Published in final edited form as:

Child Abuse Negl. 2009 June ; 33(6): 362–371. doi:10.1016/j.chiabu.2008.10.003.

Childhood Abuse and Current Family Conflict: The Role of Shame

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Abstract

Objective—To examine whether shame-proneness mediates the relationship between women's histories of childhood sexual abuse and their current partner and family conflict and child maltreatment. Previous research has found that women with childhood sexual abuse histories experience heightened shame and interpersonal conflict. However, research examining the relationship of shame to interpersonal conflict is lacking.

Method—Participants were 129 mothers of children enrolled in a summer camp program for at-risk children from financially disadvantaged families. Data were collected on women's childhood abuse histories, shame in daily life, and current interpersonal conflict involving family conflict, intimate partner conflict (verbal and physical aggression), and child maltreatment.

Results—Consistent with our hypothesis, the results of hierarchical regressions and logistic regression indicated that shame significantly mediated the association between childhood sexual abuse and interpersonal conflict. Women with sexual abuse histories reported more shame in their daily lives, which in turn was associated with higher levels of conflicts with intimate partners (self-verbal aggression and partner-physical aggression) and in the family. Shame did not mediate the relationship between mothers' histories of sexual abuse and child maltreatment.

Conclusion—The role of shame in the intimate partner and family conflicts of women with sexual abuse histories has not been examined. The current findings indicate that childhood sexual abuse was related to interpersonal conflicts indirectly through the emotion of shame.

Practical Implications—These findings highlight the importance of investigating the role of shame in the interpersonal conflicts of women with histories of childhood sexual abuse. Healthcare professionals in medical and mental health settings frequently treat women with abuse histories who are involved in family and partner conflicts. Assessing and addressing the links of abused women's shame to interpersonal conflicts could be important in clinical interventions.

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Keywords

child abuse; shame; interpersonal relations

Introduction

Disturbed interpersonal relationships and family conflict have been repeatedly identified as long-term sequelae of childhood sexual abuse (DiLillo, 2001; DiLillo & Long, 1999; Dong, Anda, Dube, Giles, & Felitti, 2003; Liang, Williams, & Siegel, 2006; Mickelson, Kessler, & Shaver, 1997; Mullen, Martin, Anderson, Roman, & Herbison, 1994; Nelson et al., 2002; Zuravin & Fontanella, 1999). The magnitude of the destructive impact on individuals and families is suggested by the prevalence rates of childhood sexual abuse: rates ranging from 13% to 33% are reported in general female population studies in the United States (Molnar, Buka, & Kessler, 2001); even higher rates are found in primary care and psychiatric settings (Arnow, 2004; Polusny & Follette, 1995). Although the debilitating interpersonal effects of childhood sexual abuse are well-established, the specific characteristics of abused women that are associated with interpersonal difficulties are much less well understood. The work of medical and mental health professionals could be assisted by research identifying negative emotions that play a significant role in their interpersonal conflicts.

Interpersonal Functioning among Women with Childhood Sexual Abuse

A number of studies have demonstrated that women with childhood sexual abuse histories are at greater risk for adult victimization, either sexual or physical (Cohen et al., 2000; DiLillo, Giuffre, Tremblay, & Peterson, 2001; Kendler, Gardner, & Prescott, 2002; Messman & Long, 1996; Testa, VanZile-Tamson, & Livingston, 2005), although prospective research is scarce (DiLillo, 2001; Testa et al., 2005). Increasingly, researchers have also attended to women's violence towards their intimate partners and found that sexual abuse histories, either alone (Feerick, Haugaard, & Hien, 2002) or in combination with other child abuse experiences (Sullivan, Meese, Swan, Mazure, & Snow, 2005), are positively associated with women's aggression towards their partners. Outside of overt violence, interpersonal conflict is also evident or suggested in research documenting other difficulties in interpersonal functioning. Compared to women without sexual abuse histories, women who were abused report poorer communication in couple relationships (DiLillo et al., 2001; DiLillo & Long, 1999; Mullen et al., 1994), more controlling or distancing behaviors in relationships (Cloitre, Scarvalone, & Difede, 1997; Mickelson et al., 1997; Whiffen et al., 2000), less satisfaction in couple relationships (DiLillo & Long, 1999; Liang et al., 2006), and have higher rates of separation and divorce (Colman & Widom, 2004; Mullen et al., 1994). In addition, an important realm of interpersonal functioning for women with CSA concerns parenting practices and interactions with their children. There is evidence that mothers' histories of childhood sexual abuse may also be linked to abusive parenting behaviors (Banyard, 1997; DiLillo, Tremblay, & Peterson, 2000; Dixon, Browne, & Hamilton-Giathritsis, 2005; Dubowitz et al., 2001).

Sexual Abuse and Shame

Some research suggests that the emotion of shame has an important role in the psychological adjustment of women with sexual abuse histories (Andrews, 1995; Andrews, Brewin, Rose, & Kirk, 2000; Talbot, Talbot, & Tu, 2004). Shame has also been implicated (Finkelhor & Browne, 1985), although little studied (Feinauer, Hilton, & Callahan, 2003), in the interpersonal difficulties of women with sexual abuse histories. To our knowledge, the relationship between shame and family conflict has not been investigated among women with sexual abuse histories.

Shame is a highly aversive, debilitating affective experience associated with a profound negative evaluation of the self (H. B. Lewis, 1971; M. Lewis, 1992; Tangney & Dearing, 2002). Shame's intensity may be more than the individual can bear, resulting in attempts to modulate or escape the affective experience: hiding or shrinking from view, going blank, submissiveness or angry defensiveness and even violence have been described as examples of such attempts (H. B. Lewis, 1971; M. Lewis, 1992; Tangney, Wagner, Hill-Barlow, Marschall, & Gramzow, 1996). Childhood sexual abuse can produce profound feelings of shame (Feiring & Taska, 2005).

Shame and Problems in Interpersonal Relationships

A developmental view holds that the abused child's shame can become chronic, coloring experiences of self and others in painful ways that impede constructive social interaction (Dutton, Van Ginkel, & Starzomski, 1995; Feiring, Rosenthal, & Taska, 2000; Finkelhor & Browne, 1985). Interpersonal problem-solving and dispute resolution skills are, in turn, poorly developed. Shame may, as a result, produce hostile interpersonal responses, from angry withdrawal to humiliated fury, in particular when others are seen as critical or rejecting (H. B. Lewis, 1971; Miller, 1985).

Indeed, some empirical research evidence points to the significant role of shame in the psychological functioning of abused women. In a community sample, women with histories of childhood sexual or physical abuse had more chronic or recurrent depression, and this association was mediated by shame related to the body (Andrews, 1995). Among women in a psychiatric inpatient service, higher levels of general shame-proneness were associated with dissociation, particularly among those with sexual abuse histories (Talbot et al., 2004). A history of childhood sexual abuse has been associated with higher rates of self-blame (Coffey, Leitenberg, Henning, Turner, & Bennett, 1996), self-depreciation (Higgins & McCabe, 2000), and self-consciousness (Gamble et al., 2006), constructs conceptually related to shame. Another construct closely related to shame—stigmatization—was included in Finkelhor and Browne's (1985) traumagenic dynamics model of the effects of child sexual trauma on adult interpersonal and psychological adjustment. In their conceptual model, the individual's experience of stigmatization from sexual abuse was conceived as mediating the effects of sexual abuse in adulthood.

In Kallstrom-Fuqua et al.'s empirical test of the traumagenic dynamics model in a community sample of low-income women, stigmatization was operationalized as a shame-guilt composite reflecting the frequency of those emotions in the everyday lives of the

participants (Kallstrom-Fuqua, Weston, & Marshall, 2004). The findings supported the traumagenic dynamics model suggesting that the impact of childhood sexual abuse severity on mental health and social relationships were largely indirect through powerlessness and stigmatization. In particular, stigmatization mediated the effects of sexual abuse severity on women's psychological distress, but did not mediate the effects of sexual abuse severity on maladaptive social relationships. In contrast, shame has been associated with social impairment, in particular more direct and indirect aggression, and poorer conflict resolution skills, in general child and adult populations (Tangney, 1995; Tangney et al., 1996).

The Present Study

Prior studies suggest significant relationships between childhood sexual abuse and shame, between sexual abuse and interpersonal conflict, and between shame and interpersonal conflict. Yet the inter-relationships among childhood sexual abuse, shame, and interpersonal conflict have been little examined. Given theoretical arguments and empirical evidence that shame-proneness impedes constructive social interaction (Dutton et al., 1995; Feiring et al., 2000; Finkelhor & Browne, 1985; H. B. Lewis, 1971; M. Lewis, 1992; Tangney, 1995; Tangney et al., 1996), and the established relationship of shame-proneness with anger and aggression (Tangney et al., 1996), the possible role of shame in the interpersonal conflicts of women with abuse histories merits empirical investigation. This study examined the role of shame in the current intimate partner and family conflicts as well as child maltreatment of women with and without sexual abuse histories. We hypothesized that childhood sexual abuse would be related to interpersonal conflicts, mediated by shame. We elected to use a generic measure of shame (Kallstrom-Fuqua et al., 2004) rather than one specific to the sexual abuse experience (Andrews, 1995) to capture the breadth of the experience of shame in the daily lives of both abused and nonabused women.

Method

Participants

The data were drawn from a larger study on family functioning and child maltreatment among low-income families with school-aged children (Kim & Cicchetti, 2004). Participants were women residing in the community who were mothers of children enrolled in a week-long summer day camp program in a Northeastern urban city. The summer camp program was designed to provide maltreated and nonmaltreated children, ages 6 to 12, from economically disadvantaged families, with a naturalistic setting in which children's behavior and peer interactions could be observed in an ecologically valid context.

Out of 193 women whose children participated in the summer camp research program, we included only the 129 women who had a partner at the time of data collection because a main goal was to study intimate partner violence. The mean (SD) age of participants was 34.25 (6.70) years. In regard to racial/ethnic backgrounds, 50% were African American, 34% were European American, 12% were Latina, and 4% were classified as some other ethnic background. The average number of children under the age of 19 in the home was 3 ($SD = 1.65$). About 57% ($n = 74$) were married or living with partners. Among the women, about 48% had earned a high school diploma, 46% had partial college experience, and 6%

had earned a four-year college or higher degree. At least 74% of the families were from the lowest socioeconomic strata according to Hollingshead (1975). Socioeconomic status on the Hollingshead Index is derived from education level and type of employment, and yields five socioeconomic levels.

Procedures

Participants were recruited from three social service programs: the Department of Social Services, Aid to Families with Dependent Children (AFDC), and Temporary Assistance to Needy Families (TANF). Because poverty is linked to more familial violence, marital conflict, and punitive parenting (Evans, 2004), research focused on interpersonal conflict among disadvantaged families is crucial. Maltreated children had been identified through the Department of Social Services (DSS) as having experienced child maltreatment. Parental consent was obtained for examination of any DSS records. Nonmaltreated children were recruited from families receiving AFDC or TANF. These families were selected based on their similarity to the demographic characteristics of the maltreating families. Potentially eligible families were administered screening interviews by telephone or in their homes to inform them about the study procedures and camp program, obtain written informed consent, and collect demographic information from the primary caregivers. Informed consent included the parents' agreement for Department of Social Services records to be obtained. Following informed consent, the presence or absence of a child maltreatment history was assessed through parent interviews and review of DSS records. Children were designated as 'maltreated' when there were legally documented reports of child maltreatment with services provided through DSS. Among maltreated children whose perpetrators were identified ($n = 56$), 96% ($n = 54$) had mothers as a perpetrator, although not necessarily the sole perpetrator. Mothers ($n = 61$) were designated as "nonmaltreating" in the absence of any DSS service provision for child maltreatment or report of child maltreatment during research interviews. Data for the present study were obtained from interviews with mothers conducted within one month of their child's completion of camp. In camp, children participated in a variety of recreational activities and research assessments in groups of six to eight same-age and same-sex peers. Camp days lasted for 5 days, 7 hours per day.

Measures

Childhood Sexual Abuse—Five questions comprising the sexual abuse scale of the *Child Trauma Questionnaire—short form* (CTQ; Bernstein & Fink, 1998) assessed severity of participants' childhood sexual abuse experiences. The CTQ is a self-report instrument that instructs participants to rate the frequency with which each of the events occurred "when they were growing up (as a child and a teenager)" using a 5-point scale ranging from "never true" (1) to "very often true" (5). In the CTQ, sexual abuse was defined as "sexual contact or conduct between a child and older person" (Bernstein et al., 2003). Examples from the 5-item sexual abuse scale are: "Someone tried to touch me in a sexual way, or tried to make me touch them;" and "Someone molested me." Previous research with long and short versions of the CTQ has shown that the measure has good internal consistency (alphas ranging from .79 to .94), test-retest reliability, and convergent validity with other childhood trauma questionnaires (Bernstein et al., 2003; Fink, Bernstein, Handelsman, Foote, &

Lovejoy, 1995; Scher, Stein, Asmundson, McCreary, & Forde, 2001). The sexual abuse subscale demonstrated strong internal consistency for the current sample: the Cronbach alpha was .96. In the current analysis, we used severity of sexual abuse as a continuous variable which was calculated by recoding the total score of the sexual abuse scale into four levels of severity according to the CTQ manual (Bernstein & Fink, 1998): none/minimal (score = 5; recoded as 1), low/moderate (score = 6-7; recoded as 2), moderate/severe (score = 8-12; recoded as 3), and severe/extreme (score = 13; recoded as 4).

Shame—The *Differential Emotions Scale* (DES-IV; Izard, Libero, Putnam, & Haynes, 1993) requires respondents to rate the frequency with which they experience 12 basic emotions in their daily lives. Each item is rated on a 5-point scale from “rarely or never” (1) to “very often” (5). The shame subscale consists of three items: In your daily life, how often do you: “Feel embarrassed when anybody sees you make a mistake?”; “Feel like people laugh at you?”; and, “Feel like people always look at you when anything goes wrong?” Stability correlations of .60 at a retest interval of 3.5 months and .64 at a 3-year retest interval have been reported for the shame subscale (Izard et al., 1993). The Cronbach alpha of the shame subscale in this sample was .71.

Family Conflict—A family conflict measure was selected that elicited women's views on the family climate of open anger and aggression without requiring them to identify individual family members' roles in the conflicts. The conflict subscale from the *Family Environment Scale* (FES; Moos & Moos, 1986) was used to measure mothers' perceptions of current family conflict. This subscale assesses the amount of openly expressed anger and aggression typical in the family. The FES asks respondents to decide whether statements were generally true (1) or generally false (0) about their “current family.” The conflict subscale consists of nine items, including: “We fight a lot in my family”; “Family members hardly ever lose their tempers” (reverse coded); and, “Family members sometimes hit each other.” Mean stability coefficients ranging from .66 to .91 over 8 weeks have been reported (Moos & Moos, 1986; 1994), and validity data have been reported (Foster & Robin, 1997). Although the FES has been used extensively in family research, concerns have been raised about the internal reliability of some subscales (Boyd, Gullone, Needleman, & Burt, 1997). The Cronbach alpha of the conflict subscale was .67 in this sample.

Intimate Partner Conflict—The *Conflict Tactics Scale* (CTS; Straus, 1979) is an 18-item self-report measure and consists of three subscales that assess different means of dealing with disagreement: (1) Reasoning: use of rational discussion and agreement, for example, “discussed an issue calmly” (three items); (2) Verbal Aggression: use of verbal and non-verbal expressions of hostility, for example, “insulted or swore at the other” (six items); and (3) Physical Aggression: use of physical force or violence (nine items), for example, “threw something at the other.” The items assessed the frequency of behaviors over the previous year on a frequency scale ranging from “never” (1) to “more than 20 times” (6). Respondents were asked to indicate both how often they carried out each action in relation to their partner or spouse (i.e., self-to-partner score; “self-” hereafter) and how often the partner or spouse carried out each action (i.e., partner-to-self score; “partner-” hereafter). In the current analysis, we used verbal aggression and physical aggression subscales to

measure intimate partner aggression and violence. The CTS is widely used in research on intimate partner violence (Straus, 1979; 1990); its psychometric properties have been well-described (Straus, 1990). In the current sample, the Cronbach alphas of the verbal aggression and physical aggression subscales were .88 and .81 respectively for the self-to-partner scores. The Cronbach alphas of the verbal aggression and physical aggression subscales were .88 and .93 respectively for the partner-to-self scores.

Child Maltreatment—The narrative reports of the maltreatment incidents from the DSS records were coded according to the Maltreatment Classification System (MCS, Barnett et al., 1993). The MCS provided operational definitions and specific criteria for rating the severity of multiple subtypes of maltreatment (See Barnett et al. 1993, for a detailed description of the nosological system used to code incidents for maltreatment). Severity of each subtype was rated along a 5-point scale, with 1 indicating mild maltreatment to 5 indicating severe maltreatment of the specified subtype. Additionally, the MCS coding involved measurement of onset and frequency of each subtype, perpetrator(s) within each subtype, and the developmental period(s) during which each subtype occurred. For each subtype, weighted kappa statistics were calculated to account for reliability. Interrater agreement was good, with *kappas* of 1.0 for sexual abuse, .94 for physical abuse, .78 for emotional maltreatment, and a range of .79-.85 for physical neglect. Among maltreated children in the current sample ($n = 64$), 76% had been emotionally maltreated, 80% had been neglected, 28% had been physically abused, and 4% had been sexually abused. Consistent with the high co-occurrence of subtypes that are found in the literature (cf. Manly, Kim, Rogosch, & Cicchetti, 2001), 69% of the maltreated children in this sample experienced two or more forms of maltreatment. Given the high overlap in the multiple child maltreatment subtypes, we compared maltreating and nonmaltreating mothers rather than considering distinct subtypes.

Data Analytic Strategy

The main focus of this study was to examine the hypothesized mediating effects of shame in the link between childhood sexual abuse and interpersonal conflict. We conducted a series of hierarchical regression analyses using mediational procedures described by Baron and Kenny (1986) and Kenny, Kashy, and Bolger (1998). First, the dependent variable (DV) must be regressed onto the independent variable (IV). Second, the mediator must be regressed on the IV and third the DV is regressed onto the moderator while controlling for any effects of the IV. Finally, for full mediation, the DV should no longer be significantly regressed onto the IV, while controlling for the effects of the mediator. However, partial mediation may be achieved when the pathway is reduced in absolute size but not reduced to non-significant levels. We tested the statistical significance of partial mediators using the Sobel test (MacKinnon, Lockwood, Hoffman, West, & Sheets, 2002). An α level of .05 was used for all statistical tests.

Results

Table 1 presents means (average across items) and standard deviations of childhood sexual abuse, shame, and interpersonal conflict. Mean sexual abuse severity in the total sample was

2.02 (1.42) which represents a moderate severity rating (Bernstein & Fink, 1998). Examination of distributions of the study variables indicated that all but the CTS partner-physical aggression had skewness less than the absolute value of 3.00 and kurtosis less than the absolute value of 10.00 (Kline, 1998). We performed square root, log, and inverse transformations on the partner-physical aggression scores, which were severely positively skewed (skewness = 5.53, kurtosis = 33.35). However, none of these transformations satisfactorily improved normality of the distribution. Therefore, as recommended by Tabachnik and Fidell (2001), we dichotomized the physical aggression variables (both self-to-partner and partner-to-self).

Because demographic factors could be associated with participants' reports of interpersonal conflict, we examined these as potential covariates. In a multivariate general linear model (GLM), we tested the influences of maternal age, race/ethnicity (recoded as Caucasian vs. minority), living arrangements (married/living with partner vs. not), socioeconomic status (SES; Hollingshead, 1975; two lowest SES levels vs. not), and number of children in the household on six scores of interpersonal conflict DVs: family conflict, self-verbal aggression, self-physical aggression, partner-verbal aggression, partner-physical aggression and child maltreatment. Race/ethnicity, living arrangements, and socioeconomic status were not significantly associated with the levels of interpersonal conflict, $F(6, 99) = 2.04, p = .07$ for race/ethnicity, $F(4, 116) = 1.76, p = .12$ for living arrangements, $F(4, 116) = 1.23, p = .28$ for socioeconomic status. However, maternal age was associated with self-verbal aggression, $F(4, 104) = 4.61, p < .05$, indicating that younger mothers reported higher self verbal aggression than older mothers. The number of children in the household was related to family conflict, $F(1, 104) = 8.88, p < .05$ as well as child maltreatment, $F(1, 104) = 6.95, p < .05$, demonstrating that higher numbers of children in the household were related to higher levels of family conflict and greater risk of child maltreatment. Accordingly, maternal age and number of children in the household were considered as covariates in the main analyses of the relevant DVs.

In the mediational models, the IV was severity of childhood sexual abuse (CSA: continuous; 1 = none/minimal to 4 = severe/extreme) and the mediator was shame (continuous). Childhood sexual abuse was associated with shame ($B = 1.91, SE = .14, \beta = .23, t = 13.69, p < .05$), $F(1, 128) = 7.07, p < .05$, suggesting that the step two of the mediational procedure was met.

The role of shame in the relationship between CSA and family conflict

For the hierarchical regression model of family conflict (continuous), Table 2 displays the R squares, B β coefficients, SE, β coefficients, t values and significance levels (p). There was a significant effect of the CSA on family conflict controlling for the number of children in the household, $F(2, 128) = 8.58, p < .05$. In the second step, shame was added to the equation, which accounted for 11% additional variance, $F(3, 125) = 12.27, p < .05$. In this final model, the shame variable was the strongest predictor of the family conflict outcome indicating that participants with higher shame scores had higher conflict scores. As predicted, the association between childhood sexual abuse and family conflict became weakened, although remaining marginally significant ($p = .05$), suggesting that shame partially mediated that

association. A Sobel test revealed that the relationship between severe childhood sexual abuse and family conflict was significantly diminished once shame was added to the regression equation ($Z = 3.96, p < .05$).

The role of shame in the relationship between CSA and intimate partner conflict

There was a significant effect of the CSA on self-verbal aggression (continuous) controlling for maternal age, $F(2, 125) = 8.58, p < .05$. Shame was added to the regression and it accounted for 9% additional variance, $F(3, 124) = 7.27, p < .05$. In this final model, the shame variable was the strongest predictor of the self-verbal aggression scores, and the direct effect of the CSA on self-verbal aggression was reduced to a non-significant level, indicating full mediation of shame (see Table 2). A Sobel test statistic also demonstrated the significant mediation effects of shame in the link between severe childhood sexual abuse and later intimate partner conflict expressed in self-verbal aggression ($Z = 3.44, p < .05$). Regarding partner-verbal aggression (continuous), the CSA was not a significant predictor, $F(1, 126) = 1.75, p = .19$. In the second step, Shame was a significant predictor of the partner-verbal aggression scores, and accounted for 6% additional variance, $F(2, 125) = 4.99, p < .05$.

The mediation models for the self- and partner-physical aggression outcomes (dichotomous) were tested by logistic regression analyses to account for the categorical nature of the data. For each logistic regression, Table 3 displays the Nagelkerke R^2 values, B coefficients, SE, Wald statistics (test of the significance of individual independent variable), significance levels, and adjusted odds ratios (OR). The Nagelkerke R^2 is provided as approximations to ordinary least squares (OLS) R^2 . The odds ratio is a statistic that demonstrates an increase or decrease in the odds of an outcome occurring with an increase or decrease in the predictor variables. Concerning self-physical aggression, the CSA was not a significant predictor, omnibus test likelihood ratio $\chi^2 = 2.24, p = .14$. In the second step, Shame was a significant predictor of the self-physical aggression scores, omnibus test likelihood ratio $\chi^2 = 19.42, p < .05$ (when the step was to add a variable, the inclusion is justified if the significance of the step is less than 0.05).

Turning to partner-physical aggression, the direct effect of CSA on intimate partner conflict was significant, omnibus test likelihood ratio $\chi^2 = 11.72, p < .05$. When Shame is added, both CSA and Shame were significant predictors of partner-physical aggression, omnibus test likelihood ratio $\chi^2 = 6.62, p < .05$. The effects of CSA decreased, however they were not reduced to non-significance levels (see Table 3). The derivation of the Sobel standard error presumes that the path between the IV and the mediator (a) and the path between the mediator and the DV (b) are independent, which is true when the tests are from multiple regression but not necessarily true when other tests are used such as logistic regression. In such cases, it is recommended to standardize regression coefficients prior to estimating mediation (MacKinnon & Dwyer, 1993). Thus we proceeded a Sobel test based on standardized regression coefficients and found that the mediation effects of shame were significant in the link between CSA and later intimate partner conflict expressed in partner-physical aggression ($Z = 2.98, p < .05$).

The role of shame in the relationship between CSA and child maltreatment

The current sample included 54 mothers who were identified as maltreating their children and 61 nonmaltreating mothers, controlling for the number of children in the household. As shown in Table 3, logistic regression analyses indicated that CSA was significantly predictive of mothers' maltreating behaviors of their children, omnibus test likelihood ratio $\chi^2 = 11.08$, $p < .05$. However, Shame was not a significant predictor of child maltreatment status, omnibus test likelihood ratio $\chi^2 = 1.42$, $p = .23$ (see Table 3).

Discussion

This study evaluated whether shame mediates the association between childhood sexual abuse and current interpersonal conflict in a sample of economically disadvantaged mothers. We found that one of the possible pathways between childhood sexual abuse histories and interpersonal conflict involves the emotion of shame. The role of women's shame in accounting for the relationship between childhood abuse histories and interpersonal conflict seems to depend upon (1) the nature of the relationship or context such as family, intimate partner, or offspring, and (2) the type of interpersonal conflict such as verbal aggression vs. physical aggression.

Our findings in general are in accord with previous research findings that women with sexual abuse histories report more shame-proneness (Andrews, 1995) and interpersonal conflict (Cohen et al., 2000; DiLillo et al., 2001; DiLillo & Long, 1999; Messman & Long, 1996; Mullen et al., 1994; Testa et al., 2005) than women without such histories. Previous research has found that sexual abuse histories are a risk factor for disturbed interpersonal functioning, yet not all abused women suffer interpersonal problems. This study examined an emotional experience, that of shame, which may help to explain the relationship between childhood sexual abuse and heightened interpersonal conflict, and extends prior research by demonstrating that shame mediates the relationship between sexual abuse in childhood and interpersonal conflict in adulthood. These cross-sectional findings are consistent with the developmental view that childhood abuse enhances shame-proneness, which undermines the development of effective interpersonal problem-solving and dispute resolution, and leads to greater conflict in adult relationships (Feiring, Taska, & Lewis, 1996; Finkelhor & Browne, 1985; M. Lewis, 1992). However, the cross-sectional nature of these data necessarily precludes causal conclusions. In one prospective study among 147 children and adolescents who had been sexually abused, high abuse-related shame sustained over one year following the abuse discovery predicted poorer psychological adjustment (Feiring, Taska, & Lewis, 2002). More prospective research is needed to test relationships among childhood abuse, shame, and various indices of adjustment.

In this study, shame fully mediated the link between childhood sexual abuse and intimate partner conflict expressed as women's verbal aggression towards their partners. Women with childhood sexual abuse were more likely to experience shame, which in turn, was associated with their verbal conflict in intimate relationships. Shame also provided partial explanation of the higher levels of family conflict and physical aggression performed by their partners among women with more severe sexual abuse in childhood. Our findings are in accordance with previous literature that has indicated that an abusive childhood may predispose an

individual to exhibit aggression in later life and may put an individual at increased risk of being drawn to violent partners (Dixon et al., 2005; Egeland, Bosquet, & Chung, 2002; Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997; Tajima, 2000). Speculatively, the current findings are consistent with a theoretical model (M. Lewis, 1992) which posits that shame produces submissiveness as well as angry defensiveness and aggression, thereby making abused women both more likely to lash out at partners (perhaps in response to their partners' abusive behavior) and more vulnerable to being physically abused by their partners. Interestingly, shame did not explain the link between women's childhood sexual abuse and their maltreatment of children. It may be that other emotions, such as anger, are more influential in predicting the association between childhood sexual abuse and later child maltreatment (e.g., DiLillo et al., 2000).

Our findings appear to be inconsistent with those reported by Kallstrom-Fuqua and colleagues (2004), which did not find that stigmatization mediated the relationship between sexual abuse severity and maladaptive interpersonal relationships. Both studies used the Differential Emotions Scale (DES-IV; Izard et al., 1993) to assess emotion. Whereas our study used only the DES-IV shame subscale, the Kallstrom-Fuqua et al. (2004) measure of stigmatization was a composite of the DES-IV shame and guilt subscales. Some research in general adult samples suggests that shame has a more robust relationship to psychological and interpersonal impairment than does guilt (Tangney, 1999; Tangney & Dearing, 2002). Other research among women with sexual abuse histories suggests that shame and guilt have different patterns of association with psychological disturbances (Ginzburg et al., 2006). Another difference between the two studies is that ours assessed interpersonal conflict, whereas the Kallstrom-Fuqua et al. (2004) measure of maladaptive social functioning (e.g., lower tendency to turn to others for social support) did not assess conflict per se. It may be that these measurement differences account for the discrepant findings.

Although these data were not collected from a "treatment-seeking" sample, they could have implications for health care providers in both medical and mental health settings. Women with sexual abuse histories may present in a variety of clinical settings with concerns involving interpersonal conflict, including child maltreatment and domestic violence (Buist & Janson, 2001; Dubowitz et al., 2001; Duffy, McGrath, Becker, & Linakis, 1999). The effects of women's experience of self as shamed are presumably manifest in their relationship disturbances in the family and intimate partner conflicts. Clinicians may want to assess the links of abused women's shame to interpersonal conflicts. The aversiveness of the shame experience necessitates a nuanced clinical approach, which may include: understanding that shame exploration must be titrated to be tolerable; awareness that shame may be disguised by or closely tied to other emotions, such as anger; containment of patient's self or other damaging behaviors; empathic, active listening; and, elicitation and reinforcement of the woman's strengths and areas of resilience (M. Lewis, 1992; Miller, 1985; Nathanson, 1987; Talbot, 1996).

We hypothesized a mediational model based upon the theoretical models described by Finkelhor and Browne (1985) and tested by Kallstrom-Fuqua and colleagues (2004). The current data support our conceptualization of shame as a potential mediator of the relation between childhood sexual abuse and interpersonal conflict. However, levels of shame may

fluctuate in individuals and interpersonal conflict may itself produce shame among women. It is in fact likely that women's shame and interpersonal conflict have a bidirectional relationship. Longitudinal research is needed to establish temporal and causal relationships between abuse, shame, and interpersonal conflict. In addition, this study examined only the emotion of shame, but other emotions independently or in concert with shame must also have a significant role in the interpersonal conflict of women with abuse histories (Ferguson, 2005; Negrao, Bonanno, Noll, Putnam & Trickett, 2005).

The current data cannot explain how shame is implicated in partner and family conflict. Possible sequences involving shame-to-appeasement behaviors and shame-to-anger behaviors must be tested in future research (Ferguson, 2005). Abused and shame-prone women may react to a perceived criticism or rejection by withdrawing or submitting, perhaps as a consequence of their own self-blame or to avoid further shame-inducing conflict (H. B. Lewis, 1971; Miller, 1985). In other instances, women with abuse histories may quickly react in angry defensiveness or "humiliated fury" to protect the shame-prone self. The latter scenario could be part of a shame-anger cycle, wherein the intense experiencing of one emotion produces a defensive movement towards the other emotion (H. B. Lewis, 1971; Miller, 1985). Both scenarios represent potentially problematic responses to interpersonal conflicts in which active negotiation and problem-solving are absent and successful conflict resolution is short-circuited.

Other methodological considerations also warrant comment. Our study is directed at a high-risk sample of financially disadvantaged mothers of children in a summer day camp. Given evidence that childhood poverty raises risk for exposure to family violence and punitive parenting (Evans, 2004), this is a group in need of attention. It is not known, however, how these findings might apply to fathers, other sociodemographic groups, or clinical samples. Shame is variously defined and measured in the literature (Ferguson, 2005); thus, the shame measure used in this study likely does not reflect all possible dimensions of the shame experience. Measures of childhood sexual abuse and interpersonal conflict were not independently verified, and either over-reporting or under-reporting is possible. Retrospective reports of child abuse are subject to recall bias from factors such as health status, mood, and current life circumstances (Hardt & Rutter, 2004; Widom, Raphael & DuMont, 2004). As well, there may be individual differences, to some degree culturally mediated, among participants in their interpretations of questions such as, "We fight a lot in our family." Further research is needed to determine women's specific behaviors in interpersonal conflicts. Finally, other possible mediating factors between childhood abuse and interpersonal conflict, such as childhood family environment characteristics, other critical life events, mental disorders, other emotions, and personality traits could not be included in this model.

The damaging effects of interpersonal conflict on the health of women, their children, and the entire family can be far-reaching (Cicchetti & Toth, 1995; Kitzmann, Gaylord, Holt, & Kenny, 2003; Repetti, Taylor, & Seeman, 2002). Learning more about the psychological experience that accompanies interpersonal conflict could point towards more effective interventions. Findings from this study suggest that shame may be a key psychological component in the conflicts of women with sexual abuse histories. Given the evidence for the

psychologically damaging effects of shame in abused women (Andrews, 1995; Buchbinder & Eisikovits, 2003; Kallstrom-Fuqua et al., 2004; Talbot et al., 2004), clinicians may wish to inquire about the role of shame in abused women's interpersonal conflicts. Research into the links between shame and accompanying emotions, cognitions, and behavioral patterns in conflicts is needed to inform interventions. The identification and therapeutic address of shame may prove instrumental in helping women with abuse histories whose interpersonal relationships and quality of family life are marred by disputes.

Acknowledgments

This research was supported by a grant from the National Institute of Mental Health (K01-MH068491). We would like to thank Fred Rogosch, Jody Todd Manly, and Michael Lynch for their help with data collection and Carol Ann Dubovsky for her assistance in data management. We also thank Paul Duberstein and Erin Ward for their helpful comments.

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Table 1
Descriptive statistics among childhood sexual abuse, shame, and interpersonal conflict

Variables	N	Possible Range	<i>M</i>	<i>SD</i>
Sexual Abuse	129	1-5	2.03	1.42
Shame	129	1-5	2.23	.83
Family Conflict	129	0-1	.38	.23
Self-Verbal Aggression	128	0-6	1.92	1.59
Partner-Verbal Aggression	129	0-6	1.64	1.59
Self-Physical Aggression	128	0-6	.33	.64
Partner-Physical Aggression	129	0-6	.24	.80

Table 2
Hierarchical regression models testing mediating effects of shame on childhood sexual abuse (CSA) predicting interpersonal conflict

Variables Step:	R ²	B	SE	β	t	p
DV: Family Conflict (FC)						
1. CSA predicting FC	.12	.04	.02	.25	2.87	<.05
Number of children predicting FC		.03	.01	.20	2.37	<.05
2. Shame predicting FC	.23	.10	.02	.34	4.17	<.05
CSA predicting FC		.03	.02	.16	1.96	.05
Number of children predicting FC		.03	.01	.23	2.81	<.05
DV: Self Verbal Aggression (SVA)						
1. CSA predicting SVA	.06	.22	.10	.19	2.15	<.05
Maternal age predicting SVA		-.04	.02	-.17	-1.91	.06
2. Shame predicting SVA	.15	.58	.16	.30	3.56	<.05
CSA predicting SVA		.14	.10	.12	1.37	.17
Maternal age predicting SVA		-.04	.02	-.15	-1.83	.07
DV: Partner Verbal Aggression (PVA)						
1. CSA predicting PVA	.01	.14	.11	.12	1.32	.19
2. Shame predicting PVA	.07	.48	.17	.25	2.85	<.05
CSA predicting PVA		.07	.11	.06	.67	.51

Note. Sample size is 129 for FC data, and 128 for SVA and PVA data.

Table 3
Logistic regression models testing mediating effects of shame on childhood sexual abuse (CSA) predicting interpersonal conflict

Variables Step:	Nagelkerke R ²	B	SE	Wald	Sig.	Exp (B)
DV: Self Physical Aggression (SPA)						
1. CSA predicting SPA	.02	.21	.14	2.23	.14	1.23
2. Shame predicting SPA	.21	1.10	.28	16.03	< .05	3.01
CSA predicting SPA		.08	.15	.25	.62	1.08
DV: Partner Physical Aggression (PPA)						
1. CSA predicting PPA	.12	.51	.15	11.06	< .05	1.66
2. Shame predicting PPA	.19	.64	.26	6.18	< .05	1.91
CSA predicting PPA		.44	.16	7.72	< .05	1.55
DV: Child Maltreatment (CM)						
1. CSA predicting CM	.12	.35	.15	5.53	< .05	1.42
Number of children predicting CM		.24	.13	3.48	.06	1.28
2. Shame predicting CM	.14	.30	.25	1.40	.24	1.35
CSA predicting CM		.33	.15	4.64	< .05	1.39
Number of children predicting CM		.25	.13	3.63	.06	1.29

Note. Sample size is 129 for SVA and PVA data, and 115 for CM data.