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Development of post-traumatic stress disorder as a function of shame in child abuse survivors

Guadalupe Valdivia

DEVELOPMENT OF POST-TRAUMATIC STRESS DISORDER AS A FUNCTION OF SHAME IN CHILD ABUSE SURVIVORS

A Thesis

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

in

Psychology:

Child Development

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by

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ABSTRACT

The purpose of this study was to identify differences in shame as a mediator between childhood trauma and post-traumatic stress disorder (PTSD) across ethnic groups and types of abuse. All participants in the study were college women who had survived emotional, physical, and or sexual childhood abuse. Neither Latinas nor White women differed in PTSD or shame symptoms within the childhood abuse sample. Increases in all types of abuse were related to increases in PTSD and shame symptoms. No ethnic differences were found in the relationships between shame and PTSD symptoms, when they were separated by type of abuse. For both ethnic groups and all abuse types, PTSD decreased substantially when controlling for shame. These results suggest that future studies should consider investigating how ethnic identity influences the role of shame contributing to PTSD, particularly for women who have experienced childhood abuse.

ACKNOWLEDGMENTS

First and foremost I would like to thank Dr. David Chavez, for giving me permission to use his archival database and for unlimited personal and academic mentoring during the process of completing the present study. I would also like to thank the NIH/NCMHD funded Research Infrastructure for Minority Serving Institutions (RIMI) Grant (MD002722) for support and training. Lastly, I would like to thank the McNair Scholars Program, The Women's Trauma & Resiliency Research Team, Dr. Kelly Campbell, Dr. Christina Granillo, and Mr. Roy Ramon for their unconditional support to complete the present study.

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CHAPTER ONE

BACKGROUND

Context of the Problem

A history of childhood abuse may cause developmental psychopathology in child abuse survivors as they age. However, little evidence exists to explain factors that may mediate the relationship between a history of child abuse and psychopathology in an ethnically diverse sample. Understanding how ethnic groups report the feeling of shame can help explain why some people develop more symptoms of PTSD than others. Additionally, it is important to understand which types of abuse are associated with a greater risk of feeling shame and PTSD symptoms. It is important to increase understanding about abuse, shame, and ethnic differences because these factors can impact a person's mental health and development. The current literature review will discuss previous and current research in an attempt to expand the understanding of ethnic and abuse differences in the development of Post-Traumatic Stress Disorder (PTSD) when mediated by the feeling of shame in childhood abuse survivors.

Purpose of the Study

The purpose of the project was to provide support regarding the need for more research to investigate whether ethnic differences and types of abuse differences exist regarding whether shame is a mediator between childhood trauma and PTSD.

Hypotheses

Hypothesis I

It was predicted that there would be differences in shame and PTSD symptoms between ethnic groups (Latinos and Whites) with regard to women who experience childhood abuse.

Hypothesis II

It was predicted that there will be a relationship in shame and PTSD symptoms across all types of childhood abuse (emotional, physical, and sexual).

Hypothesis III

It was predicted that there will be ethnic differences (Latinos and Whites) in the relationships between shame and PTSD symptoms, separated by type of abuse (emotional, physical, and sexual).

Hypothesis IV

It was predicted that there will be differences in PTSD symptoms between ethnic groups (Latinos and Whites) and between the types of childhood abuse (emotional, physical, and sexual) that impact the development of symptoms related to Post-Traumatic Stress Disorder, mediated by the feeling of shame (refer to Figure 1).

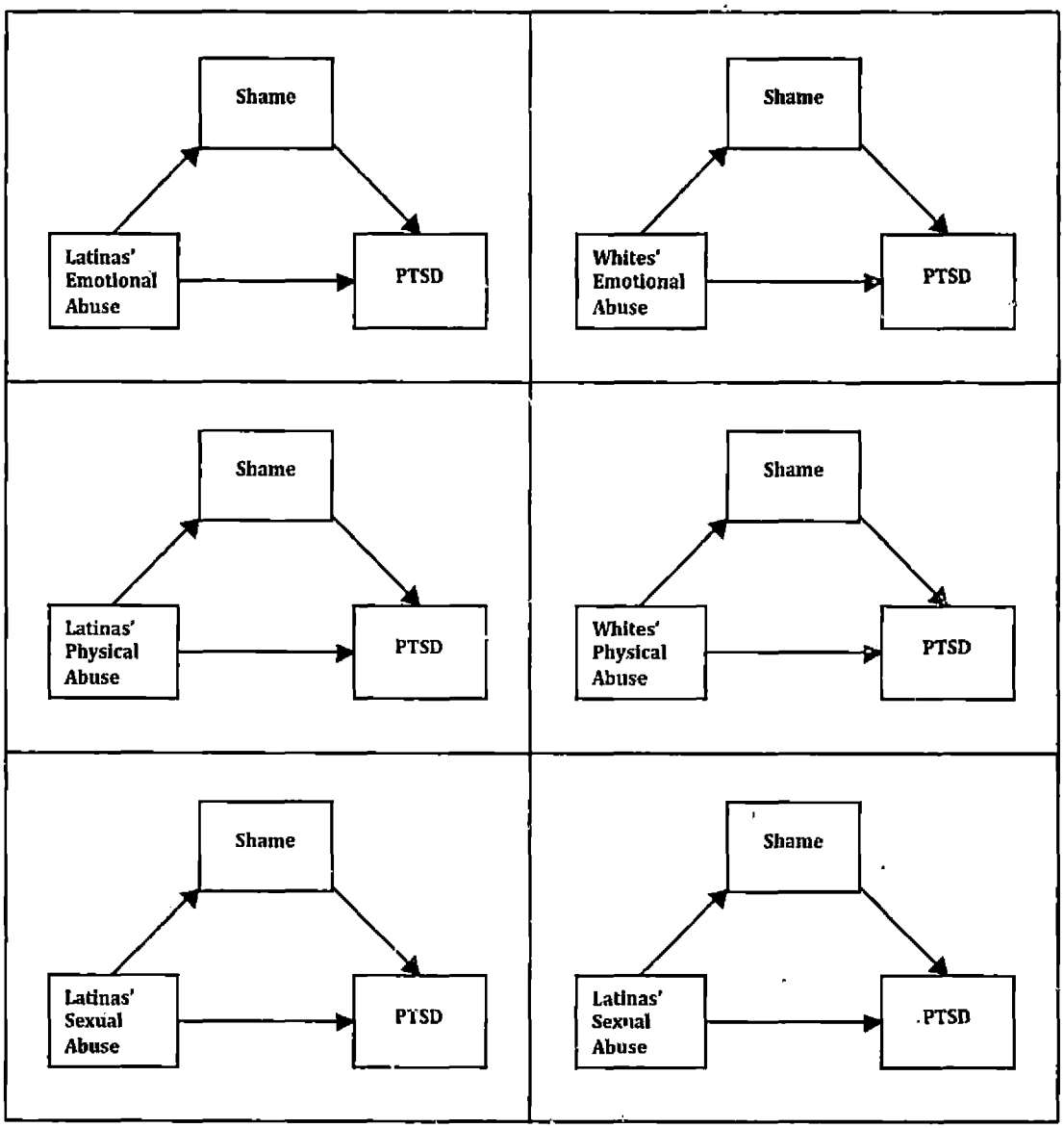

Figure 1. Hypothesis 4: Proposed Ethnic Differences in Shame as a Mediator on the Relationship between Abuse Type and Post-Traumatic Stress Disorder

CHAPTER TWO

REVIEW OF THE LITERATURE

Introduction

The 2010 Child Abuse and Neglect statistics of the U.S. Department of Health and Human Services reported that in the state of California, 17.8% reported emotional abuse (n=13,657), 11% reported physical abuse (n=8,453), and 6.6% reported sexual abuse (n= 5,091). In that sample 21.4% were Latino and 44.8% were White. Forty-eight percent of boys (child population= 4,832,846, n= 36,944) and 51.8% of girls (child population= 4,602,836, n= 39,756) were victims of childhood abuse in the state of California (U.S. Department of Health and Human Services, 2010).

Having experienced various types of childhood abuse can result in many long-term psychological negative outcomes. Statistics have shown that girls (3-15%) are much more likely than boys (1-6%) to develop PTSD as a result of experiencing traumatic experiences (Watts-English, Fortson, Hooper, & De Bellis, 2006).

In a study that looked at Vietnam combat veterans, they found 27.9% of Latinos and 13.7% of Whites reported PTSD symptoms (Kulka et al., 1990). Survivors of childhood

abuse have reported experiencing a negative view of themselves (Feinauer, Hilton & Callahan, 2003). Shame has been associated with the childhood experiences of emotional abuse (Hoglound & Nicholas, 1995; Webb, Heisler, Call, Chickering & Colburn, 2007; Wright, Crawford & Castillo, 2009) and sexual abuse (Feirings & Taska, 2005; Finkelhor & Browne, 1986). Andrews (1995) assessed body shame in his study and found that there was a relationship in the reports of childhood physical and sexual abuse and shame.

As far as I am aware, no prior research has explored ethnic differences in different types of abuse when the relationship of abuse and PTSD is mediated by shame. This study seeks to examine whether ethnicity and childhood abuse type predicts differences in the rates of shame and PTSD symptoms. This study also seeks to see if ethnic differences exist when different types of abuse are individually explored in the relationship of abuse and PTSD as mediated by shame.

Childhood Abuse History in Women

Childhood abuse is defined by the experience of any type of abuse or neglect that occurred before the age of 18 years. Within the United States, more girls (51.5%) than boys (48.2%) report being victims of childhood abuse or

neglect (U.S. Department of Health and Human Services, 2009). It is possible that the socialization of boys to be strong and manly prevent them from expressing their emotions or seeking help as that is thought to show signs of weakness. Consequently, it is highly possible that society influences different reporting rates of abuse across genders. Bernat, Ronfeldt, Calhound, and Aries (1998) explained that because PTSD and exposure to traumatic events can be related to "vulnerability," and vulnerability is more often observed in females, women are more likely to develop PTSD than men. In fact, they found that men and women rate their experience of traumatic events differently. They believe this difference may be explained by the nature of trauma that each gender experiences. Males were more likely to report that their traumatic events were related to serious accidents, or observing a serious injury or death. Women were more likely to report trauma related to sexual coercion and sexual assault.

Resnick, Kilpatrick, Dansky, Saunders, and Best (1993) studied a sample of 4,008 women in which they measured traumatic events history and PTSD symptoms. They estimated that 6.7% of women with childhood abuse history, of any

type met the criteria for a current PTSD diagnosis and 17.9% met the criteria for lifetime PTSD diagnosis (Resnick et al., 1993). Also, Latino survivors from the September 11 terrorist attacks in New York were more likely to develop PTSD symptoms compared to other ethnic groups (Adams, Boscarino, & Galea, 2006; Galea et al., 2002). Similarly, Latina police officers have higher rates of PTSD or report more severe PTSD symptoms than White police officers (Pole et al., 2005). Although the prevalence rate is indeed higher for women than men, one still wonders why 75.4% of women experiencing abuse do not develop PTSD symptoms at all (Resnick et al., 1993). In fact, research has found that Latina girls who have experienced prior child sexual abuse are at a higher risk of expressing shame and self-blame compare to Whites (Feiring, Coates, & Taska, 2001; Fontes, 2007). Due to the history of high rates of women reporting past abuse, this study will focus only on women.

Buffers Towards Childhood Abuse History

Some researchers have identified factors that may help individuals foster resiliency and serve as a buffer towards negative outcomes. A strong sense of ethnic identity, optimism and hope, social support, parental caring and support among other factors have been associated with

resiliency in childhood (Gayla & Gordis, 2004; Mrazek & Mrakek, 1987; Jankowski, Harold, Kris, & Coffey,2002; Spaccarelli & Kim, 1995; White, O'Brien, Jackson, et al., 2008). For example, in 1987, Mrazek and Mrazek reported that regardless of stressors, having access to good health, education, and social welfare services helped children foster resiliency.

Another possible explanation for the fact that there are relatively few diagnoses of PTSD symptoms in child abuse survivors is that there might be different levels of PTSD symptoms being expressed by victims. Those victims who express the highest levels of PTSD may develop "full-blown PTSD" (Bernat et al., 1998, p. 648) whereas victims with low shame will develop mild or no PTSD symptoms.

Consequences of Childhood Abuse History

Although children and adults experience similar types of traumatic experiences, individuals have different attributions and interpretations of traumatic events, which may affect their development through the life span (Pearce & Pezzot-Pearce, 2006). For example, a majority of sexual and physical abuse occurs at younger ages (Jones & Curdy, 1992), and most children tend to develop similar negative outcomes. However, various individuals as a function of age

of abuse, developmental level, and individual differences have different trajectories and outcomes as a function of the abuse.

Several researchers who focus on childhood abuse have found that those who have been sexually abused also often suffer from motor, social/emotional, and or cognitive problems. In addition, they may also express inappropriate sexual behaviors, develop anxiety or social withdrawal, and have cognitive or academic delays (White, Halpin, Strom, & Santilli, 1988). Similar to sexually abused children, physical abuse survivors have been found to develop somatic complaints, insecure relationships, poor social problem solving skills, have low cognitive maturation, are at higher risk for abusing alcohol or drugs, and are at a higher risk of being involved in criminal activities (Erickson & Egeland, 1987; Greenwald, Leitenberg, Cabo & Tarran, 1990; Malisnosky-Rummell & Hansen, 1993; Rivera & Widom, 1990; Trickett, 1993). Experiencing childhood abuse can also contribute to a variety of other external behavioral problems, such as attempting suicide (Anderson, Tiro, Price, Bender, & Kaslow, 2002) or developing an eating disorder (Wonderlich, Brewerton, Jocic, Dansky, & Abbott, 1997). Additionally, there may be mental health

problems such as attachment disorders (Cicchetti & Toth, 1995), or PTSD symptoms (Cicchetti & Toth, 1995). In fact, it is extremely common for childhood abuse victims to develop PTSD symptoms.

Post-Traumatic Stress Disorder (PTSD) is defined as the re-experience of past childhood abuse or other trauma. Most people who develop PTSD symptoms related to childhood abuse suffer from avoiding places or people that trigger reminders of past abuse. These triggers, lead victims of childhood abuse to have nightmares, flashbacks, difficulty concentrating to sleeping, having over exaggerated startle responses, and or other psychological and physical problems.

Symptoms of PTSD can significantly affect a person's general health and well-being. Outcomes can include sleeping problems, eating problems, and somatic symptoms (Cromer & Sachs-Ericsson, 2006; Pearce & Pezzot-Pearce, 2006). In particular, there are other factors that may cause negative consequences in well-being. Among people who develop PTSD symptoms, shame was an important mediating factor influencing a person's recovery from childhood abuse (Andrews, Berwin, Rose, & Kirk, 2000; Feiring, Taska, & Chen, 2002).

Childhood abuse victims are at a higher risk to feel shame, especially if they blame themselves for the past abuse. Shames is defined as an emotion that leads a person to see themselves as defective, feeling ashamed of an unacceptable behavior, or see themselves as damaged. In many cases shame, can be a problem in individuals who experience abuse because it can lead to feelings of hiding, disappearing, and wanting to die.

There are a number of ways shame might worsen posttraumatic reactions. For example, by re-experiencing a painful memory, the victim may experience shame for their behavior, reactions, or their emotions at the time of the trauma (Lee, Scragg, & Turner, 2001). Vulnerable individuals, like victims of childhood abuse tend to see "care-seeking as shameful and anxiety-inducing" (Adshead, 2000, p. 145). These emotions may be a reason why victimized children do not often seek help, which can lead to greater emotional problems in adulthood.

Relationship between Childhood Abuse and Post-Traumatic Stress Disorder

Having a history of abuse as a child is linked to the development of PTSD symptoms (Adshead, 2000; Andrews, Brewin, Rose, & Kirt, 2000). In other words, a past childhood abuse history places people at a greater risk for

developing PTSD symptoms. The reason people who have been abused had higher levels of PTSD symptoms than the people who have not been abused at all may be because these people have not successfully worked through the experience of their traumatic events. Stovall-McClough and Cloitre's 2006 study provides evidence in support of this perspective. They suggest that unresolved trauma increases the chance of developing PTSD symptoms in survivors of childhood abuse. Similarly, Bremner, Southwick, Johnson, Yehura, and Charney (1993) found that men who had been physically abused as children are more prone to combat-related PTSD symptoms. In the case of the veterans who were physically abused as children, combat experiences may have reminded them of their past experiences. Taken together, these various studies suggest that a history of abuse may be a source of the development of PTSD symptoms in survivors of childhood abuse. Research by Spertus, Yehuda, Wong, Halligan, and Seremetis (2003) found that having history of emotional abuse was related to high PTSD symptoms. However, they did not explore ethnic differences.

Relationship between Shame and Post-Traumatic Stress Disorder

Among the symptoms related to PTSD, one of the most common is a sense of feeling shame (Andrews, 1998). In his

unpublished manuscript, Cook (1989) noted that shame is characterized as one of the most basic and centralized feelings in humans.

In Andrews, Brewin, Rose, and Kirt's (2000) study, they showed that shame acts as a mediator between childhood abuse and adult psychopathology. The feeling of shame can occur during the traumatic event or after the event. However, because PTSD symptoms develop over a period of time, it may not be discovered right away (Feiring, Taska, & Chen, 2002). Following the experience of childhood abuse, feelings of shame might evolve, impacting the victim's sense of self and severity of PTSD symptoms. One study found the primary theme of shame is feeling that the victim did not take effective action to prevent the trauma. A second cause for feeling shame was "looking bad in front of other people either because they witnessed the crime or because they had visible injuries sustained" (Andrews et al., 2000, p. 71).

Similarly, Arata, Langhinrichsen-Rohling, and Bowers (2005) found that people who had a history of childhood abuse scored higher on the shame and PTSD measures than the non-abused sample. In fact, experiencing multiple types of abuse predicted higher severity of abuse, feelings of shame

and greater symptoms of PTSD (Arata, Langhinrichsen-Rohling, & Bowers, 2005; Clemmons, Walsh, & DiLillo, 2007). It is believed that abuse that has been enacted with secrecy may create more shame and isolation for the victim (Kendall-Tackett & Becker-Blease, 2004). However, research also suggests that not all survivors are likely to develop PTSD symptoms. It is likely that a number of protective factors may buffer against the development of PTSD symptoms. Outside of the field of childhood abuse investigations, research has reported that a stronger sense of ethnic identity is related to better outcomes and may be a protective factor for people of color (White, O'Brien, Jackson, et al., 2008).

In a landmark physiological study of combat veterans with PTSD symptoms and associated levels of cortisol, the researchers found that feelings of shame played a particularly important role in how PTSD is experienced and expressed (Mason, Wang, Yehuda, Riney, Charney, & Southwick, 2001). Specifically, low cortisol levels were found in individuals with PTSD symptoms who had the emotion of shame that had resulted from the traumatic event. Additionally, the same individuals also expressed

psychological rather than physiological outcomes and mentioned having trouble using coping strategies.

It has been clearly reported that the presence and level of shame is a significant dimension in the development of PTSD syndrome (Wong & Cook, 1992). Wong and Cook (1992) found that individuals with clinically diagnosed PTSD had higher scores in shame characteristics. In particular, they found that alienation and inferiority were key emotions that interrupted the link between the "idealized and perceived real self," which provides the setting for the development of the feeling of shame. In fact, shame is one of most basic and centralized feelings influencing human development (Cook, 1989).

Ethnic Differences in Expressing the Feeling of Shame

Various studies have used Euro-American, Caucasian, Non-Hispanic, and, Anglo to define the White American Culture. For the purpose of this study we will identity all these interchangeable names with the tern White. Similarly, terns, such as Hispanic, Mexican-American, and Chicanos will be identified as Latinos.

Parents provide their children with socialization of emotional coaching to help them deal and respond to various situations. Socialization typically occurs through

modeling these emotions. These emotions are embedded in daily interactions, although emotional responses vary. Socialization of the emotion of shame varies across cultures (Cole, Tamang, & Shrestha, 2006). Each culture has their own values, beliefs and practices which influence the way parents socialize their children to express particular emotions (Eisenberg, Cumberland, & Spinrad, 1998).

White American culture has been predominately influenced by Euro-Americans, defined as people who have European ancestry, Middle East, or North Africa (U.S. Department of Health and Human Services, 2009). American culture tends to be a more independent society compared to other cultures (Bernstein & Rubin, 2007). In White American culture, shame is perceived as an emotion that can be harmful to a child's self-esteem (Ferguson, Stegge, Miller, & Olson, 1999). Therefore, Whites may believe that shame is a less adaptive concept, because of their focus on the individual, and their identity is less connected to themselves as a member of their family or group.

In some cultures, group connection is more important (Albert, 1992). It is considered inappropriate to reveal problems to people outside the family because it may shame one's own family. Talking about sensitive issues outside

the family can cause disappointment or even be seen as disloyal to the family, which can leave victims of abuse with an inability to address and solve their problems. In addition, in some cases the victim will be blamed for the incident, which can additionally contribute shameful feelings.

Latinos are people who come from any of the Spanish speaking cultures such as Cuba, Mexico, Puerto Rico, and South or Central America (U.S. Department of Health and Human Services, 2009). Given that Latinos are a collectivistic culture, they tend to use the feeling of shame as a form of social control (Albert, 1992). It seems that for Latinos, shame is more related to family or group membership identity (Bernstein & Rubin, 2007). Hence, the sense of shame tends to be manifested more and have a different contextual meaning in the Latin cultures than in the White American culture (Albert & Ah Ha, 2004).

Although shame may be a negative emotion in the White American culture, within the Latino culture, it may be normative to use shaming based on the context. For example, it may be more acceptable to shame a child for misbehaving to increase positive behaviors. Given this more normative viewpoint, it is conceivable that shame may have fewer

negative consequences for Latinos. On the other hand, the context in which shame occurs may determine the consequences. While shame may be used more normatively to shape behavior, shame that occurs following and focusing on the experience of childhood abuse may be more likely to have a negative outcome for Latinos.

Within the White American culture, improperly shaming the child may have negative consequences such as an increase of pathology in adulthood. There has been research that has linked childhood shaming to adult depression, anxiety, phobias, sexual dysfunctions, personality disorders, obsessive-compulsive disorders, eating disorders, and/or addictive disorders (Gilbert & Gerlsma, 1999; Kaufman, 1989; Lamont, 2006; Loader, 1998; Middelton-Moz, 1999). Although shame may not be considered a direct form of abuse it can be considered an indirect form of verbal or non-verbal abuse that has long-term effects in people's development of self-identity and self worth. It is critical to see how this link may vary across ethnic groups. A better understanding of ethnic differences in expressing shame and subsequent negative outcomes can help professionals intervene before pathology begins to develop in children.

The Role of Ethnicity and Type of Abuse in the Development of Shame and Post-Traumatic Stress Disorder in Childhood Abuse Survivors

During 2009, among the various types of abuse, physical abuse is reported most often in the United States (10.8% of child abuse reports) followed by sexual abuse (7.6%), and psychological abuse (4.2%) (U.S. Department of Health and Human Services, 2009). As mentioned earlier, research has found that some types of trauma are more likely than others to provoke PTSD, such as sexual abuse (Adshead, 2000). Unfortunately, cultural differences in the role of shame in PTSD symptoms and the likelihood of reporting abuse have not received adequate research attention.

Emotional abuse, also known as verbal, mental and psychological abuse, is also defined as verbal abuse (U.S. Department of Health and Human Services, 2009). For example, belittling, shaming, bullying, name-calling, frightening or terrorizing, ignoring and rejecting, blaming or witnessing violence are examples of emotional abuse. The National Child Abuse and Neglect Data Systems reported in their Child Maltreatment 2008 Annual report that far more Latino children (11%) experience psychological abuse than White children (6.9%) (U.S. Department of Health and Human

Services, 2008). According to O'Hagan (1995), there is lack of research on this type of abuse due to inconsistency of the definition of emotional and psychological abuse. Physical abuse is defined as abuse that causes physical injuries (U.S. Department of Health and Human Services, 2009). Some examples of physical abuse are slapping, hitting, pushing, shaking, kicking, pinching, biting, choking, or hair-pulling. Physical abuse also includes, burning with cigarettes, throwing objects, scalding water, or hot objects. Both Latino (15.1%) and White (15%) children reported physical abuse at similar rates in 2008 (U.S. Department of Health and Human Services, 2008).

In contrast, a recent study found that Latinos were less likely to report physical abuse (Dakil, Cox, Lin, & Flores, 2011). However, evidence suggests that Latino parents tend to practice more harsh parenting styles, especially if they live in low income and dangerous communities (Fontes, 2002 & Gonzales, Coxe, Roosa, White, Knight, Zeiders & Saenz, 2011). Latino parents' harsh parenting has been depicted as an expression of them being proactive in protecting their children from harm.

Sexual abuse is defined as abuse that sexually violates a person's body without receiving consent (U.S.

Department of Health and Human Services, 2009). Some examples of sexual abuse are touching or kissing a child's genitals, making a child fondle an adult's genitals, forcing a child to undress, spying on a child in the bathroom, performing sexual acts in front of a child, exposing genitals, telling "dirty" stories, showing pornography, forcing child prostitution or child pornography.

Sexual abuse was reported more often for White than Latino children (10.3% vs. 8.3%) (U.S. Department of Health and Human Services, 2008). Other studies have found more Latina women reported being sexually abuse than White (Kercher and McShane, 1984; Tzeng and Schwarzin, 1990). These discrepancies in research may be related to the feeling of shame being expressed within each culture, which enables victims to be more confused with reporting past sexual abuse. In one study, Latinas were more likely to report shame or self-blame from their childhood sexual abuse than Whites (Feiring, Coates, & Taska, 2001). A different study found that Latina college students reported lower rates of childhood sexual abuse (Urquiza & Goodlin-Jones, 1994). Latina women are highly encouraged to remain virgins until marriage. By the victim reporting childhood

sexual abuse, this may identify them as damaged goods, creating a conflict between them and enabling them reporting sexual abuse. Another explanation for these discrepancies is that Latinos may be less likely to report sexual abuse due to cultural norms of loyalty and filial piety (Comas-Diaz, 1995).

Children who have experienced sexual abuse may be more likely to not disclose their abuse due to feeling shame. A study demonstrated that abused children who experience shame associated with their sexual abuse experience were more likely to experience PTSD symptoms (Feiring, Taska, & Lewis, 1998). Feiring and colleagues suggested that the relationship between abuse specific internal attributions and PTSD symptoms is mediated by the feeling of shame.

Summary

A review of the literature suggests that the current study is unique in that very few contain a sizeable sample of Latinas sample who have experienced childhood abuse. Additionally, no known study has explored shame mediation in the relationship between abuse type and PTSD symptoms. Although there is ample research regarding the relationship between shame and PTSD symptoms in child abuse survivors, mediation research ethnic investigations of the role of

- shame in influencing the development of PTSD symptoms remains limited. Additionally, no previous study has explored the relationship between abuse type and PTSD symptoms, when controlling for shame.

CHAPTER THREE

METHODOLOGY

Design

An existing archival data set will be used, focusing on a sample of female participants who have experienced childhood abuse (emotional, physical, and sexual). The variables being used to test the proposed hypotheses are ethnicity categorization, type of childhood abuse history, shame, and PTSD symptoms. A non-experimental correlational-regression design will be use for the study because we are interested in studying the relationships between childhood abuse history and the other variables of interest.

Participants

This study will utilize an existing archival data set from a larger study that is being conducted at California State University, San Bernardino (CSUSB) that is examining victims of childhood abuse. College women were recruited from various undergraduate Psychology and Human Development classes at the CSUSB campus. Those participants who were interested in participating were able to meet with a research assistant who administered the questionnaire and provided debriefing.

All participants had to be female and at least 18 years old to participate in the study. There were no other restrictions on who was allowed to participate. The college women were offered extra credit points toward a class of their choice. All of the participants were treated in accordance with the American Psychological Association ethical standards and safety monitoring. In addition, we had the approval of the CSUSB Institution Review Board to continue to collect data for the current study. Only participants who scored higher than 6 on the abuse measure indicating some degree of abuse were selected for analyses.

Procedures

Research assistants were given instruction on how to collect data from the prospective participants. Refer to Appendix A. The participants were given a packet that consisted of an informed consent, demographic sheet, and several self-report measures. While the participants completed the surveys in a setting that permitted multiple participants to fill out the surveys, two members of the research team stayed in the room to supervise participants and answer any questions regarding the survey. During the debriefing process, all participants were asked if they would like to discuss their experiences and feelings about

the study. In closing, all participants were given a resource packet with contact information for services regarding sexual assault, domestic violence, mental health and other support agencies.

Materials

The Informed Consent Form

The informed consent contained information that identified the name of the primary researchers for the present study. It also included additional information about the duration of the study, confidentiality and anonymity of their identity, and a reminder that they have the right to withdraw from participating at anytime. Refer to Appendix B.

The Demographics Sheet

The demographic sheet collected information regarding age, marital status, ethnicity, education and income level. Refer to Appendix C.

The Childhood Trauma Questionnaire

The Childhood Trauma Questionnaire (CTQ) is a measure that contains 25 items that measures the participants' exposure to childhood trauma (Bernstein, Stein, Newcomb, Walker, Pogge, Ahluvalia, Stroke, Handlesman, Medrano, Desmond & Williams, 2003). The CTQ scale consists of

statements that describe experiences of growing up as a child and as a teenager. The three different types of abuse being assessed were sexual (e.g. "Someone tried to make me do sexual things or watch sexual things."), emotional (e.g. "People in your family called you things like, stupid, lazy or ugly."), and physical (e.g., "People in my family hit me so hard that it left me with bruises or marks."). Each item is measured with a 4 point Likert-type scale to indicate 1 "never true" to 4 "very often true". In the original 70 items measure by Bernstein the Cronbach's alpha was .84. In the current study of the modified CTQ that consisted of 25 items was .58. Refer to Appendix D.

The Experience of Shame Scale

The Experience of Shame Scale (ESS) contains 24 items that measure the sense of shame in participants (Andrews, Quian, & Valentine, 2002). Sample items included "Have you felt ashamed of any of your personal habits?" and "Have you avoided people who have seen you fail?" Each item was measured with a 5 point Likert-type scale to indicate 0 "never" to 4 "almost always". Andrews' original measure that consisted of 25 items had a Cronbach's alpha of .93. In our study Cronbach's alpha of .96 existed for the shame scale. Refer to Appendix E.

The Penn Inventory for Post-Traumatic Stress Disorder

The Penn Inventory for PTSD is a measure that contains 26 items that measures the severity, frequency, and intensity of PTSD symptoms in participants that had developed PTSD symptoms (Hammarberg, 1992). Higher scores represent higher levels of PTSD symptoms. The Penn Inventory asked participants to pick a statement that best describes the way they feel. For example, (A) "I can concentrate better than ever," (B) "I can concentrate about as well as ever," (C) "I can't concentrate as well as I used to," and (D) "I can't concentrate at all." The original Penn Inventory by Hammarber, Cronbach's alpha was .94. In our study the PTSD scale had an internal consistency of .88. Refer to Appendix F.

The Resources Sheet

The Resources Sheet contains contact information of various resources that are in Riverside and San Bernardino Counties. Refer to Appendix G.

Data Analyses

The independent variables we proposed to study for predictive value of the dependent variable of PTSD, specifically PTSD symptoms, were child abuse and level of shame. As mentioned previously, participants who have

scores of 6 or higher on the various subscales of the CTQ measure (sexual, emotional, and physical abuse) are determined to have experienced some degree of child abuse. Types of child abuse were categorized as: sexual, emotional, and/or physical abuse. In addition, ethnicity categorization analyses will be created to determine whether the relationship between shame and PTSD symptoms varies as a function of ethnicity. The shame and PTSD measures are scored so that the higher the scores, the higher the level of shame and PTSD symptoms experienced. Several statistical analyses will be conducted using SPSS for this study. A descriptive analysis will be conducted to see the samples background and variable of interest. To study the mediation hypotheses, a serious of analyses will be done using SPSS (Statistical Package for the Social Sciences). Several correlation analyses and multiple regressions were run for each type of abuse to test relationship between abuse, shame, and PTSD. Two separate regressions analyses will be run for each type of abuse, which will be separated by ethnic group. The Sobel test will be used to test shame as the mediator between type of abuse and PTSD.

CHAPTER FOUR

RESULTS

Preliminary Analyses

Prior to examining the data any participants who were missing values, had extreme outliers that were separated from the data or did not meet assumptions for multivariate analysis were not analyzed to examine the specific hypotheses. Each variable of interest was screen separately for each ethnic group. Due to the nature of the measures (i.e., being positively skewed in the sample), several variables demonstrated non-normality. Additionally, the majority of the variables were leptokurtic with the exception of shame in Latinas which was mesokurtic and shame for Whites which was platykurtic. Scatterplots of residuals and predicted scores showed that all the assumptions of linearity and homoscedascity were met. A one-way ANOVA was used to examine whether ethnic differences excited for the variables of interest (see Table 1). The results indicated that that no significant differences existed across ethnic groups for all variables of interest used in the study.

Table 1. Summary of a One-Way ANOVA and Post Hoc Analyses Predicting Ethnic Differences for All Variables Examined in the Study

	Descriptive Statistics		
Variable	*F*	*p*	η^2
PSTD	.135	.713	.00
Shame	.056	.812	.00
Emotional Abuse	.802	.371	.00
Physical Abuse	1.493	.222	.00
Sexual Abuse	.727	.394	.00

Note. N = 400, *df*= (1, 398), $p < .05$

Among the 943 female participants who participated in the study, 400 women met criteria of experiencing childhood abuse. Two hundred and twenty-three women identified themselves as Latina and 177 identified as White. The average age for the participants was 26.51 with a range of 18-62 years old. Two hundred and fifty-nine (65%) of the participants identified marital status as single, 104 (26%) participants were married, 24 (6%) were divorced or separated, and 12 (3%) reported other marital status. One participant had completed Grade School/Middle School, 2 of the participants had some high school education, 27 completed high school or receive a GED, 168 had some

college, 173 had a received an Associate's degree, 22 had receive a Bachelor's degree, and 5 had a Post Graduate degree. The income range of the participants was less than $5,000 to more than $75,000 with an average income of $25,000 to $34,999. Fifty-four participants had reported a income less than $5,000, 78 reported $5,000 to $14, 999, 62 reported $15,000 to $24, 999, 45 reported $25,000 to $34, 999, 36 reported $35,000 to $44, 999, 29 reported $45,000 to $54, 999, 32 reported $55,000 to $64, 999, 12 reported $65,000 to $74, 999 and 47 reported $75,000 or more. Table 2 is a summary of the descriptive statistics of the variables of interest.

Table 2. Descriptive Statistics of all Sample

	Descriptive Statistics		
Variable	*M*	*SD*	*N*
PSTD	19.20	10.22	400
Shame	37.71	20.17	400
Emotional Abuse	10.01	5.18	400
Physical Abuse	7.67	4.17	400
Sexual Abuse	7.89	5.13	400

The Experience of Shame Scale had scores ranging from a low of 0 to a high of 96. The Penn Inventory for PTSD had scores ranging from a low of 0 to a high of 70. The CTQ

scores were broken down into emotionally (Range=2 to 25), physically (Range=1 to 25), and sexually abused groups (Range=2 to 25). Table 3, is a summary of the descriptive statistics of the variables of interest separated by ethnic group. Latinas had a higher mean in shame, emotional and sexual abuse. Whites had a higher mean in PTSD and physical abuse.

Table 3. Descriptive Statistics Separated by Ethnic Group

		Descriptive Statistics		
Ethnicity	Variable	*M*	*SD*	*N*
Latina				
	PSTD	19.37	10.65	223
	Shame	37.51	20.71	223
	Emotional Abuse	9.80	4.97	223
	Physical Abuse	7.90	4.14	223
	Sexual Abuse	7.70	4.81	223
White				
	PSTD	18.99	9.68	177
	Shame	37.99	19.53	177
	Emotional Abuse	10.27	5.43	177
	Physical Abuse	7.38	4.21	177
	Sexual Abuse	8.14	5.51	177

Note. N = 400

Hypotheses

Hypothesis I

It was predicted that there would be differences in shame and PTSD symptoms between ethnic groups among participants who had experienced childhood abuse. An independent-samples t-test was conducted to compare shame scores between ethnicity groups. Whites had higher mean shame (M = 37.99, SD = 19.53) than Latinos (M = 37.51, SD = 20.71). However, the difference between both groups in shame scores was not significant $t(398) = -.238$, $p = .503$. Similarly, there was no ethnic difference between groups when we looked at PTSD symptoms reported, $t(398) = .368$, $p = .252$. Despite being higher, Latinas' mean scores on PTSD (M = 19.37, SD = 10.65) were not statistically significantly higher than Whites (M = 18.99, SD = 9.68). Figure 2, illustrates that differences between PTSD or shame means are not that different. To sum up the results related to hypothesis one, no ethnic differences were found in shame or PTSD scores.

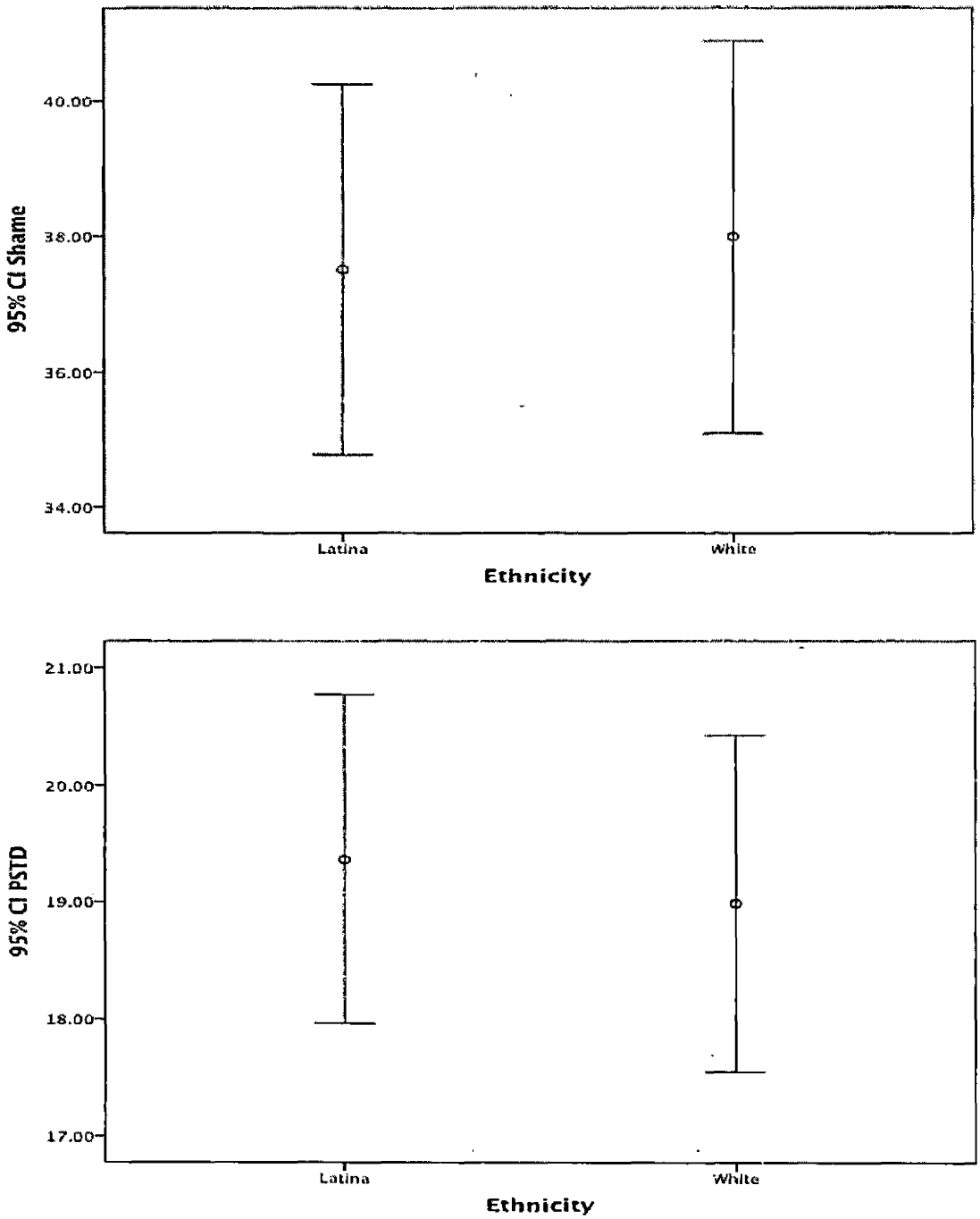

Figure 2. Error Bar Graph of Shame and Post-Traumatic Stress Disorder 95% Confidence Interval by Ethnicity

Hypothesis II

It is hypothesized that there will be a relationship in shame and PTSD symptoms with all types of childhood abuse. A series of Pearson product-moment correlation coefficients were conducted to examine these relationships. The shame and PTSD variables were expected to be highly correlated with emotional, physical and sexual abuse. As shown in Table 4, illustrates shame and PTSD positively correlated with all three types of abuse. In other words, increased symptoms of PTSD or shame were related with the increase of all types of abuse.

Table 4. Correlations of Post-Traumatic Stress Disorder and Shame by Type of Abuse

	Type of Abuse		
Variable	Emotional	Physical	Sexual
PTSD	.43*	.33*	.22*
Shame	.42*	.24*	.24*

Note. N = 400, $^{**}p < .01$.

As expected, the Pearson product-moment correlation coefficients showed all positive relationships. The strength of the relationships between emotional abuse and PTSD, and physical abuse and PTSD was medium. Shame had a

small relationship with physical and sexual abuse. The strength of the relationship between shame and emotional abuse was medium. The strength of the relationship between shame and physical and sexual abuse was small. The Fisher's r to z transformation was used to evaluate whether the correlations between types of abuse and shame or PTSD were significantly different. Refer to Table 5.

Table 5. Difference Between Type of Abuse Correlations

	Comparison between Types of Abuse		
Variable	EP	PS	SE
PTSD	1.65	1.68	3.33**
Shame	2.86**	0	2.86**

Note. EP= Emotional vs. Physical; PS= Physical vs. Sexual; SE= Sexual vs. Emotional. N = 400. Fisher's r to z transformation, $*p < .05$, $**p < .01$

The Pearson *r*-values showed that there were no differences between both ethnic groups' correlations because all the variables were statistically significant for both groups (refer to Table 6). Shame was correlated with emotional abuse, $r(398) = .42$, $p < .01$, and for physical abuse, $r(398) = .24$, $p < .01$. The difference between these correlations was statistically significant, *z*

= 2.86, $p < .01$. Also, shame was correlated with emotional abuse, $r(398)=.42$, $p < .01$, and sexual abuse, $r(398) = .24$, $p < .01$. The difference between these correlations was statistically significant, $z = 2.86$, $p < .01$. Lastly, PTSD was correlated with emotional abuse, $r(398) = .43$, $p < .01$, and for sexual abuse, $r(398) = .22$, $p < .01$. The difference between these correlations was also statistically significant, $z= 3.33$, $p < .01$. As illustrated in Table 7 Latinas, PTSD was correlated with emotional abuse, r (221) = .40, $p < .01$, and for sexual abuse, $r(221) = .17$, $p < .05$. The difference between these correlations was statistically significant, $z = 2.64$, $p < .01$. In Whites, shame was correlated with emotional abuse, $r(175) = .45$, $p < .01$, and for sexual abuse, $r(175) = .25$, $p < .01$. The difference between these correlations was statistically significant, $z = 2.14$, $p < .01$.

Table 6. Correlations of Post-Traumatic Stress Disorder and Shame Separated by Type of Abuse and Ethnic Group

		Type of Abuse		
Ethnicity	Variable	Emotional	Physical	Sexual
Latina				
	PTSD	.40**	.32**	.17*
	Shame	.39**	.22**	.23**
White				
	PTSD	.46**	.36**	.28**
	Shame	.45**	.28**	.25**

Note. N= 400, *p < .05, **p < .01

Table 7. Difference Between Type of Abuse Correlations Separated by Ethnicity

		Comparison between Types of Abuse		
Ethnicity	Variable	EP	PS	SE
Latina				
	PTSD	0.96	1.68	2.64**
	Shame	1.97	0.11	1.86
White				
	PTSD	1.12	0.83	1.96
	Shame	1.84	0.3	2.14*

Note. EP= Emotional vs. Physical; PS= Physical vs. Sexual; SE= Sexual vs. Emotional. Latina (n= 223), White (n= 177), Fisher's r to z transformation, *p < .05, **p < .01

Hypothesis III

It is hypothesized that there will be ethnic differences in the relationships between shame and PTSD symptoms for the Latinas and Whites, separated by type of abuse. Similar to the analyses for hypothesis 1, a series of Pearson product-moment correlation coefficients were conducted. It was expected to find ethnic group differences in the relationships between shame and PTSD symptoms, separated by type of abuse.

No significant correlation comparisons were found in PTSD or shame between any types of abuse (please see Table 8). Both Latinas and Whites exhibited a small relationship between shame and physical and sexual abuse. Also both ethnic groups demonstrated a small relationship between sexual abuse and PTSD. Similarly, both ethnic groups had medium strength relationships between shame and emotional abuse. Additionally, both groups had a medium strength relationship between both emotional and physical abuse and PSTD symptoms. Result showed that both ethnic groups showed stronger and positive relationships between shame and emotional abuse. Also, both ethnic groups had stronger and positive relationships between PTSD symptoms and emotional and physical abuse. Overall, when separated by

types of abuse, all correlations were positive and showed no ethnic differences between the reports of PTSD or shame.

Table 8. Difference Between Ethnicity Correlations Separated by Types of Abuse

		Comparison between Ethnic Groups
Variable	Types of Abuse	Latino vs. White
PTSD		
	Emotional	0.72
	Physical	0.63
	Sexual	0.21
Shame		
	Emotional	0.73
	Physical	0.73
	Sexual	1.14

Note. Latina (n= 223), White (n= 177), Fisher's r to z transformation, $*p < .05$, $**p < .01$

Hypothesis IV

It is hypothesized that there would be differences in PTSD symptoms between ethnic groups and between the types of childhood abuse that impact the development of symptoms related to PTSD, mediated by the feeling of shame. A significant correlation existed between the type of abuse, shame and PTSD (refer to Table 4). Table 9, illustrated that path a, b, and c are all individually significant

(refer to Figure 3). For both ethnic groups, the effect of all types of abuse on PTSD symptoms was partially mediated by shame. Hence, the relationship between all abuse types and PTSD decreased substantially when controlling for shame.

Table 9. Coefficients of Shame as a Mediator of Abuse and Post-Traumatic Stress Disorder by Ethnic Group

		Type of Abuse		
Ethnicity	Pathway (z)	Emotional	Physical	Sexual
Latina	n	223	223	223
	a	1.63*	1.10*	.98*
	b	.30*	.30*	.30*
	c	.87*	.81*	.37*
	c-prime	.25*	.27*	.29*
	z	5.42*	3.18*	3.29*
White	n	177	177	177
	a	1.63*	1.30*	.88*
	b	.28*	.28*	.28*
	c	.82*	.82*	.50*
	c-prime	.22*	.25*	.26*
	z	5.38*	3.55*	3.18*

Note. N= 400. The raw standarized coefficients are being illustrated. *$p < .05$

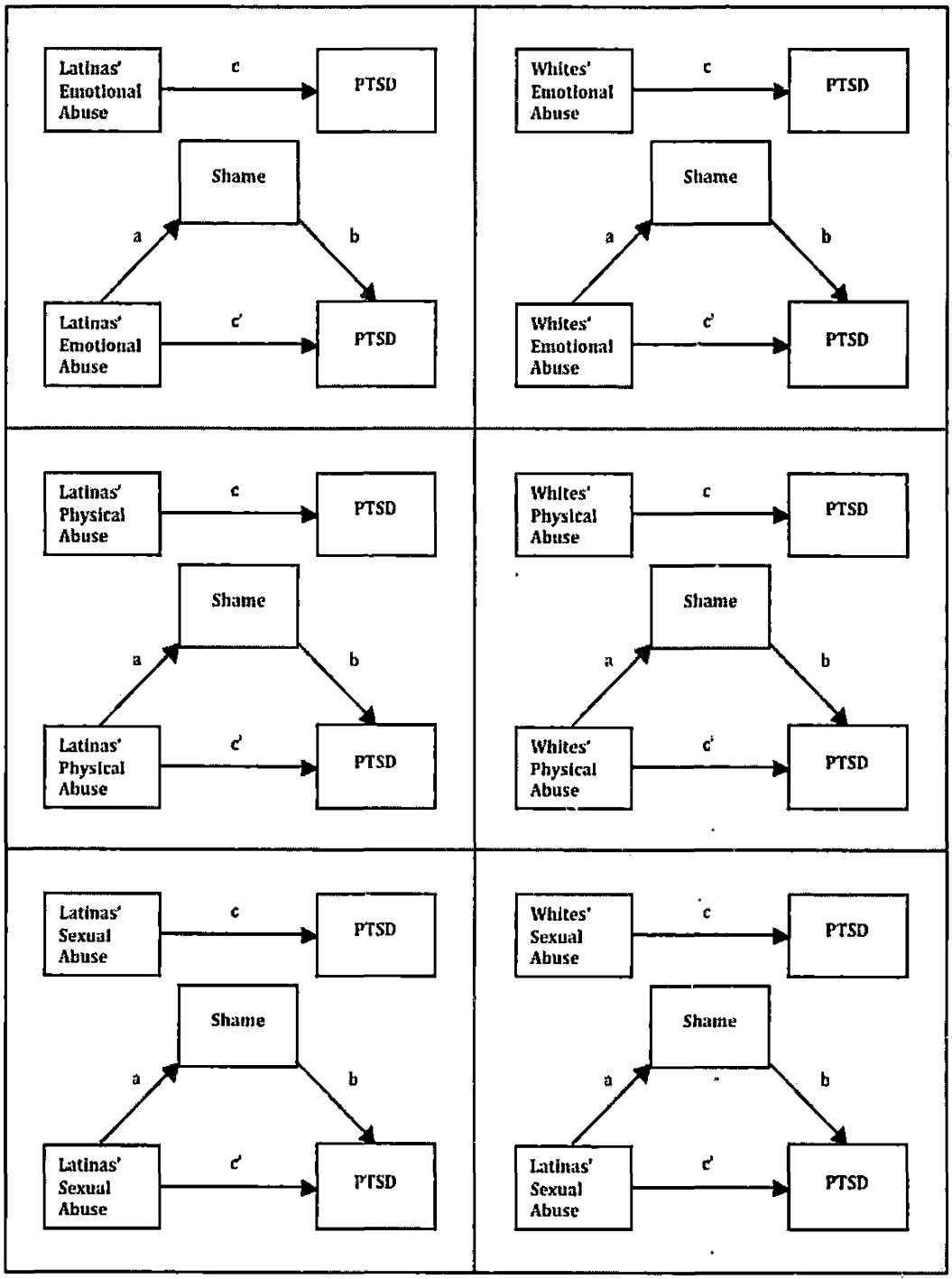

Figure 3. Hypothesis 4: Paths Demonstrated in Table 8

CHAPTER FIVE

DISCUSSION

It was hypothesized that there would be differences in shame and PTSD symptoms between ethnic groups among women who had experienced childhood abuse. Results indicated that no significant differences existed when shame and PTSD symptoms were compared across ethnic groups. Our results suggest that childhood abuse does not "discriminate" in the development of shame or PTSD symptoms within women of Latino or White ethnic backgrounds.

However, in a study by Pole, Best, Metzler and Marmar (2005), they found that Latina police officers had a higher risk of severity in the development of PTSD symptoms compared to White officers. They also found that Latinas were more likely to participate in self-blame coping. Similarly, Feiring, Coates, and Taska (2001) found that Latina children showed higher general shame than Whites, but it was not related to past childhood abuse. White children showed the highest level for internal shame. They explained that ethnic differences existed among Latinos due to the influence of the dominant Catholic religion on

shame. Catholic religion adherents often report feeling shame in everyday situations related to sin.

One explanation of not finding ethnic differences in our study may be that cultural and ethnicity factors were less influential in our sample due to it being a sample of university students and Latinas in the sample are less likely to be traditional in their world view than non-university Latinas. Despite this being a more ethnically diverse sample population than those in private or UC level colleges, new immigrant or early generation students in a four-year institution likely have adapted to the White American culture to help them successfully navigate through their new residential environment. Essentially, it could be possible that shame and PTSD symptoms did not differ in ethnic groups due to both groups sharing the same general culture.

Secondly, it was hypothesized that there would be a relationship between increase of shame and PTSD symptoms across all types of childhood abuse. Over all, increased rates of all types of abuse were related to an increase of shame and PTSD symptoms. Results from the correlation comparisons suggested that emotional abuse was significantly more strongly associated to shame than

physical or sexual abuse. Similarly, emotional abuse was significantly more strongly associated to PTSD than sexual abuse.

Regardless of who is abusing the child, each act of abuse is a form of being shamed. It can be possible that emotionally abused children may grow up with an internalized belief that there is something wrong with them. Children's lack of logical thinking and egocentrism may lead them to blame themselves for the abuse without questioning the perpetrator's actions. More specifically, it may be possible that emotional abuse may confirm a child owns negative self-blaming believes, especially if the perpetrator is much older. This possibility helps to explain our finding that emotional abuse was most strongly linked with shame within our college women sample.

The development of PTSD in physical and sexual childhood abuse survivors have been explored more often than emotional abuse (Yehuda, Halligan, & Gross, 2001; Yehuda, Spertus, & Golier, 2001). Our findings were consistent with the study of Spertus and colleagues (2003), who found that having a higher emotional abuse experience had significantly higher PTSD symptoms. They explained that

exposure to emotional abuse can be an important risk factor for predicting the development of PTSD symptoms.

In this study, we did not take into account how many distinct types of abuse each woman experienced. It is possible that not controlling for the number of types of abuse experienced by each woman could have impacted the results. Generally, while research has primarily focused on single types of abuse and trauma, most abused children experience more than one type of abuse across the period of time they are abused (Higgins, 2004; Kinard, 1994). Having a history of two or more types of abuse has been found to predict higher levels of traumatic symptoms in childhood abuse survivors (Clemmons, Walsh, & DiLillo, 2007; Green, Goodman, & Krupnick, 2000; Vranceanu, Hobfoll, & Johnson, 2007).

Third, it was hypothesized that there would be ethnic differences in the relationships between shame and PTSD symptoms, separated by type of abuse. In general, for both ethnic groups increased rates of all types of abuse were related to an increase of shame and PTSD symptoms. Significant findings in the comparison of ethnic and type of abuse relationships to shame and PTSD symptoms were found. Results indicated that Latinas' PTSD was much higher

in relation to emotional abuse compared to sexual abuse. For Whites shame was much higher in relation to emotional abuse compared to sexual abuse. It appears that emotional abuse may have greater negative outcomes than physical and sexual abuse.

We extended Spertus, Yehuda, Wong, Halligan, and Seremetis (2003) findings of emotional abuse predicting PTSD by looking at ethnic differences. We found that Latinas' PTSD related to emotional abuse was much more than Whites. Since emotional abuse can brainwash a child's self-beliefs and identity, it can be possible that minority women who experience childhood emotional abuse may grow up having experienced many forms of emotional abuse such as neglect and verbal (social or self), especially, if they experience emotional abuse from love ones or related to their ethnicity or race. This may lead them to feel negative emotions (self-pity, fear, anger, hostility, shame, regret, grief or resentment) that might lead to the development of PTSD symptoms. These findings demonstrate that more research should be done to understand the nature of how emotional abuse impacts the development of PTSD within Latinas.

Today, various subcategories of shame have been discussed in the literature. For example, body shame, internal shame, false shame, genuine shame, behavioral shame, secret shame, and vicarious shame. Pines (2005) identified that toxic shame is the closest subcategory of shame that mainly develops in all types of childhood abuse and trauma. Toxic shame is described as the person being defective or something being wrong with them. More specifically toxic shame is related more to past childhood abuse and trauma. The ESS measure that the current study used to assessed shame only includes questions that related to behavior or bodily shame and not past childhood experience of abuse or toxic shame. The relationship between Whites' emotional abuse reports and reports of shame could be related to behavior and bodily shame, which can possibly explain why no ethnic differences were found in our shame measure.

Fourth, it was hypothesized that there will be differences in PTSD symptoms between ethnic groups and between the types of childhood abuse that impact the development of symptoms related to Post-Traumatic Stress Disorder, mediated by the feeling of shame.

Few researchers have appreciated the importance of shame for ethnically diverse victims who have developed PTSD symptoms, (Mason et al. 2001). Yet, it has been clearly reported that shame is a significant factor in the development of PTSD syndrome (Wong & Cook, 1992). A study by Feiring, Taska, & Lewis, (1998) is one of the few that has looked at shame as a mediator in the relationship between abuse and PTSD. Similarly, a study by Kim, Talbot, and Cicchetti (2009) looked at the role of shame in childhood sexually abused women and the relationship with interpersonal conflicts. However, neither study has looked at ethnic differences and examined abuse types. Unfortunately, ethnic group differences on the role of shame in PTSD have not received adequate research attention.

Our results showed no ethnic differences between Latinas and Whites. Across all abuse types, PTSD decreased substantially when controlling for shame. Our finding supports the importance of shame as a mediator for the following experiences of emotional abuse (Wright, Crawford, & Del Castillo, 2009), physical abuse(Bennett, Sullivan, & Lewis, 2005)and sexual abuse(Feiring & Taska, 2005)but do not suggest ethnic differences in this finding.

A possible explanation of the absence of differences in the effect of shame mediating the relationship between abuse and PTSD could have been related to the shame survey that we used. The Experience of Shame Scale asked questions about more general events related to shame rather than abuse specific related shame questions (Andrews, 2002). A non-abuse specific shame measure may have not discerned between negative uses of shame and culturally consonant uses of shame with regard to group socialization discussed in the literature regarding Latino socialization patterns.

These findings demonstrate that it is important to study the types of abuse that impacts the development of shame and PTSD symptoms. Furthermore, ethnicity status should not be overlooked, especially since shame and PTSD has been related to experiencing abuse. In conclusion, as far as we know, the findings from the current study are the first to be studied related to types of childhood abuse and ethnic differences, mediating shame in the relationship of abuse and PTSD.

Limitations

A limitation of the present study was that the data was archival in nature. Unfortunately, the archival data set didn't provide a measure that investigated

acculturation and specific childhood abuse- related shame questions.

A second limitation is that all the participants reside in Southern California, and the results may not be generalizable to women who live in other areas especially outside the United States because we do not yet understand how shame may play a role in different cultures.

Another limitation is that our sample is a university sample. Their rates of shame and PTSD symptoms may not be as high as those in the general population. This is because their ability to be enrolled in a 4-year university may make them resilient despite prior childhood abuse. Therefore, generalizing the result to the population can have a problem in applying the results from the university sample.

The final limitation was that no other ethnic groups were explored to see if ethnic differences exist in abuse type, shame, and PTSD symptoms across other groups in the current study. The archival data set includes data from other ethnic groups but the sample sizes limit their utility.

Future Research

Prospective studies should further document the relationship across various ethnic groups between types of childhood abuse and PTSD development when mediated by shame. Replicating studies should also add more shame measures specifically related to toxic shame that more specifically address past childhood abuse related shame. It is also important to focus on how shame influences the reporting of PTSD symptoms in ethnically diverse child abuse samples. This can clarify whether childhood abuse victims from different ethnic groups should have different types of therapy including Cognitive Behavior Therapeutic treatment.

Future studies should consider including measures that look at generational status see if reports of shame or PTSD symptoms are influenced by childhood abuse history. For example, as generations continue to develop in a new culture, more acculturation may occur towards the dominant culture. Additionally, religion status should also be measure. More specifically, it would be useful to see whether some religions use shaming towards peoples behaviors, actions, or past events.

In addition, research should focus on understanding the type of abuse leading to the greatest negative outcomes and further understand the worst combinations of abuse types that increase negative psychological outcomes. Lastly, adding male participants to the study can help understand how much society's popular cultures, impact a person report to abuse.

Conclusions

The current study did not find ethnic differences in shame and PTSD symptoms in women who experienced childhood abuse. Similarly, the findings showed no ethnic differences in shame mediating the relationship between abuse types and PTSD symptoms. It is possible that Latina women in the sample were more likely to familiarize to the dominant White culture, resulting in no ethnic differences in childhood negative outcomes. These results are inconclusive and another study should be conducted in which these relationships can be studied closely.

From this study it was evident that increased rates of any type of abuse were related to an increase of shame and PTSD symptoms. Similarly, for both ethnic groups increased rates of all types of abuse were related to an increase of shame and PTSD symptoms. However, it was shown that

emotional abuse was more strongly associated to shame than physical or sexual abuse. For Whites shame was much higher in relation to emotional abuse compared to sexual abuse. Also, it was shown that emotional abuse was more strongly associated to PTSD than sexual abuse. For Latinas' PTSD was much higher in relation to emotional abuse compared to sexual abuse. It appears that emotional abuse may have greater negative outcomes than physical and sexual abuse. More importantly emotional abuse may vary on the outcomes of shame or PTSD symptoms between Latina and White women.

Together, these findings indicate that type of childhood abuse and ethnic status are important factors in the development of shame and PTSD symptoms. It is important to continue research on understanding the role of type of childhood abuse within ethnic groups in the relation to the development of shame and PTSD symptoms. Parents, therapist, and health educators may find this information useful when developing intervention programs that focus on ethnically diverse populations that have experience childhood abuse, which in turn, impacted the development of negative outcomes.

APPENDIX A

DATA COLLECTION INSTRUCTIONS

Data Collection Instructions

1 Preferably 20 minutes before your data collection session, get materials for your data collection session(s) from research team leader.

2 Set up conference room for largest number of subjects expected (based on sign up sheet), prepare same number of packets.

3 As people arrive, check them off the sign up sheet and usher them into the room. Remember to keep your and their voices at a reasonable and professional level.

4 One research assistant should remain near the door with the sign up sheet until all individuals have shown up or until 15 minutes have elapsed into the hour.

5 Once most people are there, give the following verbal instructions:

> **"This study is designed to measure a number of factors including potentially traumatic experiences in childhood and adulthood as well as factors that may facilitate resiliency in women. In a moment, I will ask you to read the Informed Consent Form, but I would like to highlight a few points. Some of the questions are very personal. Your answers will be anonymous. No one on the research team will share the nature of any specific person's answers. In addition, your participation is voluntary. You are free to stop participating at any time without penalty. I will now ask you to read the consent form, follow the instructions if you agree to participate and begin the packet. At least one of us will be available if you have any questions."**

6 As people finish, take them to a "private space" outside the conference room, hand them a Resource sheet. Let them read it, then ask them whether they would like to discuss their experience.

7 If participants look stress recommend then to go to the Community Counseling Center. Only if you think they are in danger send them or take them to the non-emergency campus police department.

8 Returned completed and uncompleted packets to research team leader.

APPENDIX B

INFORMED CONSENT FORM

Trauma and Resiliency in Women's Lives

Informed Consent Form

The following study is designed to measure potentially traumatic experiences in childhood and adulthood as well as factors that may facilitate resiliency in women. This study is being conducted by Guadalupe Valdivia under the supervision of Dr. David Chavez, Professor of Psychology at the California State University, San Bernardino (CSUSB). This study has been reviewed and approved by the Institutional Review Board of CSUSB. The University requires that you give your consent before participating in this study.

In this study you will be asked to complete a packet of questionnaires designed to measure traumatic experiences, resiliency, and mental health. The packet should take approximately 45 min. to 1 hour to complete. All of your responses will be anonymous. At no time will your name be requested or recorded during your participation. Presentation of the results will be reported in group format only. Upon completion of this study (July, 2012), you may receive a report of the group results.

Your participation in the study is entirely voluntary. You are free to withdraw your participation at any time during the study without penalty or remove any data at any time. No services currently being provided to you will be affected if you choose not to participate. When you complete the packet of questionnaires, you will receive a debriefing statement describing the study in more detail and, if you are a CSUSB student, at your instructor's discretion, you may receive a slip for four units of extra credit.

If you have any questions concerning this study or your participation in this research, please feel free to contact Dr. David Chavez at (909) 537-5572.

I acknowledge that I have been informed of, and understand the nature and purpose of the study, and I freely consent to participate. I acknowledge that I am at least 18 years of age

_____ _____

Place an "X" above indicating your agreement

Date

APPENDIX C

DEMOGRAPHICS

Demographics

Instructions: Please fill in each item below.

Your age:_____

Your gender (circle one): Male Female

Marital Status (circle one): Single Married Divorced/Separated Other_____

Ethnicity
Check the statement that best describes your ethnic background

____ Asian-American
____ American Indian
____ Black (non-Hispanic, including African American)
____ Mexican-American/Chicano
____ Hispanic/Latino (non Mexican-American)
____ Pacific Islander
____ White (non Hispanic/Latino)
____ Other (please specify)_____

Education
Your highest level of education completed

____ Grade School/Middle School
____ Some High School
____ High School Diploma/GED
____ Some College
____ Associates Degree
____ Bachelors Degree
____ Post Graduate Degree

Yearly Gross Income
Check the statement that most nearly reflects your family's annual gross income

____ Less than $4,999
____ 5,000 to 14,999
____ 15,000 to 24,999
____ 25,000 to 34,999
____ 35,000 to 44,999
____ 45,000 to 54,999
____ 55,000 to 64,999
____ 65,000 to 74,999
____ 75,000 or more

Demographics. Unpublished manuscript.

APPENDIX D

CHILDHOOD TRAUMA QUESTIONNAIRE

CTQ

Instructions: These questions ask about some of your experiences growing up as a child and a teenager. Although these questions are of a personal nature, please try to answer as honestly as you can.

1 = Never True **3 = Sometimes True** **5 = Very Often True**
2 = Rarely True **4 = Often True**

When I was growing up…

1 I didn't have enough to eat. 1 2 3 4 5

2 I knew that there was someone to take care of me and protect me. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

____Mother ____Parent's Boyfriend or Girlfriend
____Father ____Ones Own Relationship Partner
____Family member ____Foster Parent/Someone in the Home
____Friend ____Cousin
____Both Parents ____Sibling(s)
____Stepparent ____Babysitter
____School Personnel ____Stranger
____Other:_____

3 People in your family called you things like, stupid, lazy or ugly. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

____Mother ____Parent's Boyfriend or Girlfriend
____Father ____Ones Own Relationship Partner
____Family member ____Foster Parent/Someone in the Home
____Friend ____Cousin
____Both Parents ____Sibling(s)
____Stepparent ____Babysitter
____School Personnel ____Stranger
____Other:

4 My parents were too drunk or too high to take care of the family. 1 2 3 4 5

5 There was someone in my life that helped me feel that I was important or special. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

____Mother	____Parent's Boyfriend or Girlfriend
____Father	____Ones Own Relationship Partner
____Family member	____Foster Parent/Someone in the Home
____Friend	____Cousin
____Both Parents	____Sibling(s)
____Stepparent	____Babysitter
____School Personnel	____Stranger
____Other:	

6 I had to wear dirty clothes. 1 2 3 4 5

7 I felt loved. 1 2 3 4 5

8 I thought that my parents wished I had never been born. 1 2 3 4 5

9 I got hit so hard by someone in my family that I had to see a doctor or go to the hospital. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

____Mother	____Parent's Boyfriend or Girlfriend
____Father	____Ones Own Relationship Partner
____Family member	____Foster Parent/Someone in the Home
____Friend	____Cousin
____Both Parents	____Sibling(s)
____Stepparent	____Babysitter
____School Personnel	____Stranger
____Other:	

10 There was nothing I wanted to change about my family. 1 2 3 4 5

11. People in my family hit me so hard that it left me with bruises or marks. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

____Mother	____Parent's Boyfriend or Girlfriend
____Father	____Ones Own Relationship Partner
____Family member	____Foster Parent/Someone in the Home
____Friend	____Cousin
____Both Parents	____Sibling(s)
____Stepparent	____Babysitter
____School Personnel	____Stranger
____Other:	

12 I was punished with a belt, a board, a cord, or some other hard object. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

____Mother	____Parent's Boyfriend or Girlfriend
____Father	____Ones Own Relationship Partner
____Family member	____Foster Parent/Someone in the Home
____Friend	____Cousin
____Both Parents	____Sibling(s)
____Stepparent	____Babysitter
____School Personnel	____Stranger
____Other:_____	

13. People in my family looked out for each other. 1 2 3 4 5

14 People in my family said hurtful or insulting things to me. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

____Mother	____Parent's Boyfriend or Girlfriend
____Father	____Ones Own Relationship Partner
____Family member	____Foster Parent/Someone in the Home
____Friend	____Cousin
____Both Parents	____Sibling(s)
____Stepparent	____Babysitter
____School Personnel	____Stranger
____Other:_____	

15 I believe I was physically abused. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

____Mother	____Parent's Boyfriend or Girlfriend
____Father	____Ones Own Relationship Partner
____Family member	____Foster Parent/Someone in the Home
____Friend	____Cousin
____Both Parents	____Sibling(s)
____Stepparent	____Babysitter
____School Personnel	____Stranger
____Other:	

16 I had the perfect childhood. 1 2 3 4 5

17 I got hit or beaten so badly that it was noticed by someone like a teacher, neighbor, or doctor. 1 2 3 4 5

If you answered 2 - 5, please specify who hit you (check all that apply):

____Mother	____Parent's Boyfriend or Girlfriend
____Father	____Ones Own Relationship Partner
____Family member	____Foster Parent/Someone in the Home
____Friend	____Cousin
____Both Parents	____Sibling(s)
____Stepparent	____Babysitter
____School Personnel	____Stranger
____Other:	

18 I felt that someone in my family hated me. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

____Mother	____Parent's Boyfriend or Girlfriend
____Father	____Ones Own Relationship Partner
____Family member	____Foster Parent/Someone in the Home
____Friend	____Cousin
____Both Parents	____Sibling(s)
____Stepparent	____Babysitter
____School Personnel	____Stranger
____Other:_____	

19 People in my family felt close to each other. 1 2 3 4 5

20 Someone tried to touch me in a sexual way, or tried to make me touch them. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

____Mother	____Parent's Boyfriend or Girlfriend
____Father	____Ones Own Relationship Partner
____Family member	____Foster Parent/Someone in the Home
____Friend	____Cousin
____Both Parents	____Sibling(s)
____Stepparent	____Babysitter
____School Personnel	____Stranger
____Other:_____	

21 Someone threatened to hurt me or tell lies about me unless I did something sexual with them. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

____Mother	____Parent's Boyfriend or Girlfriend
____Father	____Ones Own Relationship Partner
____Family member	____Foster Parent/Someone in the Home
____Friend	____Cousin
____Both Parents	____Sibling(s)
____Stepparent	____Babysitter
____School Personnel	____Stranger
____Other:_____	

22 I had the best family in the world. 1 2 3 4 5

23 Someone tried to make me do sexual things or watch sexual things. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

____Mother	____Parent's Boyfriend or Girlfriend
____Father	____Ones Own Relationship Partner
____Family member	____Foster Parent/Someone in the Home
____Friend	____Cousin
____Both Parents	____Sibling(s)
____Stepparent	____Babysitter
____School Personnel	____Stranger
____Other:_____	

24 Someone molested me. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

____Mother	____Parent's Boyfriend or Girlfriend
____Father	____Ones Own Relationship Partner
____Family member	____Foster Parent/Someone in the Home
____Friend	____Cousin
____Both Parents	____Sibling(s)
____Stepparent	____Babysitter
____School Personnel	____Stranger

____Other:_____

25 I believed that I was emotionally abused. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

____Mother	____Parent's Boyfriend or Girlfriend
____Father	____Ones Own Relationship Partner
____Family member	____Foster Parent/Someone in the Home
____Friend	____Cousin
____Both Parents	____Sibling(s)
____Stepparent	____Babysitter
____School Personnel	____Stranger

____Other:

26 There was someone to take me to the doctor if I needed it. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

____Mother	____Parent's Boyfriend or Girlfriend
____Father	____Ones Own Relationship Partner
____Family member	____Foster Parent/Someone in the Home
____Friend	____Cousin
____Both Parents	____Sibling(s)
____Stepparent	____Babysitter
____School Personnel	____Stranger

____Other:_____

27 I believed that I was sexually abused. 1 2 3 4 5

If you answered 2 - 5, please specify who (check all that apply):

____Mother	____Parent's Boyfriend or Girlfriend
____Father	____Ones Own Relationship Partner
____Family member	____Foster Parent/Someone in the Home
____Friend	____Cousin
____Both Parents	____Sibling(s)
____Stepparent	____Babysitter
____School Personnel	____Stranger
____Other:	

28 My family was a source of strength and support. 1 2 3 4 5

Some items adapted from: Bernstein, D. P., Stein, J. A., Newcomb, M. D., Walker, E., Pogge, D., Ahluvalia, T., Stroke, J., Handlesman, L., Medrano, M., Desmond, D., & William, Z. (2003). Development and validation of a brief screening version of the childhood trauma questionnaire. *Child Abuse & Neglect, 27*(2), 169-191.

APPENDIX E

EXPERIENCE OF SHAME SCALE

ESS

Instructions: Everybody can feel embarrassed, self-conscious or ashamed at times. Below are a series of questions about such feelings. Please indicate if this feeling has occurred *at any time in the past year*. Be as honest as possible. Remember that there are no right or wrong answers. Read each item carefully and decide how you feel about it; then circle the number of the item that best describes your feelings in the past year. Put down your first impressions. Please answer every item.

0 = Never
1 = Rarely
2 = Sometimes
3 = Often
4 =Almost Always

1	Have you felt ashamed of any of your personal habits?	0	1	2	3	4
2	Have you worried about what other people think of any of your personal habits?	0	1	2	3	4
3	Have you tried to cover up or conceal any of your personal habits?	0	1	2	3	4
4	Have you felt ashamed of your manner with others	0	1	2	3	4
5	Have you avoided people because of your manner?	0	1	2	3	4
6	Have you felt ashamed of the sort of person you are?	0	1	2	3	4
7	Have you worried about what other people think of you?	0	1	2	3	4
8	Have you tried to conceal the sort of person that you are from others?	0	1	2	3	4
9	Have you felt ashamed of your ability to do things?	0	1	2	3	4
10	Have you worried about what other people think of your ability to do things?	0	1	2	3	4
11	Have you avoided people because of your inability to do things?	0	1	2	3	4
12	Do you feel ashamed when you do something wrong?	0	1	2	3	4
13	Have you worried about what other people think of you when you do something wrong?	0	1	2	3	4
14	Have you tried to cover up or conceal things you felt ashamed of having done?	0	1	2	3	4
15	Have you felt ashamed when you said something you felt was stupid?	0	1	2	3	4
16	Have you worried about what others people think of you when you say something stupid?	0	1	2	3	4
17	Have you avoided contact with anyone who knew you had said something stupid?	0	1	2	3	4
18	Have you felt ashamed when you failed at something that was important to you?	0	1	2	3	4
19	Have you worried about what other people think of you when you fail?	0	1	2	3	4
20	Have you avoided people who have seen you fail?	0	1	2	3	4
21	Have you felt ashamed of your body or any part of it?	0	1	2	3	4
22	Have you worried about what other people think of your appearance?	0	1	2	3	4
23	Have you avoided looking at yourself in the mirror?	0	1	2	3	4
24	Have you wanted to hide or conceal your body or any part of it?	0	1	2	3	4

Andrew, B., Quian, M., & Valentine, J.V. (2002). Predicting depression symptoms with a new measure of shame: The experience of shame scale. *British Journal of Clinical Psychology, 41,* 29-42.

APPENDIX F

PENN INVENTORY FOR POST-TRAUMATIC STRESS DISORDER

Penn Inventory

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group that best describes the way you have been feeling during the **PAST WEEK, INCLUDING TODAY**! Circle the number beside the statement you picked. Be sure to read all the statements in each group before making your choice. Please continue on the other side.

1 A. I don't feel much different than other people my age.
B. I feel somewhat different than most other people my age.
C. I feel so different than most other people my age that I choose pretty carefully who I'll be with and when.
D. I feel so totally alien from most other people my age that I stay away from all of them at all costs.

2 A. I care as much about the consequences of what I'm doing as most other people.
B. I care less about the consequences of what I'm doing that most other people.
C. I care much less about the consequences of what I'm doing that most other people.
D. Often I think, "Let the consequences be damned!" because I don't care about them at all.

3 A. When I want to do something for enjoyment I can find someone to join me if I want to.
B. I am able to do something for enjoyment even when I can't find someone to join me.
C. I lose interest in doing things for enjoyment when there's no one to join me.
D. I have no interest in doing anything for enjoyment at all.

4 A. I rarely feel jumpy or uptight.
B. I sometimes feel jumpy or uptight.
C. I often feel jumpy or uptight.
D. I feel jumpy and uptight all of the time.

5 A. I know someone nearby who really understands me.
B. I'm not concerned whether anyone nearby understands me.
C. I'm worried because no one nearby really understands me.
D. I'm very worried because no one nearby really understands me at all.

6 A. I'm not afraid to show my anger because it's not worse or better than anyone else's.
B. I'm sometimes afraid to show my anger because it goes up quicker than other people's.
C. I'm often afraid to show my anger because it might turn to violence.
D. I'm so afraid of turning violent that I never allow myself to show anger at all.

7 A. I don't have any past traumas to feel overly anxious about.
B. When someone reminds me of my past traumas I feel anxious but I can tolerate it.
C. When someone reminds me of my past traumas I feel very anxious and must really make an effort to tolerate it.
D. When someone reminds me of my past traumas I feel so anxious I can hardly stand it and have no way to tolerate it.

8 A. I have not re-experienced a flashback to a trauma event "as if I were there again."
B. I have re-experienced a flashback to a trauma event "as if I were there again" for a few minutes or less.
C. My re-experience of a flashback to a trauma event sometimes lasts the better part of an hour.
D. My re-experience of a flashback to a trauma event often lasts for an hour or more.

9 A. I am less easily distracted than ever.
B. I am as easily distracted as ever.
C. I am more easily distracted than ever.
D. I feel distracted all the time.

10 A. My spiritual life provides more meaning than it used to.
B. My spiritual life provides about as much meaning as it used to.
C. My spiritual life provides less meaning than it used to.
D. I don't care about my spiritual life.

11 A. I can concentrate better than ever.
B. I can concentrate about as well as ever.
C. I can't concentrate as well as I used to.
D. I can't concentrate at all.

12 A. I've told a friend or family member about the important parts of my traumatic experiences.
B. I've had to be careful in choosing the parts of my traumatic experience to tell friends or family members.
C. Some parts of my traumatic experience are so hard to understand that I've said almost nothing about them to anyone.
D. No one could possibly understand the traumatic experiences I've had to live with.

13 A. I generally don't have nightmares.
B. My nightmares are less troubling than they were.
C. My nightmares are just as troubling as they were.
D. My nightmares are more troubling than they were.

14 A. I don't feel confused about my life.
B. I feel less confused about my life than I used to.
C. I feel just as confused about my life as I used to.
D. I feel more confused about my life than I used to.

15 A. I know myself better than I used to.
B. I know myself about as well as I used to.
C. I don't know myself as well as I used to.
D. I don't feel like I know who I am at all.

16 A. I know more ways to control or reduce my anger than most people.
B. I know about as many ways to control or reduce my anger as most people.
C. I know fewer ways to control or reduce my anger as most people.
D. I know of no ways to control or reduce my anger.

17 A. I have not experienced a major trauma in my life.
B. I have experienced one or more traumas of limited intensity.
C. I have experienced very intense and upsetting traumas.
D. The traumas I have experienced were so intense that memories of them intrude on my mind without warning.

18 A. I've been able to shape things toward attaining many of my goals.
B. I've been able to shape things toward attaining some of my goals.
C. My goals aren't clear.
D. I don't know how to shape things toward my goals.

19 A. I am able to focus my mind and concentrate on the task at hand regardless of unwanted thoughts.
B. When unwanted thoughts intrude on my mind I'm able to recognize them briefly and then focus my mind on the task at hand.
C. I'm having a hard time coping with unwanted thoughts and don't know how to refocus my mind on the task at hand.
D. I'll never be able to cope with unwanted thoughts.

20 A. I am achieving most of the things I want.
B. I am achieving many of the things I want.
C. I am achieving some of the things I want.
D. I am achieving few of the things I want.

21 A. I sleep as well as usual.
B. I don't sleep as well as usual.
C. I wake up more frequently or earlier than usual and have difficulty getting back to sleep.
D. I often have nightmares or wake up several hours earlier than usual and cannot get back to sleep.

22 A. I don't have trouble remembering things that I should know.
B. I have less trouble than I used to remembering things I should know.
C. I have about the same trouble as I used to remembering things I should know.
D. I have more trouble than I used to remembering things I should know.

23 A. My goals are clearer than they were.
B. My goals are as clear as they were.
C. My goals are not as clear as they were.
D. I don't know what my goals are.

24 A. I'm usually able to let bad memories fade from my mind.
B. Sometimes a bad memory comes back to me, but I can modify it, replace it, or set it aside.
C. When bad memories intrude on my mind I cant seem to get them out.
D. I'm worried that I'm going crazy because bad memories keep intruding on my mind.

25 A. Usually I feel understood by others.
B. Sometimes I don't feel understood by others.
C. Most of the time I don't feel understood by others.
D. No one understands me at all.

26 A. I have never lost anything or anyone dear to me.
B. I have grieved for those I've lost and can now go on.
C. I haven't finished grieving for those I've lost.
D. The pain of my loss is so great that I can't grieve and don't know how to get started.

Hammarberg, M. (1992). Penn inventory for posttraumatic stress disorder: Psychometric properties. *Psychological Assessment, 4,* 67-76.

APPENDIX G

RESOURCE SHEET

San Bernardino County Rape Crisis Centers:

San Bernardino Sexual Assault Services, Inc.
505 N. Arrowhead Avenue, Suite 100
San Bernardino, CA 92401-1221
(909) 885-8884

Victorville Office
15437 Anacapa Road, Suite
Victorville, CA 92392
(760) 952-0041

Redlands Office
30 Cajon Street
Redlands, CA 92373
(909) 335-8777

Yucaipa Outreach
34282 Yucaipa Blvd.
Yucaipa, CA 92399
(909) 790-9374

San Bernardino County Domestic Violence Shelters:

Better Way
14114 Hisperia Road
Victorville, CA 92392
(760) 955-8723

High Desert Domestic Violence
17100-B Bear Valley Road #284PMB
Victorville, CA 92392
(760) 843-0701

Doves
P.O. Box 3646
Big Bear Lake, CA
92315
(909) 866-1546
(909) 866-5723

Morongo Basin Unity Home
61738 Twentynine Palms Highway
Joshua Tree, CA 92252

(760) 366-9663
1-866-367-6638

Haylee House
701 Frances Street
Barstow, CA 92311
(760) 256-3441

Option House
P.O. Box 970
San Bernardino, CA 92404
(909) 381-3471

Other Resources:

Helpline
(Suicide, Crisis Counseling & Information and Referrals)
(990) 686-4357

Child Protective Services
1 (800) 442-4918

Youth Service Center
(909) 683-5193

Resources for Riverside and San Bernardino Counties

RAINN
635B Pennsylvania Ave., S.E.
Washington, DC 20003
Phone: (202) 544-1034
Hotline: 1-800-656-HOPE
(hotline will direct survivor to nearest rape crisis center)

Riverside County Rape Crisis Centers:

Center Against Sexual Assault of Southwest Riverside Co.
P.O. Box 2564
Hemet, CA 92546
(909) 652-8300

Coachella Valley Sexual Assault Services
45-691 Monroe Street, Suite 10
Indio, CA 92201
(760) 568-9071

Riverside Area Rape Crisis Center

1465 Spruce Street #G
Riverside, CA 92507-2446
(909) 686-7273

U.C. Riverside Rape Prevention Program
1900 University Avenue
Riverside, CA 92521
(909) 787-5000

Riverside County Domestic Violence Resources:

Alternatives to Domestic Violence
P.O. Box 90010
Riverside, CA 92502
(951) 320-1370
1-800-339-7233

Lutheran Social Services (Genesis Shelter)
3772 Taft Street
Riverside, CA 92503
(951) 689-7847

Shelter From the Storm
73555 Alessandro Drive, Studio D
Palm Desert, CA 92255-4155
(760) 674-0400

REFERENCES

Adams, R. E., Boscarino, J. A., & Galea, S. (2006). Social and psychological resources and health outcomes after World Trade Center disaster. *Social Science and Medicine, 62,* 176–188.

Adshead, G. (2000). Psychological therapist for post-traumatic stress disorder. *British Journal of Psychiatry, 177,* 144-148.

Albert, R. D., (1992). Communicating across cultures. Unpublished manuscript.

Albert, R. D., & Ah Ha, I. (2004). Latino/Anglo-American differences in attribution to situations involving touch and silence. *International Journal of Intercultural Relations, 28,* 253-280.

Anderson, P. L., Tiro, J. A., Price, A. W., Bender, M. A., & Kaslow, N. J. (2002). Additive impact of childhood emotional, physical, and sexual abuse on suicide attempts among low-income African American women. *Suicide and Life-Threatening Behaviors, 32*(2), 131-138.

Andrew, B. (1998). Shame and childhood abuse. *In shame: Interpersonal behaviour, psychopathology and culture*

(eds P. Gilbert & B. Andrews), pp.176-190. Oxford: Oxford University Press.

Andrews, B., Brewin, C. R., Rose, S., & Kirk, M. (2000). Predicting PTSD symptoms in victims of violent crime: The role of shame, anger, and childhood abuse. *Journal of Abnormal Psychology, 109*(1), 69-73.

Andrew, B., Quian, M., & Valentine, J.V. (2002). Predicting depression symptoms with a new measure of shame: The experience of shame scale. *British Journal of Clinical Psychology, 41*, 29-42.

Arata, C. M., Langhinrichsen-Rohling, J., & Bowers, D. (2005). Single versus multiple-type maltreatment: An examination of the long-term effects of child abuse. *Journal of Aggression, Maltreatment & Trauma, 11*(4), 29-52.

Bennett, D. S., Sullivan, M. W., & Lewis, M. (2005). Young children's adjustment as a function of maltreatment, shame, and anger. *Child Maltreatment, 10*, 311–323.

Bernat, J. A., Ronfeldt, H. M., Calhound, K. S., & Arias, I. (1998). Prevalence of traumatic events and peritraumatic predictors of posttraumatic stress symptoms in a nonclinical sample of college students. *Journal of Traumatic Stress, 11*(4), 645-663.

Bernstein, D., & Rubin, D. C. (2007). When a trauma becomes a key to identity: Enhanced integration of trauma memories predicts posttraumatic stress disorder symptoms. *Applied Cognitive Psychology, 21,* 417-431.

Bernstein, D. P., Stein, J. A., Newcomb, M. D., Walker, E., Pogge, D., Ahluvalia, T., Stroke, J., Handlesman, L., Medrano, M., Desmond, D., & William, Z. (2003). Development and validation of a brief screening version of the childhood trauma questionnaire. *Child Abuse & Neglect, 27*(2), 169-191.

Bremner, J. D., Southwick, S. M., Johnson, D. R., Yehura, R., & Charney, D. S. (1993). Childhood physical abuse and combat-related posttraumatic stress disorder in Vietnam veterans. *American Journal of Psychiatry, 150,* 235-239.

Cicchetti, D., & Toth, S. L. (1995). A developmental psychopathology perspective on child abuse and neglect. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*(5), 541-565.

Clemmons, J. C., Walsh, K., & Dilillo, D. (2007). Unique and combined contributions of multiple child abuse types and abuse severity to adult trauma symptomatology. *Child Maltreatment, 12*(2), 172-181.

Cole, P. L, Tamang, B. L., & Shrestha, S. (2006). Culture variations in the socialization of young children's anger and shame. *Child Development, 77*(5), 1237-1251.

Comas-Diaz, L. (1995). Ruerto Ricans and sexual child abuse. In L. Fontes (Ed.), Sexual abuse in nine North American cultures (pp.31-66). Thousand Oaks: Sage Publications.

Cook, D. R. (1989). Shame and self-esteem: Two sides of the same coin. Unpublished manuscript. University of Wisconsin-Scout, Menomonie, Wisconsin.

Cromer, K. R., & Sachs-Ericsson, N. (2006). The association between childhood abuse, PTSD, and the occurrence of adult health problems: Moderation via current life stress. *Journal of Traumatic Stress, 19*(6), 967-971.

Dakil, S. R., Cox, M., Lin, H., & Flores, G. (2011). Racial and ethnic disparities in physical abuse reporting and child protective services interventions in the United States. *Journal of the National Medical Association. 103*, 926-931.

Deblinger, E., & Runyon, M. K. (2005). Understanding and treating feelings of shame in children who have experienced maltreatment. *Child Maltreatment, 10*(4), 364-376.

Eisenberg, N., Cumberland, A., & Spinrad, T. L. (1998). Parental socialization of emotion. *Psychological Inquiry, 9*, 241-273.

Erickson, M. F., & Egeland, B. (1987). A developmental view of the psychological consequences of maltreatment. *School of Psychology Review, 16,* 156-168.

Feinaure, L., Hilton, H. G., & Callahan, E. H. (2003). Hardiness as a moderator of shame associated with childhood sexual abuse. *American Journal of Family Therapy, 31*, 65-78.

Feiring, C., Coates, D. L., & Taska, L. S. (2001). Ethnic status, stigmatization, support, and symptom development following sexual abuse. *Journal of Interpersonal Violence, 16,* 1307-1329.

Feiring, C., & Taska, L. S. (2005). The persistence of shame following sexual abuse: A longitudinal look at risk and recovery. *Child Maltreatment, 10*, 337–349.

Feiring, C., Taska, L., & Chen, K. (2002). Trying to understand why horrible things happen: Attribution, shame, and symptoms development following sexual abuse. *Child Maltreatment,* 7(1), 25-39.