shame and stigmatization, an issue that keeps it from being reported.

#### Intrafamilial CSA

Intrafamilial CSA, in comparison to the experience of extrafamilial CSA, is more likely to be associated with greater intrusion, longer duration, earlier onset, and use of greater force (Fischer & McDonald, 1998). Research findings support the observation that sexual abuse by family members result in more damaging outcomes than sexual abuse perpetrated by a non-family member (Fischer & McDonald, 1998; Miller, McCluskey-Fawcett & Irving, 1993). Severe mental health problems (e.g. depression, PTSD, personality disorders) in adulthood have a high probability of association with a history of intrafamilial CSA (Courtois, 1988; Briere, 1992; Herman, 1981; Chu, 1991; Alexander & Anderson, 1994; Roche, Runtz, & Hunter, 1999).

Abuse perpetrated by a family member involves the experience of betrayal associated with the abuse (Freyd, 1996). CSA involving family members and caretakers is thought to hold the possibility of greater trauma than other forms of abuse because of the degree of violation implied and the power the perpetrator has held over the child (Finkelhor, Hotaling, Lewis, & Smith, 1990). The closer the emotional relationship, the greater the negative psychological consequences for later development (Briere, 1989; Briere & Runtz, 1988; Kendall-Tackett, Williams, & Finkelhor, 1993). Furthermore, Herman, Russell, & Trocki (1986) found that the relationship between the victim and the perpetrator is strongly related to the victim's perception of lasting harm.

Intrafamilial CSA, especially with a parent, has been related to greater trauma (Finkelhor, 1979; Russell, 1986; Friedrich, Beilke, & Urquiza, 1987; Fischer & McDonald, 1998; Miller, McCluskey-Fawcett, & Irving, 1993). The most common type of intrafamilial CSA is father-daughter and stepfather-daughter CSA (Swanson & Biaggio, 1985; Herman, 1981; Courtois, 1988; Russell, 1986; Finkelhor, 1979), although certainly intrafamilial sexual abuse occurs with grandfathers, uncles, parentified siblings and others. Cole and Putnam (1992) write:

Father-daughter incest is a particularly disturbing form because it occurs within the domain of the child's main source of support and socialization (p. 175).

Sexual abuse by stepfathers tends to be more violent and more likely to occur repeatedly than when biological fathers are the perpetrators (Russell, 1999). Most women who have suffered forceful, prolonged, or highly intrusive sexual abuse, or who had been abused by their father or stepfather, report long-lasting negative effects (Herman, Russell,

& Trocki, 1986). In the context of father-daughter CSA, the first sexual contact is often with the eldest daughter (deYoung, 1982) which typically occurs at 7–9 years of age (Conte & Berliner, 1981; Finkelhor, 1979; Kendall-Tackett & Simon, 1988), and the duration of abuse tends to be longer which is partly attributed to the insular nature of the family (Wyatt & Newcomb, 1990). Consequently, female victims are typically more symptomatic especially when abused by father-figures (Kendall-Tackett, Williams, & Finkelhor, 1993; Ullman & Filipas, 2005).

Increased emphasis on the prevalence and serious consequences of intrafamilial CSA has led to an examination of abuse by mothers. Growing literature is emerging on CSA perpetrated by mothers. Within reported CSA cases by mothers, mother-daughter sexual abuse is more commonly reported (Courtois, 1988). The thought that a mother or maternal figure is sexually abusive to her child tends to add more shame and stigma for the victims because their abuse is perceived as uncommon (Goodwin & Divasto, 1979). When the sexual abuse is perpetrated by a mother, the difficulty of disclosing the abuse and being believed is further compounded (Etherington, 1997). Mother-daughter sexual abuse not only presents a challenge to cultural images of motherhood, but also involves addressing two critical social taboos: intrafamilial CSA and homosexuality (Ogilvie & Daniluk, 1995; Courtois, 1988; Caplan, 1989; Kasl, 1989).

### Trauma

The traumatic experiences and consequences of childhood sexual abuse are often noted in the literature. The trauma from childhood sexual abuse often endures into

adulthood and is manifested in various psychological disorders and interpersonal difficulties.

The definition of *trauma* and what constitutes *traumatic* has changed over time. According to the Diagnostic and Statistical Manual of Mental Disorders-IV (American Psychiatric Association, 1994), a stressor is also traumatic by virtue of the subjective response it elicits. The person's response must involve intense reactions of fear, helplessness, or horror. In children, the response must involve disorganized or agitated behavior. The characteristics of traumatic sexual events pertaining to children are also described:

For children, sexually traumatic events may include developmentally inappropriate sexual experiences without threatened or actual violence or injury . . . The disorder may be especially severe or long lasting when the stressor is of human design (e.g. torture, rape). The likelihood of developing the disorder may increase as the intensity of and physical proximity to the stressor increase (American Psychiatric Association, 1994, p. 424).

Posttraumatic stress disorder (PTSD) is often identified with the experience of childhood sexual abuse (Briere & Runtz, 1993; Kendall-Tackett, Williams, & Finkelhor, 1993; O'Neill & Gupta, 1991; Saunders, Villepontaux, Lipovsky, Kilpatrick, & Veronen, 1992; Rowan, Foy, Rodriguez, & Ryan, 1994). According to the Diagnostic and Statistical Manual of Mental Disorders-IV (American Psychiatric Association, 1994), PTSD is a disorder resulting from a traumatic experience that involves fear of death or injury and a feeling of helplessness. It is further characterized by persistent reexperiencing of the traumatic event, persistent avoidance of stimuli associated with the traumatic event, and persistent symptoms of increased arousal. PTSD has been observed

in survivors of sexual abuse, both in children (Deblinger, McLeer, Atkins, Foa, & Ralphe, 1989; Wolfe, Sas, & Wekerle, 1994) and adults (Greenwald & Leitenberg, 1990; Molnar, Buka, & Kessler, 2001; Rowan, Foy, Rodriguez, & Ryan, 1994; Thompson, Crosby, Wonderlich, Mitchell, Redlin, Demuth, Smyth, & Haseltine, 2003).

In the CSA literature, it is not uncommon that symptoms are understood within the framework of PTSD. Rumstein-McKean and Hunsley (2001) write that while researchers have found PTSD to be associated with childhood sexual abuse, many of the symptoms found among survivors are not represented by PTSD. The authors explain that the PTSD conceptualization fails to account for interpersonal symptomatology and mainly focuses on intrapsychic distress and trauma. Some survivors do not meet the criteria for PTSD, but do suffer from other psychological, emotional, and relational problems. Consequently, treatment models of both CSA and trauma have placed emphases on interpersonal symptoms such as difficulties in attachment and pathological dependency (Cole, 1986; Finkelhor, 1984).

Courtois (1999) notes that a trauma or traumatic stressor is an event or experience that is not merely stressful but also shocking, terrifying, and overwhelming to the person who experiences it. Traumatic experiences often involve a threat to the physical or psychological integrity of the victim (Siegel, 1995; van der Kolk, Pelcovitz, Roth, Mandel, McFarlane, & Herman, 1996).

Pearlman and Saakvitne (1995) posed a subjective definition of trauma:

Unique individual experience, associated with an event or enduring conditions in which the individual's ability to integrate affective experience is overwhelmed, or the individual experiences a threat to life or bodily integrity (p. 60).

Of further relevance to the present study is van der Kolk's (1987) comment on psychological trauma:

Trauma occurs when one loses the sense of having a safe place to retreat within or outside oneself to deal with frightening emotions or experiences. This results in a state of helplessness, a feeling that one's actions have no bearing on the outcome of one's life (p. 31).

The process of traumatization is an interactive process involving the characteristics of the traumatic stressor, the individual, and the context surrounding them (Courtois, 1999). This interplay of objective, subjective, and contextual factors determine the strength and severity of the outcome for the individual (Wilson, 1989; Pearlman & Saakvitne, 1995; Pynoos, Steinberg, & Aronson, 1997). Wilson (1989) notes that the more the objective dimensions of the trauma are present as environmental and situational, the greater the potential for producing a pathological outcome.

Courtois (1999) further writes that intrafamilial CSA and other forms of CSA often pose more serious consequences:

They involve a stressor of human design, repeated exposure and physical proximity to the stressor that often increases in severity and physical intrusion over time and over the course of childhood, when the individual is physically and emotionally immature and dependent on caretakers and with whom there is a conflicted relationship and ambivalent attachment (p. 90).

This perspective was the focus of the research as it emphasizes the traumatic impact derived from the context of interpersonal trauma. In the experience of intrafamilial CSA, the child's experience of being exposed and subjected to sexual acts

by a familial-figure constitutes trauma as it violates boundaries, constitutes betrayal, and creates other reactions that are often overwhelming, influencing the development of maladaptive coping strategies to deal with the abuse.

#### Long-Term Sequelae of CSA

The consequences of CSA cover a wide range of symptoms and extend into adulthood (Yama, Fogas, Teegarden, & Hastings, 1993; Graziano, 1992; Haller & Alter-Reid, 1986; Browne & Finkelhor, 1986). Numerous research studies have found that childhood sexual abuse is associated with an increased risk of adult psychopathology (Johnson, Cohen, Brown, Smailes, & Bernstein, 1999; Kendler, Bulik, Silberg, Hettema, Myers, & Prescott, 2000; Molnar, Buka, & Kessler, 2001). Symptoms emerge and abate at different times in the individual's life (Courtois, 1999). Shapiro and Levondosky (1999) write that the extent of the disorder and level of functioning vary greatly among adult survivors, with consequences ranging from mild emotional or behavioral problems to severe psychopathology including severe depression and anxiety (Browne & Finkelhor, 1986; Peleikis, Mykletun, & Dahl, 2004).

The long-term sequelae of psychological problems most frequently noted include: *posttraumatic stress disorder* (McLean & Gallop, 2003; Briere & Runtz, 1993; Molnar, Buka, & Kessler, 2001; Rowan, Foy, Rodriguez, & Ryan, 1994; Thompson, Crosby, Wonderlich, Mitchell, Redlin, Demuth, Smyth, & Haseltine, 2003; Kendall-Tackett, Williams, & Finkelhor, 1993; Oddone-Paolucci, Genuis, & Violato, 2001); *depression* (Whiffen, Judd, & Aube, 1999; Boudewyn & Liem, 1995; Hill, et al., 2001; Briere &

Runtz, 1985; Courtois, 1988; Putnam, Guroff, Silberman, Barban, & Post, 1986); *anxiety* (Peleikis, Mykletun, & Dahl, 2004; Briere & Conte, 1993; Briere & Runtz, 1988; Browne & Finkelhor, 1986); *dissociation/DID* (Gold, Hill, Swingle, & Elfant, 1999; Briere & Runtz, 1988, 1990; Elliot & Briere, 1992; Kirby, Chu, & Dill, 1993; Coons, Bowman, Pellow, & Schneider, 1989; Ross, Norton, & Wozney, 1989; Putnam, 1989; McNally, Clancy, & Schacter, 2000); *self-mutilating behavior* (van der Kolk & Kadish, 1987; Briere & Zaidi, 1989; Turell & Armsworth, 2000); *eating disorders* (Everill, Waller, & McDonald, 1995; Miller, McCluskey-Fawcett, & Irving, 1993; Coons, Bowman, Pellow, & Schneider, 1989); *substance abuse* (Herman, 1981; Briere, 1992; Evans & Sullivan, 1995); *somatic complaints* (Briere & Runtz, 1988); *feelings of isolation and stigmatization* (Patten, Gatz, Jones, & Thomas, 1989); *depersonalization* (Blake-White & Kline, 1985); *sexual dysfunction* (Browne & Finkelhor, 1986; Gold, 1986); *personality disturbances and disorders* (McLean & Gallop, 2003; Herman & Van der Kolk, 1987; Coons, 1986; Herman, Perry, & van der Kolk, 1989; Thompson, Crosby, Wonderlich, Mitchell, Redlin, Demuth, Smyth, & Haseltine, 2003); and tendency towards *revictimization* (Russell, 1986; Kessler & Bieschke, 1999; Gidycz, Coble, Latham, & Layman, 1993; Breitenbecher, 2001; Wyatt, Guthrie, & Notgrass, 1992; Sorenson, Siegel, Golding, & Stein, 1991; Messman-Moore & Long, 2003; Siegel & Williams, 2003).

### *Purpose of Research*

The purpose of this research was to describe the relationships among adult attachment styles (secure, preoccupied, dismissing, fearful), level of shame, level of dissociation, and CSA characteristics (age of onset, relationship to the perpetrator, duration of abuse, experience of other type of abuse) in adult women survivors of CSA.

### *Research Questions and Hypotheses*

The research addressed the following four research questions:

1. What is the relationship between CSA characteristics and adult attachment styles?
2. What is the relationship between adult attachment style and shame?
3. What is the relationship between adult attachment style and dissociation?
4. What is the relationship between shame and dissociation?

The research posed the following four hypotheses:

1. Adult women survivors of parentally-perpetrated CSA with insecure attachment styles (i.e. preoccupied, dismissing, fearful) will have at least 2 of the CSA characteristics (i.e. earlier age of onset, abuse perpetrated by a father, longer duration, experience of other types of abuse).
2. Adult women survivors of parentally-perpetrated CSA with fearful attachment style will have a higher level of shame as scored on the Internalized Shame Scale (ISS) (Appendix H) than adult women survivors with other adult attachment styles (i.e. secure, preoccupied, dismissing).

3. Adult women survivors of parentally-perpetrated CSA with fearful attachment style will have a higher level of dissociation as scored on the Dissociative Experiences Scale (DES) (Appendix I) than adult women survivors with other adult attachment styles (i.e. secure, preoccupied, dismissing).
4. In adult women survivors of paternally-perpetrated CSA, higher level of shame as scored on the Internalized Shame Scale (ISS) (Appendix H) will be associated with a higher level of dissociation as scored on the Dissociative Experiences Scale (DES) (Appendix I).

## CHAPTER TWO

### LITERATURE REVIEW

This chapter focuses on theoretical and empirical literature pertaining to the variables that are included in the present study. Specifically, this chapter reviews the literature on adult attachment styles, shame, dissociation, and CSA characteristics.

First, attachment theory and its concepts are introduced. Attachment styles in children are outlined to provide a foundation for the discussion on adult attachment styles. Adult attachment styles are explored in the context of childhood sexual abuse. Elaboration on the relationship between attachment and interpersonal difficulties, and the relationship of attachment and one's ability to regulate affect, are explored by highlighting various strategies within each particular adult attachment style. Second, shame and affect regulation are explored. This is followed by a discussion on the relationship of shame to attachment and childhood sexual abuse. Third, perspectives on dissociation are discussed along with literature on the relationship of dissociation and adult attachment styles in the context of childhood sexual abuse. Fourth, relevant literature on specific CSA characteristics in relation to other variables in this research is elaborated.

## *Attachment*

### Introduction to Attachment Theory and its Concepts

Bowlby's (1969) attachment theory elaborates on normative parent-child bonding as the result of an evolutionarily adaptive set of organized care-giving and care-seeking strategies that are activated in times of distress or threat. Attachment is construed as the biologically based bond between an infant and a caregiver that assures the infant's survival (Bowlby, 1969, 1988). The infant's close proximity to a predictable and responsive caregiver provides the child with a secure base from which to explore the world (Bowlby, 1988). Thus, the attachment figure serves as a source of security for the infant in situations that involve anxiety or fear.

A central component of attachment theory is the concept of the internal working model (Bowlby, 1973). Alexander (1992) notes that on the basis of early experience with the attachment figure, the infant develops expectations about his or her own role in relationships (worthy and capable of getting others' attention versus unworthy and incapable of getting needed attention) and others' roles in relationships (trustworthy, accessible, caring, and responsive versus untrustworthy, inaccessible, uncaring, and unresponsive). Both relational roles are internalized, thus, the infant learns caregiving while receiving care (Sroufe & Fleeson, 1986).

## Attachment Styles

### *Early Child Attachment Styles*

The strange situation paradigm developed by Ainsworth, Blehar, Waters, and Wall (1978) supported Bowlby's attachment theory (1969, 1973). In a laboratory setting that observed mothers and their infants, it was discovered that in the first three months, mother-child interactions predicted 12-month-olds' behaviors during brief separations and reunions. Children either: actively sought physical contact with the mother or greeted her after a separation; ignored or avoided the mother on her return, showed little preference for her over a stranger and also displayed episodes of spontaneous aggression toward her; or showed a combination of contact-seeking and angry tantrums toward the mother upon her return (Ainsworth, Blehar, Waters, & Wall, 1978). Initially, three persistent patterns of attachment were associated with the pattern of responsiveness shown by the parents: secure; resistant; and avoidant. (Bowlby, 1980; Ainsworth, Blehar, Waters, & Wall, 1978; Main & Weston, 1982).

*Secure* attachment develops when accepting parents help their children tolerate negative affect while maintaining their positive engagement with others (Main & Cassidy, 1988). Among preschoolers, secure attachment style has been found to predict greater competence with peers, ego resiliency, resourcefulness, empathy, and popularity (Sroufe, 1988).

*Resistant* attachment is characterized by the child's approach-avoidant, angry behavior aimed at increasing proximity to the caregiver in a clinging, dependent manner

(Greenberg & Speltz, 1988), and by the parent's inconsistent responsiveness and role reversal (Sroufe, 1988). Among preschoolers, resistant attachment style has been associated with attention-seeking, neediness, tenseness, impulsivity, frustration, passivity, and helplessness (Sroufe, 1988, as cited in Alexander, 1992). The child's sense of unworthiness and undeserving of the attention of others relates to neediness as well as potential vulnerability to victimization by others (Sroufe, 1988; Troy & Sroufe, 1987).

*Avoidant* attachment style is characterized by the child's detachment, affective neutrality in the relationship, and compulsive self-reliance (Bowlby, 1973), and by the parent's insensitive or rejecting behavior (Cummings, 1990; Troy & Sroufe, 1987). Among preschoolers, avoidant attachment style has been associated with emotional insulation, a lack of empathy, hostile or antisocial behavior (Sroufe, 1988).

#### *Later Child Attachment Styles*

As infant attachment research extended into more high-risk populations, the three attachment classifications described could no longer be used to accurately classify increasing numbers of subjects (Crittenden, 1988; Main & Solomon, 1986). As a result, Main and Solomon (1986, 1990) identified an additional pattern of insecure attachment labeled *disorganized*. This attachment style develops when the child lacks a stable and consistent approach in emotionally laden situations (Carlson, Cicchetti, Barnett, & Braunwald, 1989).

Alexander (1992) notes that the disorganized child exhibits no single coherent strategy for dealing with the separation and then the reunion of the attachment figure

because the attachment figure is simultaneously the source of and the solution to the child's anxiety. Thus, when confronted with the parent's return, the disorganized child displays a diverse array of behaviors including contradictory behavior patterns, undirected expressions of fear or distress, apprehension on the parent's return, and dazed or disoriented expressions (Main & Solomon, 1986).

According to Main and Hesse (1990), the child's disorganized and conflicted behavior may result from the parent's display of frightened behavior toward the child. The child's presence may trigger the parent's own attachment anxieties and memories of unresolved trauma such as loss of a parent or an experience of sexual abuse (Ainsworth & Eichberg, 1991). The parent may also turn to the child for nurturance and may become hostile or aggressive when the child necessarily fails to meet the parent's attachment needs (Bowlby, 1988; Liotti, 1992). The child is placed in the dilemma of trying to avoid the very person from whom he seeks reassurance when anxious or afraid (Alexander & Anderson, 1994). Since the attachment figure simultaneously functions as both the source of the problem and the solution to the problem, the child appears unable to successfully develop an organized attachment strategy for eliciting appropriate caretaking from the parent (Main & Solomon, 1986; Main & Hesse, 1990; Alexander & Anderson, 1994; Blizzard, 2003).

Children with disorganized attachment have been found to have the most difficulty later in life, exhibiting emotional, social, and cognitive impairments (Ogawa, Sroufe, Weinfeld, Carlson, & Egeland, 1997; Siegel, 1999). These children also have the

highest likelihood of having clinical difficulties in the future including affect regulation problems, social difficulties, attentional problems, and dissociative symptomatology (Lyons-Ruth & Jacobowitz, 1999).

The quality of attachment impacts the manner an individual is able to adapt to deviation from normal development without the consequence of psychopathology (Rosenstein & Horowitz, 1996). Insecure attachment is often seen as a risk factor for the development of childhood psychopathology, and forms of insecure attachment are commonly found in children who have experienced abuse or neglect (Alexander & Anderson, 1994; Rosenstein & Horowitz, 1996).

#### *Adult Attachment Styles*

Although Bowlby's (1969) attachment theory provided emphasis on the emotional bond in childhood, it also provided grounding for attachment relationships in adulthood:

Many of the most intense emotions arise during the formation, the maintenance, the disruption and the renewal of attachment relationships... Because such emotions are usually a reflection of the state of a persons affectional bonds, the psychology and psychopathology of emotion is found to be in large part the psychology and psychopathology of affectional bonds (Bowlby, 1980, p. 40).

Adult relationships show similar characteristics of attachment as with the child counterpart such as the need for access to the attachment figure - especially when stressed, comfort and security in the company of the attachment figure, and discomfort and anxiety on separation from the attachment figure (Ainsworth, 1989; Bowlby, 1980; Weiss, 1982).

The self-fulfilling nature of the internal working model explains why patterns of attachment that develop in childhood are likely to continue into adulthood (Alexander & Anderson, 1994; Ainsworth & Eichberg, 1991). Adult attachment is marked by clearly identifiable, conceptually differentiated patterns that are presumed to be continuations of attachment patterns developed during childhood (Bartholomew, 1990; Hazan & Shaver, 1987; Kobak & Sceery, 1988). Furthermore, the tendency of internal working models to remain outside conscious awareness increases their resistance to change (Bretherton, 1985).

Attachment theory has been central in explaining the consequences of childhood adversities for adult interpersonal functioning (Peleikis, Mykletun, & Dahl, 2004). Previous research have shown that maltreated infants frequently show pathological attachment styles in adult relationships- supporting Bowlby's hypothesis that internal working models of attachment figures and self in childhood have a major effect on the formation of adult relationships (DiLillo, 2001; Hill, et al., 2001; McCarthy & Taylor, 1999). Peleikis, et al. (2004) further note that the more insecure the attachment is in childhood, the more distorted and unstable the view on self and others will be in adult life. Subsequent research has focused on differences in the degree and manner in which individuals establish optimal levels of proximity and feelings of security within close childhood and adult relationships (Ainsworth, Blehar, Waters, & Wall, 1978; Bartholomew & Horowitz, 1991; Main & Goldwyn, 1984).

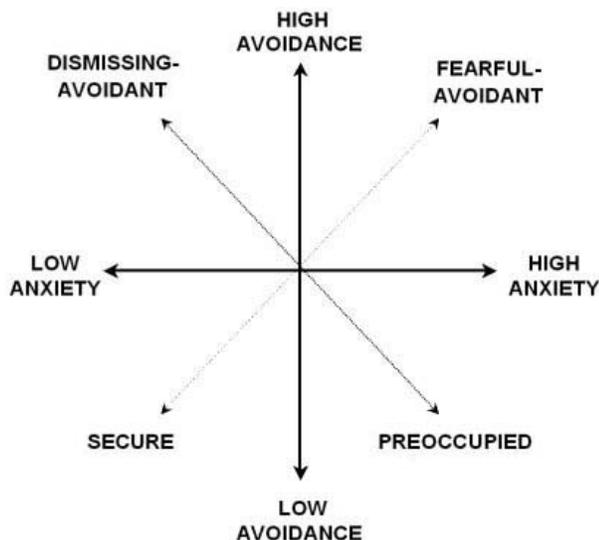
Research focusing on adult attachment styles has provided empirical support for the stability of attachment, both within individuals and across generations (Collins & Read, 1990). Furthermore, research on adult attachment indicates that an adult's recollection of past attachment relationships is predictive of current attachment relationships, specifically with intimate partners (Alexander, Anderson, Brand, Schaeffer, Grelling, & Kretz, 1998).

Since Bowlby (1969) and Ainsworth (1989) mentioned the role of attachment in adult romantic relationships, other researchers have attempted to assess and study, in the adult pair-bonding context, the attachment patterns described by Ainsworth et al. (1978). Hazan and Shaver (1987) pose that working models of attachment ongoingly influence attachment relationships throughout life. They believed that the emotional and behavioral dynamics of infant-caregiver relationships and adult relationships are governed by the same system including adult romantic relationships which are characterized by dynamics similar to the described attachment styles in infants. In their initial studies, Hazan and Shaver (1987, 1990) developed a questionnaire with brief multi-sentence descriptions of each of the three attachment types. The studies found that people's self-reported romantic attachment pattern was related to a number of theoretically relevant variables, including beliefs about love and relationships, and recollections of early experiences with caregivers.

Several concerns were raised about the three-category model posed by Hazan and Shaver (1987). Bartholomew (1990) and Bartholomew and Horowitz (1991) noted that

the avoidant pattern (as described by Hazan and Shaver) represented two different forms of avoidance strategy namely: fearful-avoidance and dismissing-avoidance. Bartholomew noted that those individuals who are fearful employ avoidance in order to prevent being hurt or rejected by partners, while individuals who are dismissing employ avoidance to maintain a defensive sense of self-reliance and independence. Thus, Bartholomew presented a four-category model of individual differences in adult attachment. This model was utilized in the current research.

Bartholomew retained the secure and anxious-ambivalent (or preoccupied) classifications from Hazan and Shaver's three-category model, however, divided the avoidant category into dismissing-avoidance and fearful-avoidance. Bartholomew further proposed that the four category could be placed within a two-dimensional space defined by the valence of people's representational models of self (the anxiety dimension) and others (the avoidance dimension) (Bartholomew & Shaver, 1998; Shaver & Mikulincer, 2002). Each of the four attachment types results from a unique combination of positive and negative models of self (anxiety) and others (avoidance) (See Figure 1) (as cited in Shaver & Fraley, 1997).



**Figure 1. Bartholomew's Two-Dimensional Model of Adult Attachment Styles**

*Secure* attachment style (low anxiety, low avoidance) is characterized by holding positive representations of the self and of others (Bartholomew, 1990). Adults with secure attachment style are described as: comfortable with closeness with others (Collins & Read, 1990); able to exhibit a wide range of emotions (Haft & Slade, 1989); confident (Feeney & Noller, 1990); well-adjusted (Bartholomew & Horowitz, 1991) having a positive self-image (Hazan & Shaver, 1987); having high self-esteem (Bartholomew & Horowitz, 1991; Feeney & Noller, 1990); able to trust others (Feeney & Noller, 1990); having ongoing valuing of attachment relationships (Kobak & Sceery, 1988; Main & Goldwyn, 1984); and having ease in recalling both positive and negative childhood experiences (Hazan & Shaver, 1987). Thus, adults with secure attachment style are presumably able to rely on their attachment figures as a source of safety, comfort, and support.

*Preoccupied* attachment style (high anxiety, low avoidance) is characterized by negative self-image and positive other-image (Bartholomew, 1990). Adults with preoccupied attachment style describe a history of both parental closeness and frustrated attempts to gain parental support during times of increased stress (Main & Goldwyn, 1984). These adults are further described as anxious (Collins & Read, 1990; Kobak & Sceery, 1988), tend to be overly expressive (Bartholomew & Horowitz, 1991); more dependent and have fears of abandonment in intimate relationships (Bartholomew & Horowitz, 1991).

*Dismissing* attachment style (low anxiety, high avoidance) is characterized by positive self-image and negative other-image (Bartholomew, 1990). Adults with dismissing attachment style tend to downplay the significance of childhood attachment relationships and the impact of childhood experiences on adult functioning (Main & Goldwyn, 1984), have higher hostility and loneliness (Kobak & Sceery, 1988; Bartholomew & Horowitz, 1991), are uncomfortable with intimacy (Collins & Read, 1990; Feeney & Noller, 1990; Hazan & Shaver, 1987), and tend to be overtly unconcerned about their lack of intimacy and trust with others (Kobak & Sceery, 1988; Main & Goldwyn, 1984). They employ strategies that minimize expressions of negative affect, inhibit overt proximity-seeking behavior, and reduce their awareness and acknowledgement of threatening information (Main & Goldwyn, 1984).

Fraley and Shaver (1997) conducted an experiment where they instructed adults to discuss losing their partner and found that dismissing adults were just as

physiologically distressed as other individuals. However, when instructed to suppress their thoughts and feelings, adults with dismissing attachment style were able to deactivate their physiological arousal as well as minimize thoughts about relationships. Fraley and Shaver (1997) posed that such ability to deactivate thoughts for dismissing adults since have less complex networks of attachment-related representations, can effectively redirect their attention away from anxiety-provoking stimuli and can keep their interpersonal world structured so as to minimize attachment-related experiences. In contrary, adults with preoccupied attachment style experienced an increase in arousal (relative to control conditions) when trying to suppress attachment-related anxiety.

An interesting notion with regards to self-esteem is that although adults with secure and dismissing attachment styles typically report high levels of self-esteem, Brennan and Morris (1997) found that adults with secure attachment style were more likely to derive their self-esteem from internalized positive regard from others, whereas adults dismissing attachment styles were more likely to derive their self-esteem other non-relational context such as abilities and competencies.

*Fearful* attachment style (high anxiety, high avoidance) is characterized by both negative self and other images (Bartholomew, 1990). Adults with fearful attachment style have the belief that others are uncaring and unavailable, and that the self is unlovable (Alexander, 1992). These adults expect the worst from an intimate relationship but need such a relationship to heal their damaged self-image (Bartholomew, 1990; Bartholomew

& Horowitz, 1991). They are described as socially inhibited and have difficulty relying on others or allowing others to serve as a secure base (Bartholomew & Horowitz, 1991).

Adults with fearful attachment style are described to have more depression, distress, and poorer social adjustment (Anderson, Yasenik, & Ross, 1993). Fearful attachment style is thought to reflect the most extreme form of anxiety and may indicate a failure to fully adopt an organized strategy that effectively establishes proximity to the caregiver (Simpson & Rholes, 1998). Furthermore, adults with fearful attachment style experience an ambivalent double avoidance (aloneness versus engulfment) that may serve as the basis for drastic shifts in attachment common in borderline pathology (Dutton, 1998).

Adults with a variety of clinical disorders are likely to be identified with *insecure* attachment styles (Fraley & Shaver, 1997). For example, adults suffering from depression are more likely to report themselves with insecure attachment style - especially preoccupied and fearful (Carnelley, Pietromonaco, & Jaffe, 1994). Similarly, individuals with eating disorders such as bulimia and anorexia are more likely to report themselves as insecure (Brennan & Shaver, 1995).

#### Attachment Perspectives on CSA

The experience of childhood sexual abuse impacts the development and persistence of attachment strategies. It jeopardizes self-definition and integration, self-regulatory processes, sense of security, and trust in relationships (Cole & Putnam, 1992). Sexual abuse by a parent violates the child's basic beliefs about safety and trust in

relationships, disturbing both the sense of self and the ability to have satisfying relationships where one feels loved and protected. In families where CSA occurs, the typical child's social supports are the source of distress.

Children will develop attachments in their families of origin (Bowlby, 1988), regardless of abuse being present. In the experience of a relational trauma, such as in CSA, the developed internal working models are geared towards survival. Patterns of adapting, coping, engaging, and relating are attributed to how the survivor attempts and manages to survive in an abusive environment. The attachment becomes the basis of relational dilemmas and other difficulties in life as the traumatic experiences are often reenacted in the adult survivor's interpersonal relationships (Courtois, 1988, 1999; Alexander & Anderson, 1994; Siegel, 1999; Davies & Frawley, 1994).

Early attachment research on CSA focused primarily on the effect of abuse-related factors on later psychological functioning and subsequent research focused on identifying other factors including family environment, individual-difference variables, and attachment style (Aspelmeier et al., 2007). Numerous studies also suggest that childhood sexual abuse and adult attachment are associated and that secure attachment is negatively associated with childhood sexual victimization within clinical and community samples (Mallinckrodt, McCreary, & Robertson, 1995; Fergusson, Lynskey, & Horwood, 1996; Roche, et.al., 1999; Twaite & Rodriguez-Srendnicki, 2004; Whiffen, Judd, & Aube, 1999; Alexander, 1993; Shapiro & Levendosky, 1999).

## Affect Regulation and Interpersonal Difficulties in Adult Survivors of Childhood Sexual Abuse

Affects function as ways of communication, attachment, and development (Russell, 1998). Bowlby's (1969) attachment theory holds that affectional bonds are formed as a result of interactions with the attachment figure. Internalization of early nurturing relationships guides the development of effective coping skills and healthy affective regulation. Communication through emotional states is a fundamental part of early attachment relationships (Siegel, 1999), and is translated into ways of relating in adulthood.

Attachment patterns are seen as coherent strategies in an attempt to feel secure as well as regulate affect (Main & Solomon, 1986, 1990; Main & Weston, 1982; Lyons-Ruth, 2001; Siegel, 1999). The system helps the child to regulate stress by seeking nurturance and protection from the caretaker. However, when a child grows up having experienced trauma within the relationship with primary caregivers, this creates an irreversible dilemma: the child cannot be attached to the traumatizing caregiver and protect the self at the same time (Blizzard, 2003).

Research on early trauma and neglect reveals that neural structure and function within the brain can be severely affected and lead to long-lasting and extensive effects on the brain's capacity to adapt to stress (Post & Weiss, 1997). Problems in affect regulation is a common problem among adult survivors and manifested through various disorders such as depression (Courtois, 1988; Putnam, Guroff, Silberman, Barban, &

Post, 1986), substance abuse (Herman, 1981; Briere, 1992), posttraumatic stress disorder (McLean & Gallop, 2003; Molnar, Buka, & Kessler, 2001; Rowan, Foy, Rodriguez, & Ryan, 1994), dissociation/DID (Gold, Hill, Swingle, & Elfant, 1999; Kirby, Chu, & Dill, 1993; Coons, Bowman, Pellow, & Schneider, 1989; Ross, Norton, & Wozney, 1989; Putnam, 1989; McNally, Clancy, & Schacter, 2000), eating disorders (Everill, Waller, & McDonald, 1995; Miller, McCluskey-Fawcett, & Irving, 1993; Coons, Bowman, Pellow, & Schneider, 1989), and self-mutilating behavior (Briere & Zaidi, 1989; Turell & Armsworth, 2000).

Moreover, research has found higher incidence rates of and more severe personality pathology in CSA survivors when compared to other populations (Allen, Coyne, & Huntoon, 1998; Herman, Perry, & van der Kolk, 1989; Shea, Zlotnick, & Weisberg, 1999; Silk, Lee, Hill, & Lohr, 1995; Dubo, Zandarini, Lewis, & Williams, 1997). Interpersonal relationships are indicative of long-term conflicts related to childhood sexual abuse experiences. The following discussion focuses on affective and relational strategies associated with particular adult attachment styles, specifically among adult survivors of childhood sexual abuse:

### *Secure*

As previously discussed, research on adult attachment style pose that adults with secure attachment style are capable of intimacy, able to trust, affectively present, and comfortable in reflecting on their past. However, among adult survivors of childhood sexual abuse with secure attachment style, childhood was presumably not as supportive

(Alexander & Anderson, 1994). These adults most likely have experienced less attunement from caregiver/s than most individuals with secure attachment style. A higher likelihood for self-reflection and ability to make use of attachment with others, such as in therapy, may be seen as higher resiliency among adult survivors with secure attachment style. Furthermore, patterns of relating emerging from childhood may have been impacted by a possible supportive relationship with a partner with a secure attachment style (Cohn, Silver, Cowan, Cowan, & Pearson, 1992).

### *Preoccupied*

Adults with preoccupied attachment style have been identified as anxious (Collins & Read, 1990; Kobak & Sceery, 1988), dependent (Bartholomew & Horowitz, 1991), and describing love as a series of emotional highs and lows characterized by extreme sexual attraction (Brennan & Shaver, 1991; Collins & Read, 1990; Feeney & Noller, 1991; Hazan & Shaver, 1987).

It can be anticipated the adult survivor with preoccupied attachment style would have an initial presentation of helplessness, desperation, and dependency in treatment (Alexander & Anderson, 1994). Alexander (1992) notes that adults with preoccupied attachment style present with negative and confused affects and memories stemming from attachment conflicts in childhood of which a common strategy in dealing with these conflicts is to focus attention on them, thus, there is the tendency for the adult survivor to ruminate incessantly about the abuse (Silver, et al., 1983) in an attempt to make sense of the sexual abuse experiences.

### *Dismissing*

The adult survivor with dismissing attachment style is less likely to seek therapy (Alexander, 1992; Alexander & Anderson, 1994) due to the tendency to isolate (Briere, 1989; Kobak & Sceery, 1988), difficulty in trusting others (Wooley & Vigilanti, 1984; Courtois, 1988), and the minimization of the value of relationships (Main & Goldwyn, 1984). Denial of problems and relationship concerns are likely to manifest in generalizations about childhood that are then further contradicted by specific memories, which may or may not be accessible (Main & Goldwyn, 1984). Familial patterns of denial and minimization protected the family and the child from the disruption of acknowledging abuse, rejection, and other conflicts (Olio & Cornell, 1993). These perspectives anchor the maintenance of estrangement from relationships among adult survivors of with dismissing attachment style.

### *Fearful*

Since the internal working model of the self develops as a result of the experience of caretaking received by the infant (Bowlby, 1973), therefore a neglect of one's needs or an active rejection by the parent often results in a sense of self as unworthy, undeserving, and bad (Alexander, 1992). In the experience of childhood sexual abuse, it is expected that the problems of self-identity would be likely to appear in adult survivors with a preoccupied or fearful attachment style.

The adult with fearful attachment style would also be expected to exhibit the severe disorders of affect regulation (Alexander, 1992), as is common with adult

survivors of childhood sexual abuse. A common personality disorder associated with fearful attachment is borderline personality disorder (BPD) (Anderson, Yassenik, & Ross, 1993; Agrawal, Gunderson, Holmes, Lyons-Ruth, 2004; Riggs, Paulson, Tunnell, Sahl, Atkison, & Ross, 2007; Critchfield, Levy, Kenneth, Clarkin, & Kernberg, 2008).

Borderline traits are characterized by affective dysregulation as highlighted by the intense vacillation between approach and avoidance strategies in dealing with relationships.

Expectedly, similar to the child with disorganized attachment – employing an approach-avoidance strategy in an attempt to seek nurturance (or have needs met) and the fear of being further abused- the adult with fearful attachment style is likely to exhibit approach-avoidance strategies in dealing with relationships. Consequently, due to the non-existence of a coherent strategy, the adult survivor may disclose too much too fast with the result that they may bolt from the treatment; they may see themselves as too invisible and ineffectual to have an impact on others; they may impulsively or explosively express their rage and terror; and then they may feel vulnerable and attacked in response to others' reactions (Alexander, 1992).

### *Shame*

Literature on shame has increasingly evolved in the past three decades. The significance of shame has been recognized in both research and clinical work. The succeeding sections highlight discussions on the affect of shame, shame in the context of attachment and childhood sexual abuse, and the relationship of shame and dissociation.

## The Affect of Shame

Theoretical perspectives on the affect of shame evolved from psychoanalytic concepts and later gained some of its definitions within the attachment perspective. The latter is discussed below.

Researchers and authors have noted that early interpersonal experiences with the primary caregivers have profound effects on self-image and relational schemas (Bornstein, 1993; Hazan & Shaver, 1994), and that shame plays a significant role in the formation of the perception of self and others (Kaufman, 1989; Nathanson, 1992; Seidler, 1997; Stern, 1985; Tomkins, 1963, 1987). The affect of shame is regarded as the most self-reflecting of emotions, with subsequent self-evaluation in terms of uselessness, defectiveness, powerlessness and exposure in relation to the other (Gilbert, 1998; Nathanson, 1987, 1992; Tangney, 1999; Tomkins, 1963). Moreover, shame is a considered a debilitating affect associated with a desire to hide and disappear, impedes active coping, and is difficult to modulate (Feiring, Taska, & Lewis, 1996; Lewis, 1992; Tangney, Burggraf, & Wagner, 1995).

Lewis (1987) grounds the concept of shame in attachment theory and defines shame as the vicarious experience of rejection and that it is always accompanied by “humiliated fury” (p. 32). For Lewis, this helps account for the angry resistance of the ambivalent child. The avoidant child, on the other hand, may be showing a reaction pattern that involves bypassing the shame of being rejected. In another perspective, Lewis (1992) considers that the stimuli that elicit shame can be understood from a

phenomenological point of view since person's responses to events and situations are specific to his/her unique histories of experiences, expectations, desires, and needs. Lewis (1992) proposes four phenomenological features of shame: (1) the desire to hide or to disappear; (2) the experience of intense pain, discomfort, and anger; (3) the feeling that one is no good, inadequate, unworthy; and (4) the fusion of subject and object (as cited in Evans, 2001).

### Shame and Affect Regulation

Schore (1991) poses that affects develop within an interpersonal context and that specific affects imply a particular form of relatedness. Specifically, the affect of shame plays a central role in the regulation of all emotional expression, and thereby a part of effective social interaction (Schore, 1994).

Schore (1991) considers shame as rising from early child-parent interactions in which the child experiences a failure in parental attunement. The ability to tolerate the conscious experience of this negative affect is essential to the development of the capacity for autonomous functioning. The regulation of shame, first externally performed by the caregiver as rejection developmentally transforms into an internal psychobiological mechanism (Schore, 1994). The parents' active participation in regulating the child's shame state is critical to enabling him to shift from the negative affective state of deflation and reduced importance to the reestablished state of positive affect which underlies the narcissistic sense of specialness (White, 1985). Schore (1994)

notes that such transition illustrates the role of stress recovery mechanisms in affect regulation.

Schore (1994) writes that there is evidence that indicates a prominent role of early unregulated shame in the etiology of various primitive psychopathologies. Shame has been considered as a central emotion in psychological disturbances (Gilbert, 1998; Lansky & Morrison, 1997; Lewis, 1987) and represents major disturbances of the self (Broucek, 1991; Kaufman, 1992). Shame has been documented in many forms of psychopathology and has also been empirically linked to a number of pathologies and problems (Cook, 1994; Harder, 1995; Retzinger, 1998). Of particular relevance to this research, there is strong clinical evidence that shame-humiliation dynamics always accompany child abuse (Kaufman, 1989; Lewis, 1992). Thus, shame is an important variable to consider when dealing with psychological suffering (Claesson & Sohlberg, 2002).

#### Shame, Attachment, and CSA

Shame is tied inextricably to the experience of childhood sexual abuse (Courtois, 1988; Herman, 1991). Shame has been identified as a core emotional experience among women survivors of CSA (Andrews, 1995; Lewis, 1992; Talbot, 1996; Kessler & Bieschke, 1999) and has been identified as having a damaging impact on the development of the identity (Bromberg, 2001). Kessler & Biesche (1999) write that the traumatic experience of CSA dictates the development of an identity ridden by excessive shame.

Shame is a common self-representation of adult survivors of childhood sexual abuse due to the perception that the abuse was perpetrated because of something inherently wrong with them (Courtois, 1988). The silence imposed on a child connotes the indication of the behavior being wrong and leads to the development of shame (Haller & Alter-Reid, 1986). Shame is intensified as the child becomes convinced she has caused the abuse which further maintains the secrecy of the occurrences of the abuse. The child's inner framework is one of self-concealment (Rosenthal, 1988). Survivors feel that if their abuse is known, it will result in others knowing their own *badness* contributed to or condoned the abuse. The child develops an internal representation of the self as dirty and bad, leading to a chronic state of shame (Violette, 1995). Thus, being shameful of one's self becomes the core of the survivor's overall functioning.

It has been noted that there is a high correlation between trauma and shame (Catherall & Shelton, 1996; Courtois, 1992; Wong & Cook, 1992). Courtois (1992) notes that virtually all traumatized patients have some degree of internalized shame. The link between shame and trauma has been noted clinically and incorporated into several psychological and neuropsychological models (Courtois, 1992; Nathanson, 1992; Tomkins, 1987; van der Kolk, Pelcovitz, Roth, Mandel McFarlane, & Herman, 1996).

Several studies have identified the influence of shame in understanding how CSA leads to other symptomatology (Barker-Collo, 2001; Coffey et al., 1996; Feiring, Taska, & Lewis, 1996, 1998; Mannarino & Cohen, 1996; McMillen & Zuravin, 1997). Feiring, Taska, and Lewis (2002) examined adjustment following CSA as a function of shame and

attributional style. Patterns of change in shame and attribution predicted which children remained at risk or improved in adjustment. Feiring and Taska (2005) also investigated the persistence of abuse-related shame on sexually abused youth over a six -year period. The authors reported that persistent shame may explain failure to process the abuse and the maintenance of posttraumatic stress disorder symptoms.

Other studies have focused on the influence of shame on adult functioning of adult survivors of childhood sexual abuse. Moon (1989) examined how CSA victims differ from other sexually abused women and non-abused women on self-concept, shame, guilt, and psychosexual functioning. The study found that abuse occurring for five years or less predicted higher shame and guilt levels. Subjects who had a history of childhood sexual abuse demonstrated significantly more psychological dysfunction (symptomatology and negative affective states) than non-abused women. Playter (1990) found that women with a history of childhood sexual abuse had higher-levels of shame than those who didn't have CSA experiences. Bondeson's (as cited in Cook, 1993) findings confirmed that both severity of abuse and duration of abuse were significant predictors of shame. Eakin (1995) investigated the differences in the relationships between levels of internalized shame and adjustment in adult women who experienced CSA and those who had not. Factor analyses indicated significant differences between the CSA group and the no abuse group on a number of traumatic childhood family and adult experiences. In the CSA group, shame accounted for more of the variance in adult adjustment than did any of the characteristics of the abuse such as age at onset, duration,

frequency, or severity. Similarly, Wolfgang (1998) assessed the long-term effects of CSA and the concept of internalized shame was utilized to understand the emotional effects of CSA. The group of women who reported experiences of childhood sexual abuse had significantly higher levels of shame (ISS score) than the group of women who reported no experiences of child sexual abuse. Six CSA characteristics (onset, duration, multiple perpetrator, relationship to the perpetrator, and severity of abuse) were hypothesized to be predictive of shame (ISS score) and two were significant (subject's rating of the severity of the trauma and longer duration of the abuse). The study suggests that further investigation into the causal links between childhood sexual abuse, shame, and attachment can help in the conceptualization of treatment and the identification of treatment goals.

Few studies have examined the relationship between shame and adult attachment styles. Garnett (1991) aimed to differentiate adult attachment styles (secure, anxious/ambivalent and avoidant) with global loneliness and loneliness in several types of relationships (Romantic-Sexual, Friendships, Family, and groups or Community). Shame was examined in relation to reported adult attachment styles and types of loneliness. Findings suggested a relationship between high levels of shame and global loneliness. Akashi (1994) investigated the relationship of attachment, shame, and psychological stress in adult outpatient psychotherapy clients. Attachment was found to have a negative and statistically significant effect on shame and shame had a statistically significant direct effect on psychological stress. Ruch (1996) examined the relationship

between shame and adult attachment styles of college students and found the fearful group had the greatest mean shame followed by the preoccupied, secure, and dismissing groups.

Magai, Distel, and Liker (1995) found significant correlations between shame and anxious adult attachment among non-clinical samples. Tangney and Wagner (1992) also linked shame with insecure attachment styles in two survey studies conducted with undergraduate students. Lopez, Gover, Leskela, Sauer, Schirmer, and Wyssman (1997) have found correlations between fearful and preoccupied attachment styles and shame. No further research has been done to examine the relationship between shame and adult attachment styles, in a clinical population, specifically among survivors of CSA.

#### Shame and Dissociation

The dissociative defense protects the victim from overwhelming trauma and affect that cannot be integrated into consciousness (Swett & Halpert, 1993; Cornell & Olio, 1991). As the defensive strategies are not successful in hiding the internal shame structure, the components of the shamed self are exposed. The desire is to isolate oneself to protect against acute vulnerability or catastrophic anxiety states which may completely shut down the entire body system (Herman, 1991; Cuortois, 1999; Chu, 1991; Siegel, 1999). Thus, the powerful response to debilitating shame through dissociation illustrates the power of the attack of shame on one's core identity (Bromberg, 2001).

Earlier research has noted the relationship between dissociation and shame. Some researchers have hypothesized that shame promotes dissociative tendencies among

abused children and adolescents (Feiring, Taska, & Lewis, 1996) and adults (Kessler & Bieschke, 1999; Irwin, 1998; Lewis, 1992). It is hypothesized that sexual abuse leads to shame in the victim and dissociation is a defense against this affect (Lewis, 1992; Ross, 1989).

Ross (1989) found relationships among sexual abuse, shame, and dissociation in clinical case histories of multiple personality disorders. Similarly, Talbot, Talbot, and Tu (2004), in a study that involved women psychiatric patients, found that greater shame-proneness was associated with higher levels of dissociation, especially among women who experienced sexual trauma early in their development. Of further interest, Kessler & Bieschke (1999) found that shame can be expected to follow dissociative re-experiencing.

### *Dissociation*

#### The Concept of Dissociation

The concept of dissociation has been utilized and developed by earlier theorists and this development continues today. The exploration of the historical origins of dissociation elucidates how such phenomena are understood and in the conceptualization of the impact of childhood trauma.

Putnam identifies Janet (1889, as cited in Putnam) as the first among all theorists to have inquired into the nature of dissociation, as in his studies of amnesia, fugues, successive existences (alter personalities), and conversion symptoms. These explorations led him to the idea that such symptoms are attributable to the existence of split-off parts of personality (as

cited in Putnam, 1989). Putnam also notes that others have followed in their studies of dissociative psychopathology, amnesia, and hysteria.

The terms *splitting* and *repression* often have been used interchangeably in discussions of dissociation. Freud developed the concept of repression relevant to the occurrence of external traumatic events and their exclusion from memory and considered *primary repression* to be the foundation of all unconscious life (Tarnopolsky, 2003). Tarnopolsky (2003) states that the notion of dissociation appears in Freud's description of "*splitting*" of the ego—a concept that is often used interchangeably with dissociation. Birtles & Scharff (1994) write that Freud developed splitting from the concept of dissociation as used by Janet. The concept of splitting becomes synonymous with the separation or fragmentation of the psyche. Freud (1964) used it to describe how the mind could adopt two points of view. He asked whether we can observe ourselves, and whether we can see ourselves as the objects of study. Freud also argued that "a psychological split" occurs in all cases of pathology (1964, p. 202).

Birtles & Scharff (1994) write that in 1929, Fairbairn defined dissociation as:

cases in which elements of mental life, which are ordinarily conscious, become split off from the main body of consciousness and maintain a high degree of independence (p. 23).

For Klein and Fairbairn, splittings (or dissociations) are the obligatory consequences of the inevitable failures and frustrations experienced in early upbringing. Splitting is not only a major mechanism of defense but also the organizing principle of the normal mind (Tarnopolsky, 2003). Putnam (1989) notes that authorities in the study of

dissociation recognize that dissociation occurs in both non-pathological and pathological forms. Dissociation encompasses a daily, non-pathological disconnection from the self and can also include descriptions of dissociative self-states such as that seen in borderline personalities and in more extreme cases such as dissociative disorders. In contrast, Ross (1989) considers splitting and dissociation as synonymous. In his discussion of the concepts of splitting and dissociation, Young (1988) quotes Kernberg (1975) whom defines splitting as an “alternative activation of contradictory ego states” (p. 33) and refers to dissociation as a defense that “maintains conflict-laden material and painful affects in dissociated states” (p. 33).

Hilgard’s (1977) distinction between vertical and horizontal splitting sheds some light in the distinction between dissociation and repression. He notes that horizontal splitting refers to repression while vertical splitting refers to dissociation. Tarnopolsky (2003) quotes Klein (1952/1975) in distinguishing splitting from repression:

. . . in contrast to the earliest forms of splitting which leads to disintegration, repression does not normally result in a disintegration of the self (p. 87).

Nijenhuis, et al. (1998) discuss that empirical studies have focused on dissociation as disruptions in memory, consciousness, and identity, which may be called *psychological* dissociation (i.e., dissociation manifested in psychological variables). The authors further note that the original studies on dissociation, such as Janet's (1907) studies also pertained to phenomena called *somatoform dissociation*, i.e., dissociation which is manifested in a loss of the normal integration of somatoform components of experience, bodily reactions and functions (e.g., anesthesia and motor inhibitions)

(Nijenhuis, Spinhoven, van Dyck, van der Hart, & Vanderlinden, 1996), and that somatoform dissociation is not a somatic disturbance, rather, it involves a disturbance of a mental function, hence, the adjective *somatoform* is used.

Most definitions of dissociations are concerned with distinguishing when an individual's consciousness, sense of identity, or behavior is sufficiently dissociated to represent an abnormal and/or pathological process (Putnam, 1989). Dissociation may be of an everyday type such as daydreaming - which does not imply the formation of disconnected memories and which would better be labeled absorption, or it may be considered a qualitatively different and pathological type (Waller, Putnam, & Carlson, 1996)- which is further characterized by the formation of dissociative memory structures (Janet, 1907; van der Hart, Boon, & Op den Velde, 1991; Yates & Nasby, 1989) (as cited in Nijenhuis, Spinhoven, Van Dyck, van der Hart, & Vanderlinden, 1998)

Tarnopolsky (2003) writes:

The concept of dissociation itself and the pathology of multiple personalities are totally natural and central, rather than an exceptional expression of infrequent pathology (p. 9).

He further notes that at present, the dissociation term is used in at least five different ways: observable clinical phenomena or symptoms; a general principle of psychic organization; a general term that covers several mechanisms of defense; a synonym for splitting (mainly in the UK and within Object Relations); and specific clinical and dynamic phenomena observable in multiple personalities now known as dissociative identity disorder (DID).

Overall, dissociation falls on a continuum ranging from full awareness through suppression to repression and finally, to dissociative identity disorder (Ross, 1989). It is characterized as the lack of normal integration of thoughts, feelings, and experiences into the stream of consciousness and memory resulting in disturbances of identity (Putnam, 1985). In the pathological range, dissociation prevents the integration of dissociated material into the sense of self, producing discontinuities in conscious awareness which subsequently become entrenched in the overall view of the self as damaged.

#### Dissociation and Trauma

Of specific relevance to the present study is Fairbairn's perspective that focused on the concepts of splitting and dissociation as consequences of the trauma experiences. It implies that the nature and severity of trauma determines the level of disintegration or fragmentation. Tarnopolsky (2003) put emphasis on Fairbairn's theory and its fit on the work with dissociative disorders. He quoted in Fairbairn (1951/1952) stating that his theoretical model:

would throw light . . . upon the phenomena of multiple personality and hysterical dissociation (p. 168 ).

It has long been hypothesized that dissociation reaching pathological proportions is generally trauma-induced (Janet, 1907; Spiegel, 1994; Van der Kolk & Van der Hart, 1991). Putnam (1989) writes:

Pathological forms of dissociation are characterized by a major disturbance of memory and a profound disturbance of the individual's sense of self, and are often a response to overwhelming physical and psychological trauma (p. 25).

Dissociation is unconsciously utilized as a protection from the psychological sequelae resulting from trauma (Kessler & Bieschke, 1999). Howell (2005) describes dissociation as an automatic response to overwhelming reality where there is an inability to reflect on experience. Davies and Frawley (1994) further placed emphasis on dissociative outcomes of trauma on personality structure.

Correlations between pathological dissociation and trauma were found in several studies involving patients with dissociative disorders (Hornstein & Putnam, 1992; Ross, Miller, Bjornson, Reagor, Fraser, & Anderson, 1991); posttraumatic stress disorder (Bremner, Steinberg, Southwick, Johnson, & Charney, 1993); eating disorder (Vanderlinden, Vandereycken, van Dyck, & Vertommen, 1993); and borderline personality disorder (Herman, Perry, & van der Kolk, 1989).

Traumatic experiences that take place during childhood, especially involving interpersonal trauma, have been related to the development of dissociative disorders (Chu & Dill, 1990; Draijer & Langeland, 1999; Kisiel & Lyons, 2001). Talbot, Talbot and Tu, (2004) discuss that children dissociate to protect themselves from overwhelming terror, pain, powerlessness, and betrayal in response to trauma (Butler, Duran, Jasiukaitis, Koopman, & Spiegel, 1996; Gershuny & Thayer, 1999; Putnam & Trickett, 1993). In addition, the authors note that those who have been severely or chronically abused may dissociate in response to stimuli connected with trauma – which may generalize to other painful emotions (Chu, Frey, Ganzel, & Matthews, 1999).

## Dissociation and CSA

CSA becomes a precursor to the development of self-protective mechanisms (van der Kolk & Kadish, 1987). Dissociation has been identified in the experience of childhood sexual abuse (Gold, Hill, Swingle, & Elfant, 1999; Kluft, 1990; Chu & Dill, 1990). Classen, Koopman, and Spiegel (1993) suggest that a child may use dissociative strategies to feel relief and protection from the abuse experience. The child may not be able to control the traumatic event, but may be able to control his or her perception of the event. To survive in both inner and external worlds, the child is forced to utilize a host of defensive strategies and adjustments to cope with the reality. Herman (1991) notes these defenses in her comment:

The pathological environment of childhood abuse forces the development of extraordinary capacities, both creative and destructive. It fosters the development of abnormal states of consciousness in which the ordinary relations of body and mind, reality and imagination, knowledge and memory, no longer hold (p. 98).

Davies and Frawley (1994) note that dissociation is a concomitant of the experience of childhood sexual abuse. The child uses cognitive and affective distortions (Price, 1994; Robbins, 1989) to maintain ego integrity and attachments (Courtois, 1999), all of which become the foundation of overall relating to others. Dissociation is developed to manage the abuse experiences, and to interrupt the process of integration by diminishing the capacity for self-awareness and self-expression (Putnam, 1989; Kluft, 1990; Herman, 1991). With this notion, dissociative defenses are instrumental in numbing stressful experiences and memories of these experiences (Rodriguez-Srednicki, 2001; Kirby, Chu, & Dill, 1993; Anderson, Yassenik, & Ross, 1993).

Numerous studies document that adults with early CSA histories exhibit high levels of dissociation (Dalenberg & Palesh, 2004; Banyard, Williams, & Siegel, 2001; Butzel, Talbot, Duberstein, Houghtalen, Cox, & Giles, 2000; Chu, Frey, Ganzel, and Matthews, 1999; Nijenhuis, Spinhoven, van Dyck, van der Hart, & Vanderlinden, 1998; Foote, Smolin, Kaplan, Legatt, & Lipschitz, 2006; Zlotnick, Zakriski, Shea, Costello, Begin, Pearlstein, & Simpson, 1996; Chu & Dill 1990; Sanders & Giolas, 1991; Spiegel & Cardena, 1991). In addition, Chu, Frey, Ganzel, and Matthews (1999) reported that women with a CSA history presented with higher levels of dissociative symptoms than did women without a history of CSA.

Talbot, et al. (2004) note that the severity of dissociative symptoms in CSA survivors may depend on the complex interactions of multiple variables, including characteristics of the CSA (Chu, Frey, Ganzel, & Matthews, 1999; Gershuny & Thayer, 1999), other factors in the early social environment (Banyard, Williams, Siegel, 2001; Mulder, Beautrais, Joyce, & Fergusson, 1998), and psychological characteristics of abused women- including high hypnotizability (Butler, Duran, Jasiukaitis, Koopman, & Spiegel, 1996), immature defensive styles (Simeon, Guralnik, Knutelska, & Schmeidler, 2002), and harm avoidance (Grabe & Spitzer, 1999; Simeon, Guralnik, Knutelska, & Schmeidler, 2002).

Furthermore, previous research has also investigated the possibility of different thresholds for dissociation (Putnam, Helmers, Horowitz, & Trickett, 1995; Spiegel, Hunt, & Dondershine, 1988). Johnson, Pike, & Chard (2001) note that researchers supporting

such theory further postulate that individuals who dissociate may have experienced previous traumatic incidents that exacerbate this tendency (Marmar, Weiss, & Metzler, 1997). The authors further discuss that another theory poses that dissociation occurs more readily in children and that this ability decreases with age, therefore, sexual abuse in childhood may cause younger survivors to develop and maintain dissociative abilities (Chu, 1998) that later become problematic.

#### Dissociation and Attachment

Main (1991) elaborated on the concept of internal working models providing a potential link between the development of severe dissociation in childhood and its maintenance into adulthood. Because of the extremely contradictory behavior of the parent toward the child, the child develops multiple and contradictory models of the self.

A characteristic of the disorganized child is the inability to seek and gain support from the parent to help regulate her own affect. In adulthood, this translates into an inability to self-soothe. This deficit in affect regulation can be seen both in an over-reliance on dissociation and in higher rates of impulsivity and self-injurious behavior (Cole & Putnam, 1992; Herman, Perry, & van der Kolk, 1989). Specifically, the adult survivor with fearful attachment style is likely to view feelings, and by extension, intimate relationships as inexplicable, powerful, and uncontrollable (Alexander & Anderson, 1994).

Similar to the descriptions of disorganized children (Main & Solomon, 1986), adults with fearful attachment style present as though they are frozen and lacking in a

sense of personal agency or efficacy. This is consistent with the decreased affective responsivity and trance states observed in dissociative individuals, which presumably serves as a strategy for managing overwhelming affect (Putnam, 1996).

Additionally, role reversal may occur as a result of the parent's unconscious expectations that the child soothe the parent. The result is a variety of inconsistent and incompatible models of self in the child (Main, 1991) that exceed the child's capacity for integration, thereby producing dissociation. The subsequent experience of sexual abuse ensures the child's continued reliance upon dissociation as a strategy to regulate affect and may even spur the child to use multiple models of self as a template for an alter personality (Liotti, 1992). Therefore, the predisposition to dissociate presumably exists in a disorganized child as a function of their attunement to the parents' confusing mental states.

Alexander and Anderson (1996) discussed that the role of the non-offending parent may also help explain the child's intense reliance upon and attunement to the perpetrator as an attachment figure. In sexual abuse cases where the father, as well as the mother, are physically abusive, or the non-offending parent exhibits severe depression or psychosis, the child is left to maintain an attachment with the perpetrator. Non-responsiveness, unavailability, and further abuse from the other caregiver have been significantly correlated with closeness to the perpetrator. Thus, although the perpetrator was solely responsible for the sexual abuse, the failure of the non-offending parent to be a 'nurturing other' seems to exacerbate the trauma resulting from the sexual abuse.

It has also been suggested that untreated disorganized attachment in children have its counterpart in adulthood both fearful attachment and dissociation. Since the etiology of disorganized attachment includes the same type of double-bind experience referred to by Spiegel (1989), and since the behaviors observed in disorganized toddlers show remarkable similarity to descriptions of dissociation (Main & Hesse, 1990), and since both disorganized attachment and dissociation are associated with early childhood trauma (Ainsworth & Eichberg, 1991; Carlson, Cicchetti, Barnett, & Braunwald, 1989; Chu & Dill, 1990; Coons, Bowman, Pellow, & Schneider, 1989), disorganized attachment would seem appear to be theoretically related to the development of dissociation. In further support of this notion, Anderson and Alexander (1996) hypothesized that the fearful attachment provides the developmental link between a history of childhood sexual abuse and subsequent dissociation. The authors found that fearful avoidant attachment was significantly related to dissociation and this relationship emerged most strongly when attachment was assessed as a continuous variable.

#### *CSA Characteristics*

The experience of sexual abuse itself is primarily what is disruptive to the victim and leads to patterns of problems (Waldman, Silber, Holmstrom, & Karp, 1998). As discussed earlier, intrafamilial CSA, especially with a parent, has been related to greater trauma (Finkelhor, 1979; Russell, 1986; Friedrich, Beilke, & Urquiza, 1987; Fischer & McDonald, 1998; Miller, McCluskey-Fawcett & Irving, 1993). Research has shown that female victims are typically more symptomatic especially when abused by father-figures

(Kendall-Tackett, Williams, & Finkelhor, 1993; Ullman & Filipas, 2005; Roche, et al., 1999). Numerous studies have suggested that the closer the emotional relationship, the greater the negative psychological consequences for later development (Briere, 1989; Briere & Runtz, 1988; Kendall-Tackett, Williams, & Finkelhor, 1993). A study by Ullman (2007) reported that more posttraumatic stress disorder symptoms were found for victims of betrayal traumas (intrafamilial abuse).

Early onset of abuse leads to more severe psychological consequences that last through adult functioning (Courtois, 1988; Russell, 1986; Meiselman, 1978). Research on CSA characteristics indicates that more severe abuse and longer duration is typically experienced by survivors of intrafamilial CSA (Kendall-Tackett, Williams, & Finkelhor, 1993; Gold, Hill, Swingle, & Elfant, 1999; Fox & Gilbert, 1994; Ullman, 2007). Long duration of CSA is consistent with greater frequency of the occurrence of incest (Turell & Armsworth, 2000). Fox & Gilbert (1994) note that women who experienced more than one type of childhood trauma have more problematic outcomes. The severity of the sexual violation is related to long-term negative outcomes (Russell, 1999) and invasive acts of abuse lead to more severe long-term effects (Gold, Hill, Swingle, & Elfant, 1999). More serious forms of sexual contact have been shown to be related to greater trauma (Kendall-Tackett, Williams, & Finkelhor, 1993; Russell, 1986). In general, studies have consistently shown that more severe abuse of longer duration, by trusted perpetrators, is associated with poorer mental health outcomes (Bennett, Hughes & Luke, 2000; Kendall-Tackett, Williams & Finkelhor, 1993; Ketring & Feinhauer, 1999).

Although the experience of CSA does not always result in the development of psychopathology, personality disturbances and disorders are often assessed among adult survivors (Barker-Collo & Read, 2003; Price, 1994; Schetky, 1990; Lundberg, Marmion, Ford, Geffner, & Peacock, 1992; Herman & van der Kolk, 1987; Wheeler & Walton, 1987; Jumper, 1995). It has been noted that earlier occurrence of CSA correlates to more severe consequences for later personality development (Waldman, Silber, Holmstrom, & Karp, 1997). Previous research has reported a history of CSA in individuals with borderline personality disorder (Herman, Perry, & van der Kolk, 1989; Ogata, Silk, Goodrich, Lohr, Westen, & Hill, 1990; Weaver & Clum, 1993; Zanarini, Gunderson, Marino, Schwartz, & Frankenburg, 1989; Zanarini, Williams, Lewis, Reich, Vera, Marino, Levin, Yong, & Frankenburg, 1997) and borderline personality disorder in CSA samples (Shea, et al., 1999). More severe histories of childhood sexual abuse was also found related to more severe borderline pathology in adulthood (Silk et al., 1995). Furthermore, women with a history of early-onset sexual abuse were more likely to meet diagnostic criteria for both borderline personality disorder and complex posttraumatic stress disorder, and trauma variables of sexual abuse and paternal CSA were significant predictors of both diagnoses (McLean & Gallop, 2003).

#### CSA Characteristics and Attachment

Studies have addressed insecure attachments in adult survivors of childhood sexual abuse in community samples (Alexander, et al., 1998; Styron & Janoff-Bulman, 1997; Alexander, 1993). A study by Anderson (1994) investigated possible relationships

among sexual abuse characteristics, fearful attachment style, and dissociation. It was hypothesized that both dissociation and fearful attachment style would be significantly related to the presence of certain abuse characteristics (earlier age of onset, use of greater force, more severe abuse, and a closer relationship with the perpetrator) in a sample of adult women survivors of incest. Findings revealed a significant curvilinear relationship between coercion and fearful attachment in which both extremely low and extremely high coercion were associated with fearful attachment.

Research on the specific relationship of CSA characteristics (earlier age of onset, severity of abuse, longer duration of abuse, and parental relationship to the perpetrator) to adult insecure attachment styles (preoccupied, dismissing, and fearful) in the clinical population- specifically in adult women survivors of intrafamilial CSA perpetrated by a parental- figure- remains necessary.

#### CSA Characteristics and Shame

Feiring, et al. (1996) note that based on clinical report and research, it is possible to hypothesize regarding which abuse factors may be related to shame. Sexual abuse by a parent, and in particular a biological parent, has been hypothesized to be related to shame because it represents a violation of a social standard which is made public upon disclosure (Lewis, 1992). Also, to the extent that such abuse represents a betrayal by a trusted person, in combination with the violation of a social taboo, greater shame would be expected and as well as greater trauma (Browne & Finkelhor, 1986). Shame is a likely result in an environment where the self is denigrated and humiliated, (Finkelhor &

Browne, 1986; Friedrich, Berliner, Urquiza, & Beilke, 1988; Lewis, M., 1992). Repeated occurrences of sexual abuse would be expected to elicit more shame as they represent a “greater magnitude of transgression from acceptable behavior.” The authors further pose that more shame would be predicted when the victim is forced to play an active role compared to a more passive role in the abuse acts.

#### CSA Characteristics and Dissociation

A significant amount of research has been devoted to CSA characteristics and subsequent development of adult dissociative symptoms (Gold, Hill, Swingle, & Elfant, 1999; Briere & Runtz, 1988; Elliot & Briere, 1992; Kirby, Chu & Dill, 1993; Rodriguez-Srednicki, 2001; Roesler & McKenzie, 1994; Williams, 1993; Maynes & Feinauer, 1994; Swett & Halpert, 1993; Farley & Keaney, (1996); Anderson, Yassenik, Ross, 1993; McNally, Clancy, & Schacter, 2000; Briere & Conte, 1993; Herman & Schatzhow, 1987). There is evidence to suggest that women who have a history of childhood sexual abuse tend to dissociate more than women with no such history (Briere & Conte, 1993; Briere & Runtz, 1987).

The nature of relationship between the child and the perpetrator of the abuse has also been hypothesized to be pertinent to the development of dissociation. Anderson (1993), in the study that involved adult women survivors of incest, found that women with multiple personality (MPD) were more likely to have been closer to their perpetrator. As discussed earlier, CSA perpetrated by fathers and father-figures tend to be more forceful, prolonged, intrusive (Herman, Russell, & Trocki, 1986), and result in

lasting negative consequences (Kendall-Tackett, Williams, & Finkelhor, 1993; Ullman & Filipas, 2005). In addition, intrafamilial CSA, especially with a parent, has been related to greater trauma (Finkelhor, 1979; Russell, 1986; Friedrich, Beilke, & Urquiza, 1987; Fischer & McDonald, 1998; Miller, McCluskey-Fawcett & Irving, 1993). From these perspectives, it is hypothesized that dissociation would tend to be elevated in cases of intrafamilial CSA.

Earlier age at onset of abuse has been found to be correlated with dissociative symptoms in adult survivors (Putnam, 1989; Chu & Dill, 1990; Draijer & Boon, 1993; Briere & Conte, 1993; Dalenberg & Palesh, 2004; Cox, & Giles, 2000; Banyard, Williams, & Siegel, 2001; Kirby, Chu, & Dill, 1993; Chu, Frey, Ganzel, and Matthews, 1999; Foote, Smolin, Kaplan, Legatt, & Lipschitz, 2006). Highly dissociative individuals experienced sexual abuse at a significantly earlier age and was more severe and unpredictable (Chu & Dill, 1990; Coons, Bowman, Pellow & Schneider, 1989; Kluft, 1984; Ross, Miller, Bjornson, Reagor, Fraser, & Anderson, 1991).

Severity and longer duration of abuse have also been significantly related to level of dissociation in adulthood (Putnam, 1989; Chu & Dill, 1990; Kirby, Chu, and Dill (1993; Irwin, 1994; Maynes & Feinauer, 1994; Draijer & Boon, 1993). Terr (1991) writes that dissociation is a coping strategy common to severe long-term sexual abuse. Furthermore, Nijenhuis, et al. (2003) report that pathological dissociation was best predicted by early onset as well as intense, chronic, and multiple traumatization.

## CHAPTER THREE

### METHODOLOGY

The preceding chapter provided the theoretical and empirical base for the research. This chapter describes the design, operationalization of variables, data collection instruments, population, sampling procedure, ethical issues and concerns, and data collection and data analysis procedures.

#### *Research Design*

The present descriptive study included 49 women with a history of childhood sexual abuse perpetrated by a parental-figure. The purpose of the study was to identify the relationships among adult attachment styles, shame, dissociation, and specific CSA characteristics (age at onset, relationship to the perpetrator, duration of abuse, experience of other types of abuse). The study utilized a non-probability convenience sampling method as participants in the study were determined by their experiences of parental CSA.

#### *Conceptual and Operational Definitions of Variables*

##### Major Variables

The study's major *independent variables* were *CSA characteristics*. These variables were defined below:

### *CSA Characteristics*

CSA characteristics were the major independent variable. They were conceptualized as factors that are descriptive of what was involved in the CSA experiences. CSA characteristics and other types of abuse experienced were assessed through Part 2 of the Demographic Questionnaire (DQ) (Appendix F). CSA characteristics in the present study included:

1. age at the onset of CSA;
2. relationship to the perpetrator;
3. duration of CSA; and
4. experience of physical abuse, verbal abuse, and psychological abuse with the experience of CSA.

The study's major *dependent variables* were *adult attachment styles*, *shame*, and *dissociation*. These variables were defined in detail below:

#### *Adult Attachment Styles*

Adult attachment styles were conceptualized as patterns of relating and engaging in relationships. Adult attachment styles were identified as:

1. secure attachment style - characterized of holding positive representations of the self and of others (low anxiety, low avoidance);
2. preoccupied attachment style - characterized by negative self-image and positive other-image (high anxiety, low avoidance);

3. dismissing attachment style - characterized by positive self-image and negative other-image (low anxiety, high avoidance); and
4. fearful attachment style – characterized by negative self-image and negative other-image (high anxiety, high avoidance).

Adult attachment styles were identified using the Relationship Questionnaire (RQ) (Appendix G). Adult attachment styles were determined by participants choosing one of four paragraphs (each paragraph corresponds- to each attachment style) as the way participants would characterize their relationships.

### *Shame*

Shame was conceptualized as an affect in relation to the CSA experiences. Shame was measured through the Internalized Shame Scale (ISS) (Appendix H). A score of 50 and over in a clinical population indicates a high level of shame.

### *Dissociation*

Dissociation is a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment. The disturbance may be sudden or gradual, transient or chronic (American Psychiatric Association, 1994).

Dissociation was measured through the Dissociative Experiences Scale (DES) (Appendix I). Scores of 30 and over on the DES in a clinical population often indicate a likelihood of dissociative disorder. Consequently, that cutoff was used in the present analysis. In general, high scores on the DES reflect greater dissociation.

## Control Variables

Control variables include the type of treatment being received at the agency, the frequency of treatment, and the total duration of treatment from previous and current agencies. These variables may influence how shame and dissociation have been alleviated and therefore may affect the levels of shame and dissociation reported.

### *Type of Treatment*

The type of treatment, individual therapy and/or group therapy, being received in the agency, was assessed through Part 3 of the Demographic Questionnaire (DQ) (Appendix F).

### *Frequency of Treatment*

The frequency of treatment (e.g. twice per week, weekly, bimonthly, etc.) was assessed through Part 3 of the Demographic Questionnaire (DQ) (Appendix F).

### *Total Length of Treatment*

The total length of time participants have been receiving therapy from both the current agency and previous agencies was assessed through Part 3 of the Demographic Questionnaire (DQ) (Appendix F).

## *Data Collection Instruments*

### Demographic Questionnaire (DQ)

The Demographic Questionnaire (DQ) (Appendix F) has three parts: Part 1 asked for information such as age, race, marital status, number of children, education, religion, employment, and household income; Part 2 asked for information on the experience of

CSA such as age at onset of CSA, relationship to the perpetrator of CSA, frequency of CSA, duration of CSA, other types of abuse experienced along with CSA; and Part 3 asked for treatment history such as type of treatment, frequency of treatment, and total length of treatment.

#### Relationship Questionnaire (RQ)

The Relationship Questionnaire (RQ) (Appendix G) is a single item measure made up of 4 short paragraphs, each describing a prototypical attachment pattern. The RQ was developed by Bartholomew and published by Bartholomew and Horowitz (1991). Participants were asked to rate their degree of correspondence to each prototype on a 7-point scale. The ratings (or “scores”) provide a profile of an individual’s attachment style.

This measure conceptualizes attachment in terms of internal working models of self and others. This deconstruction of attachment is based on Bowlby’s (1973) original conceptualization of attachment.

This RQ is designed to assess adult attachment within Bartholomew’s (1990) four-category framework. Bartholomew provided two theoretically unrelated dimensions giving four quadrants or categories (see Figure 1). Positive working models of the self and positive working models of others give rise to the secure attachment style. Negative working models of the self and positive working models of others give rise to the preoccupied attachment style. Positive working models of the self and negative working

models of others give rise to the dismissing attachment style. Negative working models of both the self and others give rise to the fearful attachment style.

Scharfe and Bartholomew (1994) provided evidence for the reliability of the RQ, reporting internal reliabilities ranging from a low of .49 to a high of .71. Griffin and Bartholomew (1994) conducted three different studies, using five different methods of assessment (i.e., self-reports, friend reports, romantic partner reports, trained judges' ratings of peer attachment, and trained judges' ratings of family attachment). They found strong support for the construct validity of the four attachment dimensions. The RQ also shows convergent validity with the interview ratings (Bartholomew & Horowitz, 1991; Griffin & Bartholomew, 1994).

#### Internalized Shame Scale (ISS)

The Internalized Shame Scale (ISS) (Appendix H), developed by Cook (1994), is a 30-item questionnaire designed to assess internalized shame ensuing from life-related past experiences and has been employed in many clinical investigations (Claesson & Sohlberg, 2002; Murray & Waller, 2002). The scale is composed of twenty-four negatively worded shame items and six positively worded self-esteem items. The level of measurement is ordinal. Participants were asked to rate each item on a 5-point Likert scale ranging from 0 (never) to 4 (almost always). All 30 items were utilized in the present study.

Cook (1994) reported that shame and self-esteem are highly correlated but that shame is a more intense affect that constitutes feelings of humiliation and mortification. While shame correlates highly with low self-esteem, it is not as clearly identified with high self-

esteem and feelings of positive self-worth. As self-esteem rises, shame decreases; persons with higher levels of self-esteem tend to experience less shame. For instance, the ISS correlated .74 with the Rosenberg Self-Esteem Scale. Shame is highly correlated with other emotional states such as depression (.71), anxiety (.62), and interpersonal sensitivity (.74), as measured on the Brief Symptom Inventory (Cook, 1994). Shame is not significantly correlated with trait guilt and variables, such as intelligence and achievement (Cook, 1994).

Reliability tests of the ISS demonstrate Cronbach's alphas at approximately 0.95, and test-retest correlations of 0.94 (Cook, 1994; Rybak & Brown, 1996). Extensive research has been carried out to establish the validity of the ISS. Support has been found for content, criterion and, although based on studies varying in aim and scope, discriminant validity, in non-clinical and clinical groups.

#### Dissociative Experiences Scale (DES)

The Dissociative Experiences Scale (DES) (Appendix I) is a 28-item self-report scale developed by Putnam to identify patients with dissociative psychopathology and to provide a means of quantifying dissociative experiences. The DES contains a variety of dissociative experiences, many of which are normal experiences (Ross, 1996). The scale taps a broad range of dissociative experiences including disturbances in memory, identity, and cognition, derealization, depersonalization, absorption, and imaginative involvement (Carlson & Putnam, 1993).

The DES is the most widely used measure of dissociation (Ross, 1996). The level of measurement is ordinal. The DES can be completed in 10 minutes, and scored in less

than 5 minutes. It is easy to understand, and the questions are framed in a normative way that does not stigmatize the respondent for positive responses (Ross, 1996).

Carlson & Putnam (1993) notes that the DES is a useful research tool but is not considered a diagnostic instrument. Rather, it is a screening instrument deemed useful for major dissociative psychopathology. Norms are presented for both clinical and nonclinical samples including subgroups with anxiety disorder, affective disorder, eating disorders, schizophrenia, borderline personality disorder, PTSD, and dissociative disorders. Scale means or medians are reported for each diagnostic group (Carlson & Putnam, 1993).

The DES comes in two forms: the original and the newer form. Both versions use the same items, but they differ in their item formats. The DES in its original format uses a visual analogue scale that requires examinees to mark their responses along a numerically anchored 100-millimeter line. Item responses range from 0%, “This never happens to you,” to 100%, “This always happens to you.” The new DES uses a more convenient 11-point Likert scale, therefore, it is easier to score (Carlson & Putnam, 1993). For this reason, the new DES form was utilized in the present study.

A total score for the entire scale is determined by calculating the average score for all items (add all scores divided by 28). Scores over 30 on the DES for a clinical population often indicate a likelihood of dissociative disorder. Higher scores on the DES do not prove that a person has a dissociative disorder; they only suggest that clinical assessment for dissociation is warranted. In most studies, the average DES score for a

DID patient is in the 40s, and the standard deviation about 20, and roughly about 15% of clinically diagnosed DID patients score below 20 on the DES (Ross, 1996).

Overall, the DES has very good validity, reliability, and psychometric properties (Carlson, 1994; Carlson & Armstrong, 1994; Carlson & Putnam, 1993). It has excellent construct validity, as reflected in highly significant Spearman correlations of all items with the overall DES score (Ross, 1996). DES scores have also been shown to be unaffected by sex, income level, employment status, education, and religious affiliation (Ross, 1996).

Ross (1996) writes that the scale is derived from extensive clinical experience with an understanding of DID. In the initial studies during its development and in all subsequent studies, the DES has discriminated DID from other diagnostic groups and controls at high levels of significance, based on either group mean or group median scores (Ross, 1996). Internal consistency using Cronbach's alphas was .94 for a clinical sample and .93 for the normal sample (Frischholz & Lipman, 1992), and the measure has shown across studies to have excellent discriminant, construct, and criterion-referenced validity (Chu & Dill, 1990; Frischholz & Lipman, 1992; Ross, Norton, & Anderson, 1988).

### *Population*

A total of 49 women with a history of childhood sexual abuse perpetrated by a parental-figure voluntarily and anonymously participated in completing 4 self-administered measures. All 49 participants were currently receiving treatment from not-

for-profit agencies that specialize in providing services to survivors of sexual assault and childhood sexual abuse.

Participation in the study was based on either: the clients' awareness that they are to participate only if they met the criteria posted on the Research Study Flyer (Appendix A); or therapists identified clients who met the criteria, informed these clients about the study, and upon client's verbal expression of interest in the study clients either obtained or were given by their respective therapists research packets.

In the present study, CSA refers to intrafamilial CSA perpetrated by an adult (18 years or older) *parental-figure*: (biological father, biological mother, biological grandparent, biological aunt, biological uncle, stepfather, stepmother, step grandparent, step aunt, step uncle; other parental-figure such as mother's boyfriend/partner, father's girlfriend/partner, babysitter, etc. who was residing or not residing in the same household at the time of the occurrence of sexual abuse. Parental sexual abuse was defined as sexual relations between a parental adult and a related child or adolescent wherein the child may be coerced, forced, or engaged in sexual activity solely for the gratification of the adult's need (Courtois, 1988). CSA behavior ranges from exhibitionism to intercourse, and includes nudity, disrobing, genital exposure, observation of the child, kissing, fondling, masturbation, fellatio, cunnilingus, digital penetration of the anus, digital penetration of the vagina, penile penetration of the vagina, and dry intercourse (Sgroi, 1982).

### *Sampling Procedures*

The researcher solicited non-for-profit community mental health agencies located in a metropolitan area in the Midwest specializing in providing services to survivors of sexual assault and childhood sexual abuse. The researcher informed these agencies that their clients' participation in the study was voluntary and anonymous and all measures were self-administered. All necessary IRB documentations were submitted along with Letters of Cooperation from these participating agencies. Before the study began, IRB approval was secured.

Agencies were provided with: a Research Study Flyer (Appendix A); the Information Sheet for Therapists (Appendix B); and the Information Sheet for Participants (Appendix C). These documents provided the agency's liaisons (e.g. Agency Director, Clinical Director, Executive Director) and agencies' therapists with details about the study and criteria for participation in the study. Packets were made available for prospective participants in the designated areas of the agencies (e.g. waiting areas, lobby) and enclosed the following: Information Sheet for Participants (Appendix C); Lottery Participation Form (Appendix D); Mailing Instruction Sheet (Appendix E); and 4 Questionnaires (Appendices F, G, H, & I).

Prospective participants were informed of the study in two ways: the agency's therapists identified prospective participants and informed them of the study, as well mentioned that the research was being conducted by a researcher not affiliated with the agency and that their decision has no bearing on the treatment they received from the

therapist and the agency; and a Research Study Flyer (Appendix A) which was posted in the designated areas as well as being available in these areas for clients to take. The Research Study Flyer (Appendix A) and the Information Sheet for Therapists (Appendix B) provided to the agencies as a reference for their therapists outlined the requirements for participation in the study. These criteria were: receives outpatient treatment (individual and/or group therapy) at the agency; female; 18 years or older; has a history of childhood sexual abuse perpetrated by a parental-figure; agrees to complete the instruments which will take approximately 45 minutes; and has at least a 7<sup>th</sup> grade English proficiency. The Research Flyer (Appendix A) also indicated for prospective participants to call this researcher regarding questions about participation in the study.

A total of 215 packets were provided to participating agencies. Forty-nine completed packets were returned within a 12-month data collection period. It was assumed that women either obtained research packets or were provided research packets but did not complete and return these packets. Possible reasons for the low response are to be noted. First, although the study was anonymous, disclosing baseline demographic information, history of childhood sexual abuse, relationship style, shame, and dissociation can be a difficult experience; hence, this may have affected a woman's decision to participate in the study. Second, although the length of time to complete all 4 measures was estimated at 45 minutes, a longer time may have deterred prospective participants from completing the entire packet and therefore not returning the packet. This may also have been indicated by several places where there were missing data on

the returned questionnaires. Third, it was noted for prospective participants that completion of the packets might trigger emotions and other reactions and that they could talk about this with their respective therapist or not, or with another professional outside of the agency. The possibility of being triggered or having been triggered may have deterred some prospective participants from completing the questionnaires. It is to be noted that this researcher did not receive any inquiries from prospective participants, participants, or therapists regarding questions or concerns about participation or issues that arose due to participation in the study. Fourth, anonymity in participation in the study was highly indicated as only an approximate quarter portion of the 49 participants in the study returned the Lottery Participation Form (Appendix D) (see also *Ethical Issues and Concerns* below). This indicated that the need to be anonymous outweighed the possible receipt of a gift certificate.

#### *Ethical Issues and Concerns*

A Lottery Participation Form (Appendix D) was included in each research packet. Participants were informed of the lottery drawing only after they had chosen to obtain and opened the research packet. This was done so that the lottery prize was not perceived as a bribe to participate in the study. Participants were given the option to volunteer to participate in a lottery by completing the Lottery Participation Form (Appendix D) with their name and address. Participants were asked to send the Lottery Participation Form (Appendix D) separately from the completed packet in a provided self-addressed/self-stamped envelope. Participants were also informed to send the form to the researcher at

anytime after receiving the packet. Upon completion of the study, the researcher drew 3 names out of participants who have chosen to send in their information and all 3 drawn participants were sent \$50 gift certificates. All Lottery Participation Forms (Appendix D) were destroyed after the names of 3 participants had been drawn. The gift certificate was in gratitude for their participation in the study.

#### *Data Collection Procedures*

Participants either took a research packet from the designated areas at the agencies or were provided the research packet by their respective therapist upon the participant's verbal expression of interest in participating in the study. Each research packet enclosed 4 instruments which were numbered and stapled together: Demographic Questionnaire (DQ) (Appendix F); Relationship Questionnaire (RQ) (Appendix G); Internalized Shame Scale (ISS) (Appendix H); and Dissociative Experiences Scale (DES) (Appendix I). A Mailing Instruction Sheet (Appendix E) included in the packet instructed participants to mail the completed packet in the provided self-stamped/self-addressed envelope within a week period upon obtaining the packet. All 49 completed packets were mailed in the provided self-stamped/self-addressed envelopes.

#### *Data Analysis Procedures*

The researcher utilized the SPSS software to analyze the data. Data from the Demographic Questionnaire (DQ) (Appendix F), Relationship Questionnaire (RQ) (Appendix G), Internalized Shame Scale (ISS) (Appendix H), and Dissociative Experiences Scale (DES) (Appendix I) were entered into the SPSS and analyzed.

Descriptive frequencies were conducted for each variable in order to provide a description of the characteristics of the sample, the nature of their abuse, and treatment histories.

The low response rate limited the types of analysis conducted. Chi-square analyses were primarily conducted and t-tests were also utilized on continuous variables.

Based on participants' responses and due to the small number of participants, categories on the Demographic Questionnaire (DQ) (Appendix F) such as basic demographic information, CSA characteristics, and treatment histories were collapsed to be more conducive for analysis.

The Relationship Questionnaires (RQ) (Appendix G) were scored and responses were divided into 3 categories: Preoccupied, Dismissing, and Fearful attachment styles. The Internalized Shame Scales (ISS) (Appendix H) and Dissociative Experiences Scales (DES) were scored. Raw scores from these measures were entered into the SPSS and were utilized for t-test analyses. Scores from both the Internalized Shame Scales (ISS) (Appendix H) and Dissociative Experiences Scales (DES) (Appendix I) were further recoded into dichotomous variables of high level of shame (score of 50 and over) and low level of shame (scores below 50), and high level of dissociation (score of 30 and over) and low level of dissociation (scores below 30), respectively. These cutoffs were conducive to the analyses since part of the study's focus is specific to relationships associated with the high level of shame and high level of dissociation.

## CHAPTER FOUR

### RESULTS

Forty-nine women with a history of childhood sexual abuse perpetrated by a parental-figure voluntarily and anonymously participated in completing 4 self-administered measures on demographics, adult attachment styles, levels of shame, and levels of dissociation. Treatment history was also investigated to assess its possible relationships to adult attachment styles, levels of shame and dissociation, and CSA characteristics.

In this chapter, descriptive data on the participants' demographics, CSA characteristics, history of treatment, and scores on the RQ, ISS, and DES are discussed and presented in corresponding tables. This is followed by the description of results on the relationships among CSA characteristics, adult attachment styles, shame, dissociation, and treatment.

#### *Descriptive Data*

##### Demographics

Participants ranged in age from 20 to 58 years, with a mean age of 35.7 and SD of 9.62. Two of the participants did not report their age. Of the racial identities that were reported, about half (44.9%, n=22) of the participants were Caucasian, 22.4% (n=11) were African-American, 18.4% (n=9) were Latino/Hispanic, 4.1% (n=2) were Bi-racial, and 10.2% (n = 5) of the participants did not report their race. Similarly, about half (49%,

n=24) reported that they had never been married. Seven (n=7, 14.3%) participants reported being currently married, 26.5% (n=13) were divorced, 4.1% (n=2) were separated, 4.1% (n=2) were living together, and one participant (n=1, 2%) did not disclose her marital status.

Of the participants who responded to the question pertaining to the number of children, 36.7% (n=18) reported they had no children, 32.7% (n=16) had 1 child, and 20.4% (n=10) had 2 or 3 children. Five participants (10.2%) did not provide this information. In the reported educational background, there were equal numbers of participants (40.8%, n=20) who had taken some college courses and graduated from high school, 8.2% (n=4) did not complete high school, 4.1% (n=2) were college graduates, 2.0% (n=1) completed graduate school, and 4.1% (n=2) did not report their educational background.

Reported religious backgrounds were as follows: 26.5% (n=13) had no religion; 18.4% (n=9) were Catholic; 12.2% (n=6) were Protestant; 6.1% (n=3) were Baptist; 4.1% (n=2) each were Atheist or Jewish; and 6.1% (n=3) were Christians. A number of participants (22.4%, n=11) did not report any religion.

About half of the participants (49.6%, n=23) were employed full-time, 34.7% (n=17) were employed part-time, 12.2% (n=6) were unemployed, and 6.1% (n=3) did not report their employment status. Household income was divided into 5 categories ranging from “\$11,000-\$14,000” to “More than \$100,000” and the responses were: “11,000=\$14,000” (4.1%, n=2); “15,000=\$25,000” (34.7%, n=17); “25,000=\$50,000” (36.7%, n=18); “50,000=\$100,000” (10.2%, n=5); and “More than \$100,000” (2.0%,

n=1). Six participants (n=6, 12.2%) did not provide income information. A summary of demographics is detailed on Table 1.

**Table 1- Demographic Characteristics**

	N= 49	%
<b>Race</b>		
Caucasian	22	44.9
African American	11	22.4
Latino/Hispanic	9	18.4
Bi-racial	2	4.1
No response	5	10.2
<b>Marital Status</b>		
Never married	24	49
Currently married	7	14.3
Divorced	13	26.5
Separated	2	4.1
Living together	2	4.1
No response	1	2
<b>Number of Children</b>		
0	18	36.7
1	16	32.7
2-3	10	20.4
No response	5	10.2
<b>Education</b>		
Some high school	4	8.2
High school graduate	20	40.8
Some college	20	40.8
College graduate	2	4.1
Completed graduate school	1	2.0
No response	2	4.1
<b>Religion</b>		
Catholic	9	18.4
Protestant	6	12.2
Baptist	3	6.1
Atheist	2	4.1
Jewish	2	4.1
Christian	3	6.1
No religion	13	26.5
No response	11	22.4
<b>Employment</b>		

Currently employed full-time	23	46.9
Currently employed part-time	17	34.7
Currently not employed	6	12.2
No response	3	6.1
Annual household income		
\$11,000-\$14,999	2	4.1
\$15,000-\$24,999	17	34.7
\$25,000-\$49,999	18	36.7
\$50,000-\$100,000	5	10.2
More than \$100,000	1	2.0
No response	6	12.2
Age	Mean=35.7	Range=20-58 SD=9.6
No response	2	4.1

#### CSA Characteristics

Participants' age at onset of abuse ranged from 3 to 12 of age. The mean was 8.04 and SD was 2.31. Of the 49 participants, 28.6% (n=14) were sexually abused at age 6 or younger while the remaining 71.4% (n=35) were sexually abused beginning at age 7 to 12 years old (see Table 2).

**Table 2 - Age at Onset of CSA**

			Mean	SD	Range
Age at onset	<i>N=49</i>	%	8.04	2.3	3-12
3	1	2.0			
4	1	2.0			
5	7	14.3			
6	5	10.2			
7	5	10.2			
8	10	20.4			
9	3	6.1			
10	11	22.4			
11	2	4.1			
12	4	8.2			

About half of the participants (49 %, n=24) reported that sexual abuse was perpetrated by a father (biological father, stepfather, and foster father), 2.0% (n=1) by a mother (stepmother), 12.2% (n=6) by a brother (brother and stepbrother), 10.2% (n=5) by a grandfather, 10.2% (n=5) by a cousin (not identified whether male or female), 14.3% (n=7) by an uncle, and 2.1% (n=1) by a male babysitter (see Table 3).

**Table 3 - Parental-Figure Perpetrator of CSA**

	N=49	%
Parental-figure perpetrator of CSA:		
Father	24	49.0
Mother	1	2.0
Brother	6	12.2
Grandfather	5	10.2
Cousin	5	10.2
Uncle	7	14.3
Babysitter	1	2.0

For the purpose of assessing the severity of abuse experienced, participants were asked in Part 2 of the Demographic Questionnaire (DQ) about other types of childhood abuse (physical abuse, verbal abuse, and psychological abuse) inflicted by the perpetrator of the CSA. Participants were asked to check the corresponding boxes pertaining to each type of abuse. Twenty-four participants (n=24, 49.0%) reported having experienced all 3 other types of abuse and five participants (n=5, 10.2%) reported having experienced 1 or 2 types of other abuse. Twenty participants (n=20, 40.8%) did not check any of the boxes and therefore were categorized as not having experienced other types of abuse from the identified perpetrator of sexual abuse (see Table 4). It is to be noted that if the researcher

would have included an option box for “no other types of abuse experienced” it would have been a clearer distinction between those participants who disclosed not having experienced any other types of abuse and those who did not respond or chose not to respond.

It is also to be noted that some participants voluntarily wrote other perpetrators (e.g. other immediate family members, relatives, non-relatives/strangers) of CSA and checked boxes corresponding to other types of abuse perpetrated by these other perpetrators. It is assumed that these participants saw an opportunity to disclose other abuse experienced for the present study. It is of course unknown whether such disclosures reflect disclosures also made in their treatment.

**Table 4 - Other Types of Abuse**

	N=49	%
Other types of abuse:		
None	20	40.8
One or 2 other types of abuse	5	10.2
All 3 other types of Abuse	24	49

The frequency of CSA was categorized into occurring “once” or “more than once.” The majority of the participants (89.8%, n=44) reported the abuse occurred more than once; while 4.1% (n=2) reported single occurrence of the abuse, and 6.1% (n=3) did not provide this information (See Table 5).

**Table 5 - Frequency of CSA**

	N=49	%
Frequency of CSA:		
Once	2	4.3
More than once	44	89.8
No response	3	6.1

More than half of the participants (65.3%, n=32) reported a duration of CSA as within 1-5 years, 18.4% (n=9) reported a duration within 6 months to 1 year, 6.1% (n=3) reported a duration within 1 month to 6 months, 4.1% (n=2) reported CSA as a one-time occurrence, and 6.1% (n=3) did not respond (See Table 6). None of the participants reported having been sexually abused more than the duration of 5 years.

**Table 6 - Duration of CSA**

	N=49	%
Duration of abuse:		
Once	2	4.1
1 month-6 months	3	6.1
More than 6 months – 1 year	9	18.4
More than 1 year – 5 years	32	65.3
No response	3	6.1

### Treatment

Participants were asked about their history of treatment: the type of treatment they were currently receiving at the agency; the frequency of this treatment; and the total duration of treatments from previous and current agencies. Almost all of participants (91.8%, n=45) reported currently receiving individual therapy (IT), only 1 participant (2%) reported being involved in group therapy (GT), and 6.1% (n=3) did not provide this

information (See Table 7). Possible reasons for this response rate are: participants are not currently involved in groups; groups are currently not offered at the agencies; and participation in group is presently not prescribed or deemed appropriate in the stage of treatment. It is also possible that the responses reflect confusion about what the survey was asking for. In addition, the question in Part 3 of the Demographic Questionnaire (DQ) (Appendix F) pertaining to which type/s of treatment were being received at the agency allowed the participant to check options for either individual therapy, group therapy, or both individual therapy and group. It was speculated that participants might have thought they can only choose between checking the box for individual therapy or the box for group therapy. This might have also pertained to assumed longevity of individual therapy in comparison to group therapy in that participant chose to check the box of the treatment type associated perhaps with a lengthier commitment.

With regards to the frequency of treatment, most participants were receiving IT weekly (34.7%, n=17) and IT 2x per month (36.7%, n=18). Other responses were: 6.1%, (n=3) were receiving IT 2x per week; 10.2% (n=5) receiving IT monthly; and 12.2% (n=6) did not provide information (See Table 8). The responses pertaining to the duration of treatment were as follows: 2.0% (n=1) had been in treatment for less than 1 year; 22.4% (n=11) had been in treatment for 1-3 years; 30.6% (n=15) had been in treatment for more than 3-5 years; 18.4% (9) had been in treatment for more than 5-10 years; 16.3% (n=8) had been in treatment for over 10 years; and 10.2% (n=5) had no response (See Table 9).

**Table 7 – Type of Treatment at the Current Agency**

	N=49	%
Type of Treatment:		
Individual Therapy (IT)	45	91.8
Group Therapy (GT)	1	2.0
Both IT & GT	0	0.0
No response	3	6.1

**Table 8 – Frequency of Treatment at the Current Agency**

	N=49	%
Frequency of Treatment:		
IT 2x weekly	3	6.1
IT weekly	17	34.7
IT 2x monthly	18	36.7
IT monthly	5	10.2
No response	6	12.2

**Table 9 – Total Duration of Treatment from Previous and Current Agencies**

	N=49	%
Total Duration of Treatment:		
Less than 1 year	1	2.0
1-3 years	11	22.4
More than 3 years – 5 years	15	30.6
More than 5 years – 10 years	9	18.4
More than 10 years	8	16.3
No response	5	10.2

## RQ, ISS, DES Scores

Analysis of the measure Relationship Questionnaire (RQ) yielded the following results: 42.9% (n=21) had preoccupied attachment style; 18.4% (n=9) had dismissing attachment style; and 34.7% (n=17) had fearful attachment style (See Table 10). The mean score on the Internalized Shame Scale (ISS) was 49.0, SD was 17.6, and range was 15-73. Twenty-five participants (n=25, 51.0%) scored 50 or over and 18 participants (n=18, 36.7%) scored less than 50. The mean score on the measure Dissociative Experiences Scale (DES) was 23.3, SD was 8.48, and range was 6.4-39.2. Fifteen participants (n=15, 69.4%) scored 30 and over and 34 participants (n=34, 30.6%) scored less than 30 (See Table 11).

**Table 10 - Adult Attachment Styles Assessed through Relationship Questionnaire (RQ)**

	N=49	%
Adult Attachment Styles:		
Preoccupied	21	42.9
Dismissing	9	18.4
Fearful	17	34.7
No response	2	4.1

**Table 11 - Levels of Shame and Dissociation Assessed through Internalized Shame Scale (ISS) and Dissociative Experiences Scale (DES)**

	N=49	%	Mean	SD	Range
Level of Shame (ISS scores):			49.0	17.6	15-73
50 and Over	26	46.9			
Below 50	23	53.1			
Level of Dissociation (DES scores):			23.3	8.4	6.4-39.2
30 and Over	15	69.4			
Below 30	34	30.6			

### *Bivariate Analyses*

#### CSA Characteristics

In order to conduct the bivariate analysis, and in light of the distribution of individuals on the CSA characteristics, and also the theoretical meaningfulness of the categories, the following CSA characteristics were recoded to facilitate the analysis related to the research questions and hypotheses:

##### *Age at Onset of CSA*

Age at onset of CSA was recoded to divide the sample into two groups: 0-6 years old and 7-12 years old. The researcher focused on *0-6 years old* age at onset for the purposes of supporting the existing literature that earlier age at onset of CSA is specifically related to fearful attachment style and identifying possible relationships between earlier age at onset of CSA and level of shame, level of dissociation, and treatment.

##### *Relationship to the Perpetrator of CSA*

The perpetrator variable was recoded to create two groups: those abused by a father and those abused by a non-father. The researcher focused on the *father* as the perpetrator for the purposes of supporting the existing literature that CSA perpetrated by a father leads to more severe consequences; supporting the researcher's hypothesis that CSA perpetrated by a father is related to insecure attachment style; and identifying possible relationships between the father as perpetrator of CSA and level of shame, level of dissociation, and treatment.

### *Duration of CSA*

The duration of CSA variable was recoded to create two categories: experienced less than 1 year and experienced 1-5 years. The researcher focused on *1-5 years* duration of CSA for the purposes of supporting the existing literature that longer duration of abuse leads to more damaging consequences; supporting the researcher's hypothesis that longer duration of CSA is related to insecure adult attachment styles- specifically fearful attachment style; and identifying possible relationships between longer duration of CSA and the level of shame, level of dissociation, and treatment.

### *Other Types of Abuse*

The other types of abuse variable was recoded to create three groups: having experienced no other types of abuse; having experienced 1-2 other types of abuse; and having experienced all 3 other types of abuse. The researcher focused on having experienced *all 3 other types of abuse* for the purposes of supporting the existing literature that more extensive and severe abuse relates to more traumatic outcomes; supporting the researcher's hypothesis that the experience of other types of abuse with CSA is related to insecure adult attachment styles- specifically fearful attachment style; and identifying possible relationships between having experienced all 3 other types of abuse and level of shame, level of dissociation, and treatment.

## Adult Attachment Styles

### *Adult Attachment Styles and CSA Characteristics*

Chi-square was computed to determine possible relationships between abuse characteristics and adult attachment styles (See Tables 12, 13, 14).

A statistically significant relationship was found between age at onset of CSA and fearful attachment style ( $X^2=5.009$ ,  $df=1$ ,  $p=.025$ ). Specifically, among participants whose age at onset of CSA was at 0-6 years old ( $n=14$ ), 47.1% had fearful attachment style. In comparison, among participants whose age at onset of CSA was older than 6 years old, 16.7% had fearful attachment style. There was no statistically significant relationship found between age at onset and dismissing and preoccupied attachment styles.

A statistically significant relationship was also found between relationship to the perpetrator and fearful attachment style ( $X^2=11.902$ ,  $df=1$ ,  $p=.001$ ). Among participants whose perpetrator of CSA was a father ( $n=23$ ), 82.4% had a fearful attachment style. In comparison, among participants whose perpetrator of CSA was not a father, 30.0% had fearful attachment style. There was also a statistically significant relationship between relationship to the perpetrator and dismissing adult attachment ( $X^2=10.668$ ,  $df=1$ ,  $p=.001$ ). Specifically, none of those whose father was the perpetrator of CSA had dismissing attachment style while 60.5% of participants whose perpetrator of CSA was not a father had dismissing attachment style.

A statistically significant relationship was also found between duration of CSA and fearful attachment style ( $X^2=5.887$ ,  $df=1$ ,  $p=.015$ ). Among participants who experienced CSA for 1-5 years ( $n=31$ ), 88.2% had a fearful attachment style. In comparison, among participants whose duration of CSA was less than 1 year, 53.3% had fearful attachment style. There was also a statistically significant relationship between duration of CSA and dismissing attachment style ( $X^2=5.277$ ,  $df=1$ ,  $p=.022$ ). More specifically, 33.3% of participants who experienced 1-5 years of CSA had dismissing attachment style while 73.7% of participants who experienced CSA for less than 1 year had dismissing attachment style.

Lastly, there was a statistically significant relationship between whether or not the participant experienced all of the other types of abuse and fearful attachment style ( $X^2=54.997$ ,  $df=1$ ,  $p=.025$ ). Among participants who experienced all 3 other types of abuse ( $n=24$ ), 70.6% had a fearful attachment style. In comparison, among participants who did not experience all 3 other types of abuse, 36.7% had fearful attachment style. There was also a statistically significant relationship between the other types of abuse experienced and dismissing attachment style ( $X^2=6.373$ ,  $df=1$ ,  $p=.012$ ). Only 11.1% of those who have experienced all 3 other types of abuse had dismissing attachment style while 73.7% of participants who did not experienced all 3 other types of abuse had dismissing attachment style.

There was no statistically significant relationship found between each CSA characteristics and preoccupied attachment style.

In summary, significant relationships were found between each abuse characteristics (age at onset of CSA, whether or not the perpetrator was a father, duration of CSA, and having experienced all 3 types of other abuse) and fearful attachment style. These findings further support the existing literature on CSA characteristics and fearful attachment style. There were also statistically significant relationships between whether or not the participant was abused by a father, duration of CSA, and having experienced all 3 other types of abuse and dismissing attachment style. In general, the results indicate that the more severe CSA experience was associated with greater likelihood that the individual had a fearful attachment style and a smaller likelihood of having a dismissive attachment style.

**Table 12 – Fearful Adult Attachment Style and CSA Characteristics**

CSA Characteristics	Fearful Adult Attachment Style (N=17)	Other Adult Attachment Styles (N=30)
0-6 y/o N =14	47.1%*	16.7%
Father N=23	82.4%**	30.0%
Duration of CSA [1-5 years] N=31	88.2%*	53.3%
All 3 Types of Abuse N=24	70.6%*	36.7%

\*For comparison of abuse characteristics and fearful attachment style,  $p \leq .05$

\*\*For comparison of abuse characteristics and fearful attachment style,  $p \leq .001$

**Table 13 – Dismissing Adult Attachment Style and CSA Characteristics**

CSA Characteristics	Dismissing Adult Attachment Style (N=9)	Other Adult Attachment Styles (N=38)
0-6 y/o N =14	11.1%	31.6%
Father N=23	0.0% **	60.5%
Duration of CSA [1-5 years] N=31	33.3%*	73.7%
All 3 Types of Abuse N=24	11.1%*	57.9%

\*For comparison of abuse characteristics and dismissing attachment style,  $p \leq .05$

\*\*For comparison of abuse characteristics and dismissing attachment style,  $p \leq .001$

**Table 14 – Preoccupied Adult Attachment Style and CSA Characteristics**

CSA Characteristics	Preoccupied Adult Attachment Style (N=21)	Other Adult Attachment Styles (N=26)
0-6 y/o N =14	19.0%	34.6%
Father N=23	42.9%	53.8%
Duration of CSA [1-5 years] N=31	61.9%	69.2%
All 3 Types of Abuse N=24	47.6%	50.0%

## Shame

For the purpose of determining possible relationships primarily between high level of shame and the dependent variables, shame scores from the Internalized Shame Scale (ISS) were recoded into a dichotomous variable of high level of shame (score of 50 and over) and low level of shame (scores below 50).

### *Shame and CSA Characteristics*

Chi-square was computed to determine possible relationships between shame and CSA characteristics (See Table 15). Independent sample t-tests were also computed for comparative purposes.

The Chi-square results revealed statistically significant relationships between shame and all CSA characteristics: age at onset of CSA ( $X^2=12.463$ ,  $df=1$ ,  $p=.000$ ); relationship to the perpetrator ( $X^2=9.090$ ,  $df=1$ ,  $p=.003$ ); duration of CSA ( $X^2=23.264$ ,  $df=1$ ,  $p=.000$ ); and whether or not the participant experienced all 3 other types of abuse ( $X^2=12.871$ ,  $df=1$ ,  $p=.000$ ).

Among participants whose age at onset of CSA was at 0-6 years old ( $n=14$ ), 50.0% had a high level of shame (score of 50 and over). In comparison, only 4.3% of participants whose age at onset were older than 6 years old had a high level of shame (score of 50 and over). Among participants whose perpetrator of CSA was a father ( $n=23$ ), 69.2% had a high level of shame (score of 50 and over). In comparison, among participants whose perpetrator of CSA was not a father, 26.1% had a high level of shame (score of 50 and over). Among participants who experienced CSA for 1-5 years ( $n=31$ ),

the clear majority (96.2%) had a high level of shame (50 and over). In comparison, among participants whose duration of CSA was less than 1 year, 26.1% had a high level of shame (score of 50 and over). In addition, among participants who experienced all 3 other types of abuse (n=24), 73.1% had a high level of shame (50 and over). In comparison, among participants who did not experience all 3 other types of abuse, 21.7% had a high level of shame (score of 50 and over).

Independent sample t-test results also found significant relationships between shame and all CSA characteristics: age at onset of CSA ( $t = -4.121, p = .000$ ); relationship to the perpetrator ( $t = -2.863, p = .006$ ); duration of CSA ( $t = -4.626, p = .000$ ); and experience of other types of abuse ( $t = -3.719, p = .001$ ).

These findings on the relationships of both earlier age at onset of CSA and CSA perpetrated by a father to high level of shame (50 and over) further support the existing literature on shame and CSA characteristics. Of additional contributions are the findings that longer duration of abuse and presence of other types of abuse are related to the development of high levels of shame.

**Table 15 - Shame and CSA Characteristics**

CSA Characteristics	Shame scores (N=49)	
	50 and Over N=26	Below 50 N=23
0-6 years old N =14	50.0% **	4.3% **
Father-figure N=24	69.2% *	26.1% *
Duration of		

CSA [1-5 years] N=32	96.2% **	30.4% **
All 3 Types of Abuse N=24	73.1% **	21.7% **

\* $p \leq .05$

\*\* $p \leq .001$

### *Shame and Adult Attachment Styles*

Chi-square was used to investigate possible relationships between shame and adult attachment styles (See Table 16). Independent sample t-tests were also computed for comparative purposes.

Chi-square findings on shame and fearful attachment style were in congruence with the researcher's hypothesis. Level of shame was found to have a statistically significant relationship with fearful attachment style ( $X^2=9.097$ ,  $df=1$ ,  $p=.003$ ). Fifty-six percent of those who had fearful attachment style had high level of shame while only 13.6% of participants who did not have a fearful attachment style had a high level of shame.

Level of shame was also found to have a statistically significant relationship with dismissing attachment style ( $X^2=7.917$ ,  $df=1$ ,  $p=.005$ ). Thirty-six percent of those who had a dismissing attachment style had a low level of shame while only 4.0% of participants who did not have dismissing attachment style had a low level of shame.

There was no statistically significant relationship found between preoccupied attachment style and level of shame. Participants with this attachment style were almost

equally divided in their responses on the level of shame: 40% had high level of shame and 50% had low level of shame.

Independent sample t-test results also found significant relationships between shame and the following adult attachment styles: fearful attachment style ( $t = -4.375$ ,  $p = .000$ ); and dismissing attachment style ( $t = 2.940$ ,  $p = .014$ ). Similar to the Chi-square finding, there was no significant relationship found between shame and preoccupied attachment style ( $t = .893$ ,  $p = .377$ ).

**Table 16 - Shame and Adult Attachment Styles**

Adult Attachment Styles (N=49)	Shame scores (N=49)	
	50 and Over N=26	Below 50 N=23
Fearful N=17	56.0%*	13.6%
Dismissing N=9	4.0%*	36.4%
Preoccupied N=21	40.0%	50.0%
No Response N=2		

\* $p \leq .05$

\*\* $p \leq .001$

## Dissociation

For the purpose of determining possible relationships between the level of dissociation and the abuse variables, dissociation scores from the Dissociative Experiences Scale (DES) were recoded into a dichotomous variable of high level of dissociation (30 and over) and low level of dissociation (below 30).

### *Dissociation and CSA Characteristics*

Chi-square was computed to determine possible relationships between dissociation and CSA characteristics (See Table 17). Independent sample t-tests were also computed for comparative purposes.

Similar to the findings on high level of shame, Chi-square findings showed statistically significant relationships between level of dissociation (30 and over) and all CSA characteristics: age at onset of CSA ( $X^2=21.224$ ,  $df=1$ ,  $p=.000$ ); relationship to the perpetrator ( $X^2=8.324$ ,  $df=1$ ,  $p=.004$ ); duration of CSA ( $X^2=4.353$ ,  $df=1$ ,  $p=.037$ ); and whether or not the participant experience all 3 other types of abuse ( $X^2=8.324$ ,  $df=1$ ,  $p=.004$ ).

Among participants whose age at onset of CSA was at 0-6 years old ( $n=14$ ), 73.3% had a high level of dissociation (30 and over). In comparison, only 8.8% of women whose age at onset were older than 6 years old had a high level of dissociation (30 and over). Among participants whose perpetrator of CSA was a father ( $n=24$ ), 80.0% had a high level of dissociation (30 and over). In comparison, among participants whose perpetrator of CSA was not a father, 35.3% had a high level of dissociation (30 and over).

Among participants who experienced CSA for 1-5 years (n=32), 86.7% had a high level of dissociation (30 and over). In comparison, among participants whose duration of CSA was less than 1 year, 55.9% had a high level of dissociation (score of 30 and over).

Lastly, among participants who experienced all 3 other types of abuse (n=24), 80.0% had a high level of dissociation (30 and over). In comparison, among participants who did not experience all 3 other types of abuse, 35.3% had a high level of dissociation (30 and over).

Independent sample t-test results also found significant relationships between dissociation and all CSA characteristics: age at onset of CSA ( $t = -5.513, p = .000$ ); relationship to the perpetrator ( $t = -2.697, p = .010$ ); duration of CSA ( $t = -4.159, p = .000$ ); and experience of other types of abuse ( $t = -4.074, p = .000$ ).

These findings on the relationships of high level of dissociation to earlier age at onset of CSA, CSA perpetrated by a father, longer duration of CSA, and the experience of other types of abuse along with the CSA further support the existing literature on dissociation and CSA characteristics.

**Table 17 - Dissociation and CSA Characteristics**

CSA Characteristics	Dissociation scores (N=49)	
	30 and Over N=15	Below 30 N=34
0-6 years old N =14	73.3% **	8.8% **
Father N=24	80.0% *	35.3% *
Duration of		

CSA [1-5 years] N=32	86.7%*	13.3%*
All 3 Types of Abuse N=24	80.0%*	35.3%*

\* $p \leq .05$

\*\* $p \leq .001$

### *Dissociation and Adult Attachment Styles*

Chi-square was used to investigate possible relationships between dissociation and adult attachment styles (See Table 18). Independent sample t-tests were also computed for comparative purposes.

Incongruent to the hypothesis, Chi-square findings revealed no significant relationships between fearful attachment style and high level of dissociation ( $X^2=1.652$ ,  $df=1$ ,  $p=.199$ ). In addition, there were no statistically significant relationships found between dismissing attachment style and level of dissociation ( $X^2=1.856$ ,  $df=1$ ,  $p=.173$ ) and preoccupied attachment style and level of dissociation ( $X^2=.027$ ,  $df=1$ ,  $p=.870$ ). Fifty percent of participants who had fearful attachment style ( $n=17$ ) had a high level of dissociation in comparison to 30.3% who did not have fearful attachment style. This finding is primarily attributed the small number of participants in the study. Roughly 7% of those who had a dismissing attachment style had high scores on the DES compared to 24.2% of those who had a score below 30. For preoccupied attachment style, almost similar proportions scored high (42.9%) and low (45.5%) on the DES.

Independent sample t-test results found no statistically significant relationship between dissociation and adult attachment styles: fearful attachment style ( $t = -2.382$ ,  $p = .022$ ); dismissing attachment style ( $t = 2.167$ ,  $p = .036$ ); and preoccupied attachment style ( $t = .539$ ,  $p = .592$ ).

**Table 18- Dissociation and Adult Attachment Styles**

	Dissociation scores (N=49)	
Adult Attachment (N=49)	30 and Over N=15	Below 30 N=34
Fearful N=17	50.0%	30.3%
Dismissing N=9	7.1%	24.2%
Preoccupied N=21	42.9%	45.5%
No Response N=2		

### *Dissociation and Shame*

Chi-square was used to investigate possible relationships between shame and dissociation (See Table 19). Confirming the hypothesis, Chi-square findings revealed a statistically significant relationship between level of dissociation and level of shame ( $X^2 = 6.299$ ,  $df = 1$ ,  $p = .012$ ). Among participants who had a high level of shame ( $n = 26$ ), 80% had a high level of dissociation. In comparison, among participants who had a high level of shame, 41.2% had a low level of dissociation. Among participants who had a low

level of shame (n=23), 58.8% had low level of dissociation. In comparison, among participants who had a low level of shame, 20% had a high level of dissociation.

**Table 19- Dissociation and Shame**

Shame scores (N=49))	Dissociation scores (N=49)	
	30 and Over N=15	Below 30 N=34
50 and Over N=26	80.0%*	41.2%*
Below 50 N=23	20.0%*	58.8%*

\*p ≤ .05

#### Treatment

The researcher was primarily interested in finding out whether more frequent treatment and longer duration of treatment are related to CSA characteristics, adult attachment styles, shame, and dissociation. For this purpose, the frequency of treatment was recoded into two categories: weekly or more frequent and less than weekly. The duration of treatment was recoded into two categories: 5 years or more and less than 5 years.

It is to be noted that since almost all participants reported attending individual therapy, both frequency of treatment and duration of treatment in the discussion below pertained to individual therapy.

#### *Treatment Variables and CSA Characteristics*

Chi-square was used to investigate possible relationships between frequency of treatment and CSA characteristics. In congruence with the researcher's anticipated

findings, statistically significant relationships were found between frequency of treatment and all CSA characteristics: age at onset of CSA ( $X^2=5.874$ ,  $df=1$ ,  $p=.015$ ); relationship to the perpetrator ( $X^2=5.310$ ,  $df=1$ ,  $p=.021$ ); duration of CSA ( $X^2=10.193$ ,  $df=1$ ,  $p=.001$ ), and the experience of other types of abuse ( $X=5.137$ ,  $df=1$ ,  $p=.023$ ) (See Table 20).

Among participants who were attending IT at least weekly ( $N=20$ ), 40.0% had age at onset of CSA at 0-6 years old, 70.0% were sexually abused by a father, 90.0% experienced CSA within a duration of 1-5 years, and 65.0% had experienced all 3 other types of abuse. In comparison, of the participants who were attending IT less than weekly, 8.7% had age at onset of CSA at 0-6 years old, 34.8% were sexually abused by a father, 43.5% experienced CSA within duration of 1-5 years, and 30.4% had experienced all 3 other types of abuse.

**Table 20 – Frequency of Treatment (IT-Individual Therapy) and CSA Characteristics**

CSA Characteristics	Weekly or more frequent (N=20)	Less than weekly (N=23)
Age at onset 0-6 y/o N =14	40.0% *	8.7%
Father was a perpetrator versus all others N=23	70.0% *	34.8%
Duration of CSA [1-5 years] N=31	90% **	43.5%
All 3 Types of Abuse N=24	65.0% *	30.4%

\*For comparison of abuse characteristics and weekly or more frequent treatment,  $p \leq .05$

\*\*For comparison of abuse characteristics and weekly or more frequent treatment,  $p \leq .001$

Chi-square analysis revealed no statistically significant relationships between duration of treatment and CSA characteristics: age at onset of CSA ( $X^2=2.700$ ,  $df=1$ ,  $p=.100$ ); relationship to the perpetrator ( $X^2=3.725$ ,  $df=1$ ,  $p=.054$ ); duration of CSA ( $X^2=2.564$ ,  $df=1$ ,  $p=.109$ ), and the experienced of other types of abuse ( $X=2.397$ ,  $df=1$ ,  $p=.122$ ) (See Table 21).

**Table 21– Duration of Treatment (IT-Individual Therapy) and CSA Characteristics**

CSA Characteristics	5 years or more N=17	Less than 5 years N=27
Age at onset 0-6 y/o N =14	41.2%	18.5%
Father was a perpetrator versus all others N=23	70.6%	40.7%
Duration of CSA [1-5 years] N=31	82.4%	59.3%
All 3 Types of Abuse N=24	64.7%	40.7%

*Treatment Variables and Adult Attachment Styles*

Chi-square analysis revealed no statistically significant relationships between frequency of treatment and adult attachment styles: fearful attachment style ( $X^2=3.394$ ,  $df=1$ ,  $p=.065$ ); dismissing attachment style ( $X^2=.406$ ,  $df=1$ ,  $p=.524$ ); preoccupied attachment style ( $X^2=1.616$ ,  $df=1$ ,  $p=.204$ ) (See Table 22).

**Table 22 – Frequency of Treatment (IT-Individual Therapy) and Adult Attachment Styles**

Adult Attachment Styles (N=49)	Weekly or more frequent (N=20)	Less than weekly (N=23)
Fearful (N=17)	50.0%	22.7%
Dismissing (N=9)	15.0%	22.7%
Preoccupied (N=21)	35.0%	54.5%

Similar to the findings on frequency of treatment, there were no statistically significant relationships found between total duration of treatment and adult attachment styles: fearful attachment style ( $X^2=.727$ ,  $df=1$ ,  $p=.394$ ); dismissing attachment style ( $X^2=2.019$ ,  $df=1$ ,  $p=.155$ ); preoccupied attachment style ( $X^2=.059$ ,  $df=1$ ,  $p=.808$ ) (See Table 23).

**Table 23– Duration of Treatment (IT-Individual Therapy) and Adult Attachment Styles**

Adult Attachment Styles (N=49)	5 years or more N=17	Less than 5 years N=27
Fearful (N=17)	43.8%	30.8%
Dismissing (N=9)	6.3%	23.1%

Preoccupied (N=21)	50.0%	46.2%
No Response (N=2)		

#### *Treatment Variables and Shame*

Chi-square analysis revealed a statistically significant relationship between frequency of treatment and shame ( $X^2=6.955$ ,  $df=1$ ,  $p=.008$ ) Among participants who attended IT at least weekly (N=20), 75% had a high level of shame. In comparison, 34.8% of the participants who attended IT less than weekly had a high level of shame (See Table 24).

**Table 24 – Frequency of Treatment (IT-Individual Therapy) and Shame**

	Weekly or more frequent (N=20)	Less than weekly (N=23)
50 and Over (N=26)	75.0%*	34.8%

\*For comparison of shame and frequency of treatment,  $p \leq .05$

Chi-square findings revealed no statistically significant relationship between duration of treatment and shame ( $X^2=2.876$ ,  $df=1$ ,  $p=.090$ ) (See Table 25).

**Table 25– Duration of Treatment (IT-Individual Therapy) and Shame**

	5 years or more N=17	Less than 5 years N=27
50 and Over (N=26)	70.6%	44.4%

### *Treatment Variables and Dissociation*

Chi-square analysis revealed a statistically significant relationship between frequency of treatment and dissociation ( $X^2=7.406$ ,  $df=1$ ,  $p=.006$ ) (See Table 26). Among participants who attended IT at least weekly ( $N=20$ ), 45% had a high level of dissociation. In comparison, 8.7% of the participants who attended IT less than weekly had a high level of dissociation.

**Table 26 – Frequency of Treatment (IT-Individual Therapy) and Dissociation**

	Weekly or more frequent (N=20)	Less than weekly (N=23)
30 and Over (N=26)	45.0%*	8.7%

\*For comparison of dissociation and frequency of treatment,  $p \leq .01$

Chi-square findings also revealed a statistically significant relationship between duration of treatment and dissociation ( $X^2=11.409$ ,  $df=1$ ,  $p=.001$ ) (See Table 27). Among participants whose duration of treatment was 5 or more years ( $N=17$ ), 58.8% had a high level of dissociation. In comparison, 11.1% of the participants whose duration of treatment was less than 5 years had a high level of dissociation.

**Table 27– Duration of Treatment (Individual Therapy-IT) and Dissociation**

	5 years or more N=17	Less than 5 years N=27
30 and Over (N=26)	58.8%**	11.1%

\*\*For comparison of dissociation and duration of treatment,  $p \leq .001$

## CHAPTER FIVE

### DISCUSSION

Chapters I and II provided an overview of the study, the theoretical base of the study, and the research questions to be investigated. Chapter III highlighted the methodology utilized in the study, presented data, and delineated the data analyses performed. Chapter IV described the results. The current chapter includes discussions on the limitations of the study, summary of findings, implications for clinical social work, and recommendations for future research.

#### *Limitations*

Limitations of the study are to be noted. First, the small sample (a total of 49 participants versus the 100 participants originally hoped for) limited the types of analyses conducted and thereby limited the conclusiveness of some of the study's findings. As noted, it is possible that some differences which would have been significant were not evident in the present study because of the small sample size.

Second, the researcher looked at a limited number of variables so that other explanatory factors that might explain the relationships that were found were not fully controlled. Further, because of the small sample, the researcher could not create more complex equations which might have allowed the researcher to control for the role of demographic characteristics, treatment effects, and varying abuse experiences in one equation to see what matters most related to the dependent variables. This would have

likely improved the internal validity. Such limitations are to be considered in future research in this area.

Third, it is to be acknowledged that there is limited diversity in the participants due to their voluntary participation in the study. The small number of participants also limited the generalizability of the present study. The sample for the study had predominantly Caucasian and African-American women and few Latino/Hispanic individuals. In addition, the study is only inclusive of women survivors currently receiving treatment, therefore the findings are limited in their applicability to the clinical population.

Lastly, since participants were obtained from not-for-profit community mental health agencies, it is assumed that these participants differ to some extent from adult women survivors who are able to afford services from therapists in private settings and other facilities requiring higher fees. This is an important area to explore in future research with regards to how survivors who seek services in different practice arenas might identify their characteristics.

#### *Summary of Findings*

The research investigated the relationships among adult attachment styles, shame, dissociation, and CSA characteristics. First, the research looked at the relationships among adult attachment styles (i.e. secure, preoccupied, dismissing, and fearful) and CSA characteristics (i.e. earlier age at onset, abuse perpetrated by a father, longer duration of abuse, and experience of other types of abuse). It was hypothesized that adult women

survivors of parentally-perpetrated CSA with insecure attachment styles (i.e. preoccupied, dismissing, and fearful) would have a history of at least 2 of the identified CSA characteristics. Second, the relationship between adult attachment styles and shame was investigated. It was hypothesized that adult women survivors of parentally-perpetrated CSA with fearful attachment style would have a higher level of shame as scored on the Internalized Shame Scale (ISS) (Appendix H) than adult survivors with other adult attachment styles (i.e. secure, preoccupied, or dismissing). Third, the relationship between adult attachment styles and dissociation was investigated. It was hypothesized that adult women survivors of parentally-perpetrated CSA with fearful attachment style would have a high level of dissociation as scored on the Dissociative Experiences Scale (DES) (Appendix I) than adult survivors with other adult attachment styles (i.e. secure, preoccupied, or dismissing). Fourth, the relationship between shame and dissociation was investigated. It was hypothesized that among adult women survivors of paternally-perpetrated CSA, a higher level of shame as scored on the Internalized Shame Scale (ISS) (Appendix H) would be related to a higher level of dissociation as scored on the Dissociative Experiences Scale (DES) (Appendix I).

The major findings of the research are mentioned. First, there were positive relationships between fearful attachment styles and CSA characteristics (age at onset of CSA, relationship to the perpetrator of CSA, duration of CSA, and experience of other types of abuse). There were also positive relationships between dismissing attachment style and CSA characteristics (relationship to the perpetrator of CSA, duration of CSA,

and experience of other types of abuse). Second, there was a positive relationship between fearful attachment style and shame and a negative relationship between dismissing attachment style and shame. As predicted, individuals who had fearful attachment style had higher levels of shame. Third, the research failed to find a relationship between adult attachment styles and dissociation. Lastly, there was a positive relationship between high levels of shame and dissociation.

Additional findings of interest are as follows: there were positive relationships between shame and CSA characteristics (age at onset of CSA, relationship to the perpetrator of CSA, duration of CSA, and experience of other types of abuse); there were positive relationships between dissociation and CSA characteristics (age at onset of CSA, relationship to the perpetrator of CSA, duration of CSA, and experience of other types of abuse); there were positive relationships between frequency of treatment and CSA characteristics (age at onset of CSA, relationship to the perpetrator of CSA, duration of CSA, and experience of other types of abuse), shame, and dissociation; and there was a positive relationship between duration of treatment and dissociation.

### *Implications for Clinical Social Work*

#### Adult Attachment Styles and CSA Characteristics

The findings of relationships between fearful attachment style and age at onset of CSA, duration of CSA, and experience of other types of abuse further support the existing literature on CSA characteristics and fearful attachment style. An additional contribution is the study's finding of the relationship between fearful attachment style

and the father as the perpetrator of CSA. As discussed in the literature section, previous research has noted that CSA perpetrated by a father is related to longer duration of abuse and experience of other types of abuse – CSA characteristics that have also been related to fearful attachment style. Based on these relationships, a relationship between father as a perpetrator and fearful attachment style is to be predicted i.e. adult survivors of childhood sexual abuse perpetrated by a father are likely to have fearful attachment style. The data from the present study confirm this relationship.

Dismissing attachment style was also found to be related to the relationship with the perpetrator of CSA, duration of CSA, and the experience of other types of abuse. This is an important contribution to the literature on adult attachment styles and CSA characteristics primarily since research on the relationship of dismissing attachment style to specific CSA characteristics is lacking in the clinical population- specifically among women survivors of intrafamilial CSA.

Although more participants were categorized within the preoccupied attachment style than fearful and dismissing attachment styles, there was no statistically significant relationship found between preoccupied attachment style and CSA characteristics. The small sample size is assumed to affect the conclusiveness of this finding. Nonetheless, the possible relationship between preoccupied attachment styles and CSA characteristics prompts inquiry for future research.

The findings on the relationships of fearful attachment style and dismissing attachment style with CSA characteristics confirm the study's hypothesis. These findings

suggest that the experience of CSA characteristics such as earlier age at onset, father as the perpetrator, duration of CSA, and the experience of other types of abuse have a greater likelihood of being related to fearful attachment style, a smaller likelihood of being related to dismissing attachment style, and are not necessarily related to preoccupied attachment style.

The findings on the relationships among CSA characteristics and adult attachment styles point to several implications for clinical social work practice. First, the current findings put further emphasis on the need for both early intervention and treatment for children who have experienced intrafamilial CSA as well as for their families. Existing governmental and private programs that educate and inform families and society in general of the prevalence of intrafamilial CSA as well as its impact on the victims seem essential to continue and promote. Public and private programs that provide treatment to victims and their families, primarily aimed towards decreasing the stigma of the experiences of intrafamilial CSA, increasing awareness on the importance of seeking help and disclosing the occurrence of abuse, as well as providing the necessary services and treatment that help facilitate healing are critical. Interrupting the occurrences of intrafamilial CSA can mean a shorter duration of abuse, less severity of abuse (e.g. less likelihood of experiencing other types of abuse), and decreased likelihood of revictimization by the perpetrator. Furthermore, effective programs aimed primarily towards prevention of intrafamilial CSA can ultimately decrease the likelihood of earlier

age at onset of abuse which as highlighted in the present study has been linked to greater possibility of severe impact on survivors of intrafamilial CSA.

Second, adult survivors of childhood sexual abuse presenting at various settings such as community mental health agencies and private practice - whether specializing in the treatment of adult survivors of childhood sexual abuse or not – warrant a thorough assessment specifically on the characteristics of CSA. There needs to be an emphasis on social workers’ awareness of the likelihood that adult survivors who present with earlier age at onset, those whose abuse was perpetrated by a father, those who experienced longer durations of abuse, and those who experienced other types of abuse of having a fearful attachment style. Similarly, adult survivors with a history of childhood sexual abuse perpetrated by a father, have experienced longer duration of abuse, and have experienced other types of abuse also have a likelihood of having a dismissing attachment style. Awareness of these relationships increases social workers’ understanding of the impact of CSA characteristics on the on the development of maladaptive patterns of relating which are reflected on the manners adult survivors engage and sustain relationships in treatment. Thus, the study’s findings further guide social workers toward a more attuned, and essentially effective treatment strategies.

#### Adult Attachment Styles and Shame

Congruent to the study’s hypothesis, a relationship was found between level of shame and fearful attachment style. This finding is a significant contribution since research on the relationship of shame and adult attachment style is sparse. Of those works

that do exist, very few studies have focused on clinical samples, and more specifically, none have focused on trauma and the CSA population. As previously discussed in the literature section, researchers have investigated the relationship among anxious/ambivalent and avoidant adult attachment styles with adult global loneliness and loneliness (Garnett, 1991), the relationship of high levels of shame and psychological stress in an outpatient population Akashi (1994), and correlations between shame and anxious adult attachment among non-clinical samples (Magai, Distel, & Liker, 1995). Only two particular studies have investigated the relationship between shame and adult attachment styles among non-clinical populations: Ruch (1996) found that the fearful group had the greatest mean level of shame followed by the preoccupied, the secure, and the dismissing groups; and Lopez, et al. (1997) found correlations between fearful and preoccupied attachment styles and shame. Again, no other research has been done to examine the relationship between shame and adult attachment styles in clinical populations, specifically among survivors of intrafamilial CSA.

Expectedly, a low level of shame was found to be related to dismissing attachment style. This finding confirms the affective presentation typical of dismissing attachment style. As previously described, dismissing attachment style is characterized by positive self-image and negative other-image. Adults with dismissing attachment style tend to downplay the impact of childhood experiences, tend to be overtly unconcerned about their lack of intimacy and trust with others (Kobak & Sceery, 1988; Main & Goldwyn, 1984), deny the importance of relationships, employ strategies that minimize

expressions of negative affect, and inhibit overt proximity-seeking behavior (Bartholomew & Horowitz, 1991; Kobak & Sceery, 1988). Typically, an adult with a high level of shame is more likely to seek out relationships since the alleviation of shame is done through the accepting other (i.e. mother, therapist, etc.). However, the adult with dismissing attachment style does not seek out others for the apparent lack of need to be soothed and lack of need for acceptance.

The findings on the relationships between shame and adult attachment style point to several implications for clinical social work practice. First, as highlighted in the literature section, the level of shame impacts adult survivors' decision to seek help and affects disclosure of CSA experiences in treatment. The latter specifically pertains to adult survivors' fear of being "found out" - most commonly for their perceived responsibility for the occurrences of CSA, and the fear of "being seen" i.e. shame of having been abused. As mentioned, adults with fearful attachment style are expected to seek treatment due to the higher level of shame i.e. to alleviate shame through acceptance. However, due to the vacillation between the need for engagement and distrust of relationship that is characteristic of fearful attachment style, it is to be anticipated that the adult survivor with fearful adult attachment style with high level of shame will abandon and return to treatment in part as a response to coping with overwhelming shame. This has implications on social workers' work with adult survivors of childhood sexual abuse such that keen understanding of the relationship between high level of shame and fearful attachment style in adult survivors of childhood sexual abuse

can help social workers facilitate a safer and competent environment where adult survivors can begin to address and regulate shame without triggering the repetitive outcome of abandonment and return to treatment.

Second, the finding on the relationship between low level of shame and dismissing attachment style point to a disregarded need among those with this attachment style to seek relationship and thereby a lower likelihood of addressing the impact of CSA on their functioning and relationships within treatment. Since the adult survivor with dismissing adult attachment style minimizes or denies the need for attachment, the capacity to engage in treatment is much compromised. The absence of relationship to reflect upon one's self in turn perpetuates the maladaptive ways of coping. Shame, in the context of the experiences of CSA, is not necessarily non-existent or not experienced but due to the ability to minimize affect, the adult survivor with dismissing attachment style is expected to play down its impact which in turn disregards the need to be soothed in the context of a relationship. This has further implication for social workers in sustaining work with adult survivors with dismissing attachment style since reliance on relationship is at all cost to be avoided, thus, the growing intimacy in the therapy relationship is more likely to be responded with denial, minimization, or abandonment of treatment.

#### Adult Attachment Styles and Dissociation

The lack of a relationship found between fearful attachment style and high level of dissociation was incongruent with the study's hypothesis. It was an unexpected finding since numerous studies have supported the link between fearful attachment style and

dissociation. As noted in the literature section, adults who have fearful attachment styles - unresolved with respect to attachment, present as though they are frozen and lacking in a sense of personal agency or efficacy, which is consistent with the decreased affective responsiveness and trance states observed in dissociative individuals (Chu, 1990; Putnam, 1996). Researchers in the past decades have theorized that dissociative symptoms exhibited by adult women survivors of sexual abuse are related to fearful attachment style. Of particular relevance to the present study, Anderson and Alexander (1996) found that fearful attachment was significantly related to dissociation. It is possible that no statistically significant relationship was found because of the small sample in the present study. Thus, further research, with a larger sample, exploring this relationship is warranted.

#### Shame and Dissociation

The positive relationship between level of shame and level of dissociation confirms the study's hypothesis that shame is not only experienced in relevance to the traumatic experience of CSA but has a strong relationship to dissociation.

It is an expected finding since both high levels of shame and high levels of dissociation were strongly linked with CSA characteristics (age at onset of CSA, relationship to the perpetrator of CSA, duration of CSA, and experience of other types of abuse). Thus, adult survivors with a history of childhood sexual abuse characterized by an earlier age at onset, a father as a perpetrator, longer duration, and experienced other

types of abuse have a higher likelihood of having high levels of shame and high levels of dissociation.

The current finding further highlights the persistent and damaging impact of CSA on adult survivors. This puts additional emphasis on the need for social workers' thorough understanding of the relationship between shame and dissociation. Given the relationship between shame and dissociation, a response to an overwhelming shame may trigger dissociation or dissociative processes to cope with the affect. This has significant implications such that adult survivors typically neither vocalize their shame nor their dissociative tendencies. Social workers' skillful assessment and competence in providing a safe environment can help ground manifestations of shame and dissociation. Overall, the study's findings warrant an ongoing need to focus on effective intervention and treatment strategies with adult survivors of childhood sexual abuse.

Moreover, since the level of shame and level of dissociation were only assessed at this time, it can only be assumed that the level of shame and level of dissociation may have either remained similar to when therapy began, or improved or dissipated through the course of therapy. The researcher recommends that both levels of shame and dissociation be assessed (using the scales of ISS and DES) throughout the course of treatment to ascertain possible fluctuations.

## Other Findings

### *Shame and CSA Characteristics*

The findings on the relationships of both earlier age at onset of CSA and the father as a perpetrator of CSA to high level of shame further support the existing literature on shame and CSA characteristics. These findings further confirm the notion that abuse by a parental-figure such as a father constitutes a betrayal that is likely more damaging than CSA perpetrated by a non-family member. It also supports the notion that younger children may feel more shame because they may be easier to coerce into believing they are responsible for what has occurred because of their own “badness.”

Additional important contributions are the findings that longer duration of abuse and experience of other types of abuse are related to the development of high level of shame. In the clinical setting, extensiveness and severity of CSA often come up as culprits of intense shame which are further compounded by self-deprecating and self-blaming gestures. This observation also confirms the current findings suggesting that adult survivors whose experience of CSA was also with other types of abuse and of a longer duration have high levels of shame. Awareness of this relationship enhances social worker’s perspectives in working with women with more severe history of childhood sexual abuse such that they are better able to recognize anticipatory factors leading up to manifestation and exacerbation of shame.

### *Dissociation and CSA Characteristics*

The positive relationship found between high level of dissociation and CSA characteristics support the numerous studies on these variables. These findings suggest that a high level of dissociation is associated with earlier age at onset of CSA, having a father as the perpetrator of CSA, longer duration of CSA, and the experience of other types of abuse. Furthermore, these findings confirm an ongoing need for programs focusing on education that primarily aim towards prevention of CSA, and the need for early assessment and comprehensive treatment for children and their families. Additional implications of these findings pertain to the usefulness of having an awareness of the relationship between CSA characteristics and dissociation for social workers in their work with adult survivors of childhood sexual abuse. Such knowledge can help social workers facilitate an empathic environment with regards to understanding the impact of CSA on the adult survivor's functioning and its relationship to the emergence of dissociation.

## Treatment

### *CSA Characteristics and Treatment*

Congruent with the researcher's anticipated findings, positive relationships were found between CSA characteristics and frequency of treatment. Participants with a history of earlier age at onset of CSA, whose CSA was perpetrated by a father, who experienced longer duration of abuse, and who experienced other types of abuse, were more likely than those whose CSA characteristics were less severe to be attending

individual therapy at least weekly. This supports the notion that the existence of one or more of CSA characteristics is related to a more severe or problematic functioning which in turn warrants more frequent therapy sessions.

The lack of relationship between duration of treatment and CSA characteristics is an unexpected finding. It was anticipated that a history of childhood sexual abuse characterized by more severe and extensive abuse necessitates longer duration of treatment. Such finding is primarily attributed to the small sample in the present study.

#### *Adult Attachment Styles and Treatment*

The lack of relationships between adult attachment styles and both frequency and duration of treatment were an unexpected outcomes. As previously noted in the literature section, it was predicted that among adult attachment styles, adult survivors with fearful and preoccupied attachment would be more likely to seek treatment and have the tendency to return to treatment. This notion is supported by the literature on both attachment styles such that their dependent tendencies often lead them to seek therapy. As discussed in the literature section, the adult with preoccupied attachment style is more likely to be characterized as clingy, alternately idealizing, dependent, and has considerable fears of abandonment in intimate relationships (Bartholomew & Horowitz, 1991). It can be anticipated that the initial presentation would be one of dependency; hence, she would be more likely to stay in treatment. On the other hand, fearful attachment style is characterized by the belief that others are uncaring and unavailable, and that the self is unlovable (Alexander, 1992). Adults with fearful attachment style

expect the worst from an intimate relationship but need such a relationship to heal their damaged self-image (Bartholomew, 1990; Bartholomew & Horowitz, 1991). They are thrown into an ambivalent double avoidance (aloneness versus engulfment) that may serve as the basis for drastic shifts in attachment common in borderline pathology (Dutton, 1998). This particular notion leads adults with fearful attachment style to seek therapy; however, it may also contribute to the vacillation between termination and return to therapy. Unlike preoccupied and fearful attachment styles, the adult with dismissing attachment style is less likely to seek therapy as they tend to downplay or devalue the importance of attachment relationships (Main & Goldwyn, 1984). The lack of trust, compounded by the denial and minimization of the impact of CSA, can ultimately lead to premature termination of treatment.

While the present study did not support this in relation to duration of treatment, it can say little about whether or not individuals with different attachment styles were more or less likely to seek treatment since all participants were in treatment. Nonetheless, it is interesting to speculate on trends and areas for further research in light of the literature.

Overall, the therapy relationship is ultimately the setting where profiles of attachment styles are manifested and possibly addressed. Adult survivors vary in their ways of engaging and relating, which further influence their abilities to sustain treatment. An inquiry for future research pertains to the possible relationship between adult attachment styles and commitment to therapy.

*Shame and Treatment*

Congruent with the researcher's anticipated findings, a relationship was found between the level of shame and individual therapy at least weekly. An unexpected finding pertains to the lack of relationship between shame and duration of treatment. Again, the researcher attributed this finding to the small sample size in the present study.

The alleviation of shame occurs in the presence of an accepting other, which in the clinical setting is the therapist. Shame, in the context of CSA experiences, can have a debilitating effect, and expectedly, impacts as well as is triggered by the therapy relationship. It is the growing trust that facilitates a safe enough environment for adult survivors to increasingly look at themselves without having to resort to avoidance in response to overwhelming shame. Several inquiries are of interest to the researcher: how is shame manifested in therapy among adult survivors of childhood sexual abuse and how do therapists address shame in therapy with varying adult attachment style?; and what are therapy factors that help dissipate shame among adult survivors of childhood sexual abuse with varying adult attachment styles?

*Dissociation and Treatment*

Congruent with the researcher's anticipated findings, relationships were found between the level of shame and both individual therapy at least weekly and treatment duration or more than 5 years. Predictably, adult survivors who have a high level of dissociation tend to attend treatment more frequently and have a higher likelihood to stay longer in treatment. Treatment of dissociation and dissociative disorder is a long, intense,

and complex process. Similar to shame, the progression of treatment depends upon the growth of trust in the therapy relationship.

Adult survivors often do not voluntarily account dissociation as the presenting problem or part of the presenting problem, rather it is increasingly revealed in the development of a more secure relationship. Such a relationship also facilitates workability around maladaptive patterns of relating specifically to an insecure attachment style- particularly a fearful attachment style, as identified in the present study. In addition, a more secure relationship aids in the dissipation of shame which in turn facilitates an increasing articulation of dissociative processes. Future inquiry points to the possible relationships among treatment factors and perceived alleviation of shame and dissociation.

An area to address is the knowledge base therapists have in working with adult survivors with dissociative disorders. Work with adult survivors requires competence in the field of trauma, and necessitates an understanding of the damaging impact of CSA to the psyche, and the manner this is manifested in adult survivors' functioning. An important inquiry for future research concerns the possible relationships among therapists' perception of effective treatment strategies in working with CSA survivors with dissociative disorder and adult survivors' perception of effective treatment strategies in dealing with dissociation.

## Conclusion

Overall, the present study is a significant contribution to clinical social work knowledge as it adds to the complexity of the conceptualization of childhood sexual abuse. The study's findings are vital contributions to clinical social work knowledge such that these can potentially enhance social workers' understanding of the interplay among CSA characteristics, adult attachment style, shame, and dissociation. Of most importance is that this knowledge will help guide social workers in developing and implementing effective treatment strategies for adult survivors of childhood sexual abuse.

The present study does point to several areas to focus on with regards to future contributions to clinical social work knowledge. There is a need for social work graduate curriculum to add emphasis on both obtaining knowledge on the impact of childhood sexual abuse and on future contributions to this knowledge through research and publication. Academic courses focusing on the clinical treatment of childhood sexual abuse need to be incorporated in response to an increased awareness of the prevalence of the work with survivors of CSA across all treatment settings.

More focus on clinical research is also to be considered such that clinical research is a vital basis of clinical social work practice. Clinical research helps evaluate the efficacy of treatment intervention and strategies, determines the significance of the work, and further grounds the theories utilized in social work practice. Thus, an emphasis on clinical research can help maintain critical contributions to clinical social work knowledge.

Furthermore, it is to be noted that the field of clinical social work must have a stance in contributing to the research on these topics, specifically dissociation. For instance, much of the literature on dissociation and dissociative disorders are authored by clinicians and researchers from the fields of psychiatry and clinical psychology. Clinical social workers, either in a community or in private practice settings, are often presented with the opportunity to help adult survivors of childhood sexual abuse. Being in the forefront in providing services to this population, clinical social workers can provide valuable knowledge in both clinical work and research. Equipped with the knowledge of the importance of the therapy relationship and the unique social conceptualization of person-in-situation, clinical social workers are uniquely able to help adult survivors of childhood sexual abuse.

#### *Recommendations for Future Research*

The findings on the relationships among CSA characteristics, adult attachment styles, shame, and dissociation point to several recommendations for future research.

First, it is evident that there are different aspects of the study that require a larger sample in order to more adequately explore and examine relationships among the variables. As highlighted, the present study provided groundwork for future research exploring these variables. Alternative recruitment methods are to be considered to potentially obtain a larger sample. The present study involved anonymous participation as women chose to obtain packets that were available at the agencies, completed these packets on their own, and mailed them with the included self-addressed/ self-stamped

envelope. There were no direct interviews involved, and no identifiable information obtained or provided by the participants. Future researchers may consider providing on-site guidance at the agencies and to conduct interviews with potential participants. This approach may increase the likelihood of participation in the study. In addition, a larger sample will allow for utilization of other data analyses focused on investigating more in-depth relationships among variables. Analyses of a larger sample can highlight more complex relationships among variables and further enhance the conclusiveness of the study's findings.

Second, research on the relationship between adult attachment styles and relationship to the perpetrator in adult survivors of intrafamilial CSA is non-existent and therefore warrants further inquiry. Specific inquiries pertain to the relationship (e.g. father, mother, uncle) and nature of attachment with the perpetrator of the CSA (e.g. perception of closeness, role as a caregiver). Further investigation on the presence of non-abusing caregiver and his or her relationship with the perpetrator of CSA are of interest. Such foci on future research can delineate the impact of relationship with perpetrator and relationships of non-offending caregiver with the perpetrator on the development of specific adult attachment styles.

Third, given the findings on the relationship of CSA characteristics and adult attachment styles, further research examining how CSA characteristics affect adult attachments- specifically leading to dismissing versus fearful attachment style- is deemed useful for treatment intervention. Again, research with a larger sample, looking at the

relationship between CSA characteristics and adult attachment styles could help clearly tease out the relative contributions of the different characteristics.

Fourth, research on the relationship of shame and adult attachment styles remain sparse, and investigation specifically on adult survivors of intrafamilial CSA is much warranted. Inquiries on the manner in which adult survivors of childhood sexual abuse with dismissing attachment style experience and cope with shame is of great interest—specifically for adult survivors who are able to sustain a longer duration of treatment. Furthermore, participants who were categorized as having a preoccupied attachment style were almost equally divided between those with low and high levels of shame. Therefore, it is not surprising that there was no significant relationship found between these variables. It is predicted that a larger number of participants may have added conclusiveness to this finding. This finding lends itself to further inquiry on the relationship of preoccupied attachment style and shame in adult survivors of childhood sexual abuse. Furthermore, future research utilizing other measures of shame and attachment can further investigate the possible impact of shame on the development of adult attachment styles in survivors of childhood sexual abuse.

Fifth, the lack of relationship between dismissing attachment style and dissociation also warrants further inquiry. Dismissing attachment style, characterized by the ability to downplay childhood relationship and experiences, deny the need for relationships, minimized affect, and inability to recall one's childhood, appears predictably related to dissociative tendencies. As previously highlighted, denial of

problems and relationship concerns are likely to manifest in generalizations about childhood that are then further contradicted by specific memories - which may or may not be accessible (Main & Goldwyn, 1984). It is recommended that future research investigate factors affecting the possible development of dissociation on adult survivors with dismissing attachment styles.

Lastly, there is a need for a more in-depth exploration on shame - possibly qualitative or mixed method studies - to gain the full measure of influence of shame on the variables that are involved in working with survivors of childhood sexual abuse. Future research on shame is at the forefront of work with adult survivors. The conceptualization of shame in relation to the experience of CSA warrant further inquiry on adult survivors' perception of shame and its impact on overall relationships - both intrapersonal and interpersonal.

**APPENDIX A:**  
**RESEARCH STUDY FLYER**

## RESEARCH STUDY FLYER

We are looking for participants for an important research study about the possible influence of *childhood sexual abuse experiences on women survivors' relationships and feelings*.

You must meet the following criteria to participate:

- Female;
- 18 years or older;
- Have a history of childhood sexual abuse by a parental-figure; and
- Currently receiving services at this agency.

Participation is completely voluntary and anonymous; no identifying information will be requested.

The research study involves completing questionnaires that will take about 45 minutes.

The research study's results are expected to be helpful to therapists and mental health professionals in helping adult survivors of childhood sexual abuse.

If interested in participating in this research study, you can get a packet available at the waiting area at the agency. You are asked to mail the completed questionnaires in the enclosed 9 x 12 self-addressed/stamped envelope.

If you have additional questions about the study, please contact Grace Tomas-Tolentino, LCSW, Doctoral Student 847-542-2727 or Dr. Marta Lundy, Faculty Sponsor at 312-915-7007.

*This research study has been approved by the Institutional Review Board (IRB) of Loyola University Chicago. If you have questions about your rights as a participant, you may contact the Compliance Manager in Loyola's Office of Research Services at (773) 508-2689.*

**APPENDIX B:**  
**INFORMATION SHEET FOR THERAPISTS**

## INFORMATION SHEET FOR THERAPISTS

### **Researcher:**

**Grace Tomas-Tolentino, LCSW, Doctoral Student  
School of Social Worker, Loyola University Chicago**

### **Project Title:**

**Attachment, shame, dissociation, and child sexual abuse characteristics**

### **Purpose**

The purpose of this study is to identify and describe the relationships among attachment styles, shame, dissociation, and abuse characteristics in adult women survivors who were sexually abused by a parental figure.

### **Participants**

The study will recruit one hundred adult women survivors of childhood sexual abuse. Clients need to meet the following criteria in order to be eligible to participate in the study: female; 18 years or older; has a history of childhood sexual abuse perpetrated by a parental-figure; receives outpatient treatment (individual and/or group psychotherapy) at the agency; agrees to complete questionnaires that will take approximately 45 minutes; and has at least a 7<sup>th</sup> grade English proficiency.

### **Procedure**

Each participant will receive a packet containing the following: information sheet for participants; mailing instruction sheet; lottery participation form; and four questionnaires. Participants are instructed to mail the questionnaires in the enclosed 9 x 12 self-addressed stamped/envelope within a 1-week period upon receipt of the packet.

### **Risks**

Some of the questions that will be asked in the questionnaires may be disturbing to participants. Participants are informed through the Information Sheet for Participants included in the packet that they can: 1- choose to stop participating at any time with no explanation and without consequences; and 2- choose whether or not to discuss issues that come up by completing the questionnaires in their therapy sessions.

**Significance of this study**

The knowledge gained from this research will enhance understanding on how childhood sexual abuse relates to patterns of adult relationships and to experiences of shame and dissociation. The findings of the study are hoped to provide valuable information for future research and to mental health professionals in working with adult women survivors of childhood sexual abuse.

**APPENDIX C:**  
**INFORMATION SHEET FOR PARTICIPANTS**

## INFORMATION SHEET FOR PARTICIPANTS

### **Researcher:**

**Grace Tomas-Tolentino, LCSW, Doctoral Student  
School of Social Work, Loyola University Chicago**

### **Project Title:**

**Attachment, shame, dissociation, and child sexual abuse characteristics**

### **Introduction**

This study will look at the relationships among patterns of relating, experiences of shame and dissociation, and abuse experiences in adult women survivors who were sexually abused by a *parental-figure* (biological father, biological mother, grandparent, aunt, uncle, stepfather, stepmother, step grandparent, step aunt, step uncle, other parental-figure such as mother's boyfriend/partner, father's boyfriend/girlfriend, older sibling, older cousin, etc. who was residing or not residing in the same household at the time of the occurrence of sexual abuse).

Approximately 100 adult women will participate **voluntarily** and **anonymously** in this study. This study will ask you about your history of childhood sexual abuse: age of onset; duration of abuse; severity of abuse; and relationship with your abuser. You will be asked about how you feel about your relationships with your family of origin, children, romantic partner, and others. The study will also ask you about the level of shame and dissociation you experience. The knowledge gained from this study will be used to help mental health professionals working with women survivors.

### **Purpose**

The purpose of this study is to find out how the experiences of childhood sexual abuse are related to patterns of relating, and experiences of shame and dissociation. The findings of the study are hoped to provide valuable information to mental health professionals in working with adult women survivors.

### **Procedures**

Participation in this study requires you to be receiving mental health services at this agency. You must be 18 years or older and have a history of childhood sexual abuse perpetrated by a parental-figure.

A **research packet** is available in the waiting area/s or other designated area/s at the agency. The packet contains: 1- *This form*—Information Sheet for

Participants; 2- Lottery Participation Form; 3- Mailing Instruction Sheet; and 4- Four questionnaires involving topics such as relationships, shame, dissociation, characteristics of abuse, as well as demographic information. **You are asked complete the questionnaires on your own.**

There will be questions on the questionnaires that will cover background information about yourself, for example, personal questions will be asked about your age, marital status, level of education, number of children, race and/or ethnic heritage. Questions will be asked about your abuse history such as when the abuse began, how often and how long it occurred, if there was violence involved, your relationship to the abuser. Questions will be asked about your thoughts about yourself in relationships, and whether you feel shame and if so how often and how intense. You will also be asked whether you experience dissociation such as feeling “zoned out”, experience lapses in time, or experience not recalling your whereabouts. Completion of the questionnaires will take approximately 45 minutes.

### **Risks**

Participation in this study will require some of your time, which could take time away from other interests. In order to provide sufficient time, **you are asked to complete and mail the (4) questionnaires in the enclosed 9 x 12 BROWN self-addressed/stamped envelope within a 1-week period upon getting the packet.**

Some of the questions that will be asked in the questionnaires may be disturbing to you. In fact, some of them may upset you, as the questions are asking about your experiences of childhood sexual abuse. You may find being asked questions about your experiences distressing. You may take breaks as often as is helpful to you. You can choose to stop participating at any time with no explanation and without consequences.

### **Benefits**

You will contribute to an important knowledge for therapists and mental health professionals in helping survivors of childhood sexual abuse.

### **Compensation**

You may choose to participate in a **LOTTERY** by volunteering to provide your contact information (name and address) on the Lottery Participation Form included in the packet. **You are asked to send this sheet separately.** This will further ensure anonymity since your contact information will not be linked to your provided information on the questionnaires. At the end of this study, three participant names will be drawn and will each be sent a **\$50 gift certificate.** All

contact information will be destroyed after the lottery drawing. The gift card is a form of acknowledgment of the time and energy that you have given and to thank you for your contribution to helping women survivors.

### **Confidentiality**

Completion of the packet is **anonymous**. No identifying information will be linked to participants. Data from questionnaires will be used for research purposes only, and will be stored in a secure locked file cabinet. All questionnaires will be marked with a number only and will not include any identifying information. All data will be destroyed when the study is over.

The findings of this study may be published and/or presented at meetings of professionals interested in helping survivors of childhood sexual abuse. The data obtained in this study will be used in a manner which maintains anonymity and personal rights. The data will only be presented in aggregate form; no individual information will be presented.

### **Questionnaires**

The packet will include **4 questionnaires** involving topics such as relationships, shame, dissociation, characteristics of abuse, as well as demographic information. There will be questions that will cover background information about yourself, for example, personal questions will be asked about your age, marital status, level of education, number of children, race and/or ethnic heritage. Questions will be asked about your abuse history such as when the abuse began, how often and how long it occurred, if there was violence involved, your relationship to the abuser. Questions will be asked about your thoughts about yourself in relationships, and whether you feel shame and if so how often and how intense. You will also be asked whether you experience dissociation such as feeling “zoned out”, experience lapses in time, or experience not recalling your whereabouts. Completion of the questionnaires will take approximately 45 minutes.

**You are asked to mail the completed questionnaires on the enclosed 9 x 12 BROWN self-addressed/stamped envelope within 1 week period of getting the packet.**

### **Voluntary Participation**

Participation in this study is **voluntary**. If you do not want to be in this study, you do not have to participate. Even if you decide to participate, you are free not to answer any question or to withdraw from participation at any time without penalty. The researcher has **no** affiliation with the agency and your decision to

participate will in no way affect the treatment you are currently receiving in the agency.

**Contacts and Questions**

If you have questions about this research study, please feel free to contact Grace Tomas-Tolentino, LCSW, Doctoral Student at 847-542-2727 or Dr. Marta Lundy, Faculty Sponsor at 312-915-7007, at Loyola University Chicago. If you have questions about your rights as a research participant, you may contact the Compliance Manager in Loyola's Office of Research Services at 773-508-2689.

**Please read the following carefully:**

***By completing and returning the questionnaires, you consent to participate.***

***You may keep this form for your record.***

**APPENDIX D:**  
**LOTTERY PARTICIPATION FORM**

## LOTTERY PARTICIPATION FORM

**Dear participant:**

You may choose to participate in a **lottery** by volunteering to provide your contact information (name and address) on this form.

**You are asked to send this sheet separately from the questionnaires.** This will further ensure anonymity since your contact information will not be linked to your provided information on the questionnaires.

At the end of this study, three participants' names will be drawn and will each be mailed a **\$50 gift certificate** to the **address provided in this form**. All contact information will be destroyed after the lottery drawing.

The gift card is a form of acknowledgment of the time and energy that you have given and to thank you for your contribution to helping women survivors.

**Please complete below if you choose to participate in the lottery drawing:**

Participant's Name: \_\_\_\_\_

Participant's Address: \_\_\_\_\_

\_\_\_\_\_

**Please SEND this form in the enclosed 9 x 4 PINK self-addressed/stamped envelope.**

**APPENDIX E:**  
**MAILING INSTRUCTION SHEET**

**MAILING INSTRUCTION SHEET**

**THANK YOU FOR COMPLETING THE ATTACHED FOUR (4) QUESTIONNAIRES:**

- DEMOGRAPHIC QUESTIONNAIRE (DQ)**
- RELATIONSHIP QUESTIONNAIRE (RQ)**
- INTERNALIZED SHAME SCALE (ISS)**
- DISSOCIATIVE EXPERIENCES SCALE (DES)**

**Please DO NOT remove the staple on this packet.**

**SEND ALL completed questionnaires in the enclosed 9 x 12 BROWN self-addressed/stamped envelope.**

**APPENDIX F:**  
**DEMOGRAPHIC QUESTIONNAIRE (DQ)**

**DEMOGRAPHIC QUESTIONNAIRE (DQ)**

***Please read and answer carefully the following questions by writing, checking or circling the appropriate response.***

**PART 1**

**1) Age:** \_\_\_\_\_

**2) Race**

- Caucasian
- African American
- American Indian
- Latino/Hispanic:
  - Mexican
  - Cuban
  - South American
  - Central American
  - Puerto Rican
  - Dominican
  - Other (specify): \_\_\_\_\_
- Asian American:
  - Filipino
  - South Asian Indian
  - Korean
  - Lao
  - Hmong
  - Other (specify): \_\_\_\_\_
- Other Race than identified above  
(specify): \_\_\_\_\_
- Bi-racial (specify): \_\_\_\_\_

**3) Marital status:**

- Never Married
- Currently Married
- Divorce
- Separated
- Widowed

- Common Law
- Partner

4) Number of children (if any) \_\_\_\_\_

5) Education

- Less than 6<sup>th</sup> grade
- Some high school
- High school graduate
- Some college
- College graduate
- Post-college
- Attending Graduate School
- Completed Graduate school

6) Religion (specify): \_\_\_\_\_

7) Employment

- Currently employed full time
- Currently employed part time
- Currently not employed

7) Household income

- \$ 5,000 to \$10,000
- \$11,000 to \$14,000
- \$15,000 to \$25,000
- \$25,000 to \$50,000
- \$50,000 to \$100,000
- \$100,000 or more

**PART 2**

1) How old were you when the sexual abuse started?  
\_\_\_\_\_ years old

2) Identify the *sexual abuser or abusers* by role in the family (for example: father, stepfather, grandfather, mother, stepmother, aunt, uncle, etc.) Also, place a checkmark on OTHER types of abuse experienced in addition to sexual abuse *if applicable*.

<b>Sexual abuser (for example: father, stepfather, grandfather, mother, stepmother, aunt, uncle, etc.)</b>	<b>Physical Abuse</b>	<b>Psychological Abuse</b>	<b>Verbal Abuse</b>

**3) How often did the sexual abuse happen to you? (check one)**

- Once  
 more than once

**4) How long would you say the abuse went on?**

#\_\_\_\_\_ days/months/years (*Write the number and circle either days, months or years*)

### **PART 3**

**1) What type of mental health services are you currently receiving at the current agency? Check all that apply.**

- Individual therapy  
 Group therapy  
 Both

**How many times per month do you receive these services?**

- Individual therapy  
 Group therapy

**2) How long in TOTAL have you been receiving mental health services (such as individual and/or group therapy) from mental health facilities and/or private practice including this agency? Check one.**

- Less than 1 year  
 1-3 years  
 3-5 years  
 5-10 years  
 Over 10 years

**APPENDIX G:**  
**RELATIONSHIP QUESTIONNAIRE (RQ)**

## RELATIONSHIP QUESTIONNAIRE (RQ)

*We all have different types of relationships with the important people in our lives. Below is a list of questions about how you relate to others in your life. Please answer as honestly as possible.*

Using the scale listed below, Place a **CHECKMARK** next to the letter corresponding to the style that best describes you or is closest to the way you are. Then **CIRCLE** the **NUMBER** that best corresponds to your answer.

- A. It is easy for me to become emotionally close to others. I am comfortable depending on them and having them depend on me. I don't worry about being alone or having others not accept me.

1	2	3	4	5	6	7
Disagree Strongly			Neutral/ Mixed			Agree Strongly

- B. I am uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I worry that I will be hurt if I allow myself to become too close to others.

1	2	3	4	5	6	7
Disagree Strongly			Neutral/ Mixed			Agree Strongly

- C. I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them.

1	2	3	4	5	6	7
Disagree Strongly			Neutral/ Mixed			Agree Strongly

- D. I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me.

1	2	3	4	5	6	7
Disagree Strongly			Neutral/ Mixed			Agree Strongly

**APPENDIX H:**  
**INTERNALIZED SHAME SCALE (ISS)**

### INTERNALIZED SHAME SCALE (ISS)

Below is a list of statements describing feelings or experiences that you may have from time to time or that are familiar to you because you have had these feelings and experiences for a long time. Most of these statements describe feelings and experiences that are generally painful or negative in some way. Some people will seldom or never have had many of these feelings. Everyone has had some of these feelings at some time, but if you find that these statements describe the way you feel a good deal of the time, it can be painful just reading them. Try to be as honest as you can in responding.

Read each statement carefully and CIRCLE the number below to the right of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below. Do not omit any item.

1) I feel like I am never quite good enough

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

2) I feel somehow left out

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

3) I think that people look down on me

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

4) All in all, I am inclined to think that I am a success

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

5) I scold myself and put myself down

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

- 6) I feel insecure about others' opinions of me
- |       |        |           |       |               |
|-------|--------|-----------|-------|---------------|
| 0     | 1      | 2         | 3     | 4             |
| Never | Seldom | Sometimes | Often | Almost Always |
- 7) Compared to other people, I feel like I somehow never measure up
- |       |        |           |       |               |
|-------|--------|-----------|-------|---------------|
| 0     | 1      | 2         | 3     | 4             |
| Never | Seldom | Sometimes | Often | Almost Always |
- 8) I see myself as being very small and insignificant
- |       |        |           |       |               |
|-------|--------|-----------|-------|---------------|
| 0     | 1      | 2         | 3     | 4             |
| Never | Seldom | Sometimes | Often | Almost Always |
- 9) I feel I have much to be proud of
- |       |        |           |       |               |
|-------|--------|-----------|-------|---------------|
| 0     | 1      | 2         | 3     | 4             |
| Never | Seldom | Sometimes | Often | Almost Always |
- 10) I feel intensely inadequate and full of self doubt
- |       |        |           |       |               |
|-------|--------|-----------|-------|---------------|
| 0     | 1      | 2         | 3     | 4             |
| Never | Seldom | Sometimes | Often | Almost Always |
- 11) I feel as if I am somehow defective as a person, like there is something basically wrong with me
- |       |        |           |       |               |
|-------|--------|-----------|-------|---------------|
| 0     | 1      | 2         | 3     | 4             |
| Never | Seldom | Sometimes | Often | Almost Always |
- 12) When I compare myself to others I am just not as important
- |       |        |           |       |               |
|-------|--------|-----------|-------|---------------|
| 0     | 1      | 2         | 3     | 4             |
| Never | Seldom | Sometimes | Often | Almost Always |
- 13) I have an overpowering dread that my faults will be revealed in front of others
- |       |        |           |       |               |
|-------|--------|-----------|-------|---------------|
| 0     | 1      | 2         | 3     | 4             |
| Never | Seldom | Sometimes | Often | Almost Always |

14) I feel I have a number of good qualities

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

15) I see myself striving for perfection only to continually fall short

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

16) I think others are able to see my defects

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

17) I could beat myself over the head with a club when I make a mistake

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

18) On the whole, I am satisfied with myself

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

19) I would like to shrink away when I make a mistake

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

20) I replay painful events over and over in my mind until I am overwhelmed

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

21) I feel I am a person of worth at least on an equal plane with others

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

22) At times I feel like I will break into a thousand pieces

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

23) I feel as if I have lost control over my body functions and my feelings

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

24) Sometimes I feel no bigger than a pea

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

25) At times I feel so exposed that I wish the earth would open up and swallow me

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

26) I have this painful gap within me that I have not been able to fill

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

27) I feel empty and unfulfilled

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

28) I take a positive attitude toward myself

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

29) My loneliness is more like emptiness

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

30) I feel like there is something missing

0	1	2	3	4
Never	Seldom	Sometimes	Often	Almost Always

**APPENDIX I:**  
**DISSOCIATIVE EXPERIENCES SCALE (DES)**

## DISSOCIATIVE EXPERIENCES SCALE (DES)

This questionnaire consists of twenty-eight questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are NOT under the influence of alcohol or drugs.

To answer the questions, please determine to what degree the experience described in the question applies to you and circle the number (e.g. 20, 50,...) that corresponds to the percentage of the time you have the experience. The left of the scale indicating 0% corresponds to NEVER having experienced what is described while the right of the scale indicating 100%, corresponds to experiencing what is described ALL THE TIME.

*For example:*

0%	10	20	30	40	50	60	70	80	90	100%
Never happens										Happens all the time

1. Some people have the experience of driving a car and suddenly realizing that they don't remember what has happened during all or part of the trip.  
*Circle a number to show what percentage of the time this happens to you.*

0%	10	20	30	40	50	60	70	80	90	100%
Never happens										Happens all the time

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear all or part of what was said.  
*Circle a number to show what percentage of the time this happens to you.*

0%	10	20	30	40	50	60	70	80	90	100%
Never happens										Happens all the time

3. Some people have the experience of finding themselves in a place and having no idea how they got there. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

4. Some people have the experience of finding themselves dressed in clothes that they don't remember putting on. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

5. Some people have the experience of finding new things among their belongings that they do not remember buying. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

6. Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them before. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something as if they were looking at another person. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

8. Some people are told that they sometimes do not recognize friends or family members. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

9. Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation). *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

10. Some people have the experience of being accused of lying when they do not think that they have lied. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

11. Some people have the experience of looking in a mirror and not recognizing themselves. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

12. Some people sometimes have the experience of feeling that other people, objects, and the world around them are not real. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

13. Some people sometimes have the experience of feeling that their body does not belong to them. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

18. Some people sometimes find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

19. Some people find that they are sometimes able to ignore pain. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

20. Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

21. Some people sometimes find that when they are alone they talk out loud to themselves. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were different people. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.). *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that thing (for example, not knowing whether they have just mailed a letter or have just thought about mailing it). *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

25. Some people find evidence that they have done things that they do not remember doing. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

26. Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

27. Some people find that they sometimes hear voices inside their head that tell them to do things or comment on things that they are doing. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
 Never Happens  
 happens all the time

28. Some people sometimes feel as if they are looking at the world through a fog so that people or objects appear far away or unclear. *Circle a number to show what percentage of the time this happens to you.*

0% 10 20 30 40 50 60 70 80 90 100%  
Never Happens  
happens all the time

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## VITA

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Grace is the founder and director of Core Therapy Associates, Ltd., a group private practice based in Schaumburg, IL. The practice focuses primarily on the treatment of adult survivors of childhood abuse and neglect. She specializes in the treatment of Posttraumatic Stress Disorder, dissociative disorders, self-injury, eating disorders, and other trauma-related disorders. She offers individual psychotherapy and couples treatment, and group treatments for adult survivors of childhood sexual abuse, and for those who present with self-injury and eating disorders. She is an advocate for the prevention of violence against women and offers treatment to victims of domestic violence and sexual assault.

In addition, Grace offers individual supervision and consultation, workshops, and seminars to mental health professionals. She promotes education in communities through speaking engagements and publications. She plans to continue practicing as a clinician and focus on teaching, research, and publications.