A PROCESS MODEL FOR UNDERSTANDING ADAPTATION TO SEXUAL ABUSE: THE ROLE OF SHAME IN DEFINING STIGMATIZATION

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Abstract—While sexual abuse in childhood places the individual at-risk for a variety of problems, research indicates wide variation in victims' adjustment. Limited work is available that attempts to systematically explain processes by which children adjust to the trauma. Few studies have been undertaken to examine any theory about what causes children to be symptomatic. This article presents a theoretical and testable model that specifies psychological processes related to the traumagenic dynamics of stigmatization in child and adolescent victims of sexual abuse. The model proposes that sexual abuse leads to shame through the mediation of cognitive attributions about the abuse and shame, in turn, leads to poor adjustment. Three factors, social support, gender, and developmental period are hypothesized to moderate the proposed stigmatization process. Developmental and clinical research supporting the model is reviewed, specific hypotheses are made, and the relevance of developmental psychopathology for future theory and research is discussed. Unless future research elucidates the process and circumstances whereby the experience of sexual abuse leads to poor adjustment, little progress will be made toward developing more effective treatments.

Key Words—Child sexual abuse, Stigmatization, Shame, Attribution, Adjustment.

INTRODUCTION

ATTENTION TO THE issue of sexual abuse during childhood and adolescence has primarily focused on questions concerning the consequences of sexual abuse on social and emotional adjustment. A good deal of this work has been aimed at identifying the short and long term effects of sexual abuse. Victims of sexual abuse during childhood are at risk for a variety of behavior problems. The list of problems associated with the history of child sexual abuse is extensive and includes: depression (Bagley & Ramsey, 1985; Beitchman et al., 1992; Briere & Runtz, 1985; Brooks, 1985; Goldston, Turnquist, & Knutson, 1989; Kolko, Moser, & Weldy, 1988; McGrath, Keita, Strickland, & Russo, 1990; Morrow & Sorell, 1989; Peters, 1984), feelings of isolation and stigma (Briere, 1984; Lindberg & Distad, 1985; Sedney & Brooks, 1984), poor self-esteem (Bagley & Ramsey, 1985; Conte & Schuerman, 1987; Courtois, 1979; Gomes-Schwartz, Horowitz, & Sauzier, 1985; Herman, 1981; Tong, Oates, & McDowell, 1987), sexualized behaviors (Beitchman, Zucker, Hood, daCosta, & Akman, 1991; Briere, 1984; Courtois, 1979; Deblinger, McLeer, Atkins, Ralph, & Foa, 1989; Finkelhor, 1984; Gale, Thompson, Moran, & Sack, 1988; Herman, 1981; Langmade, 1983; Mannarino & Cohen, 1986; Meiselman, 1978), and post traumatic stress disorder (Courtois, 1988; Donaldson & Gardner, 1985; Friedrich, Urquiza, & Beilke, 1986; Goodwin, 1985; Lindberg & Distad, 1985;

While sexual abuse in childhood places the individual at-risk for a variety of problems, recent research on children indicates that they vary widely in their adjustment (Caffaro-Rouget, Lang, & van Santen, 1989; Conte & Schuerman, 1987; Finkelhor, 1984; Friedrich, 1988; Kendall-Tackett, Williams, & Finkelhor, 1993; Lipovsky, Saunders, & Murphy, 1989; Mannarino & Cohen, 1986; Tong, Oates, & McDowell, 1987). Little work is available that attempts to systematically explain the mechanisms by which children adapt to the trauma of sexual abuse (Friedrich, 1988; Gomes-Schwartz, Horowitz, & Sauzier, 1985; Kendall-Tackett, Williams, & Finkelhor, 1993). While the crucial work of documenting the consequences of abuse continues, the field has begun to consider the construction of conceptual models to explain why particular effects occur (Finkelhor, 1988). Such models have employed general theories concerning the process of traumatization and integrated them with knowledge about the feelings, attitudes, and behavior of sexual abuse victims. Several general models are offered in the current literature.

The Post-Traumatic Stress Disorder (PTSD) model argues that the impact of child sexual abuse is best understood and treated within the framework of PTSD (Courtois, 1988; Deblinger, McLeer, Atkins, Ralphe, & Foa, 1989; Donaldson & Gardner, 1985; Friedrich, Urquiza, & Beilke, 1986; Goodwin, 1985; Lindberg & Distad, 1985; McLeer, Deblinger, Atkins, Foa, & Ralphe, 1988; Wolfe, Gentile, Michienzi, Sas, & Wolfe, 1991; Wolfe, Gentile, & Wolfe, 1989). Children’s responses to traumatic events include the two basic dimensions of post-traumatic reaction: repetition of the trauma and attempts to avoid or deny the trauma (Terr, 1985). PTSD symptoms can be thought of as attempts to cope with the emotions produced by the traumatic experience, either through approach strategies or through avoidance and denial (Berliner & Wheeler, 1987). The information processing model proposed by Burgess (1988) postulates that the trauma or stressor produces anxiety which the child deals with through defensive coping operations (e.g., dissociation, denial, or reenactment). Another major conceptualization proposes that rather than the sexual abuse experience itself, it is the impairment of children’s self-esteem that accounts for the development of behavior problems (Bagley & Young, 1989; Putnam, 1990). The Traumagenic Dynamics Model of Child Sexual Abuse offers four different dynamics to describe the variety of different types of symptoms, including PTSD as well as other problem constellations (Finkelhor & Browne, 1985). Traumatic sexualization, betrayal, stigmatization, and powerlessness are dynamics that explain how children’s cognitive, emotional, and social functioning may be affected by the sexual abuse. Briere (1992) has also proposed a multiple dynamics approach to explain the variation in symptoms associated with sexual abuse. This approach focuses on such factors as negative self-evaluation, reduction of painful internal states, powerlessness, and preoccupation with control. Other approaches focus on abuse as a generalized stressor with abuse as one index of general family dysfunction (Clausen & Crittenden, 1991).

As a recent review of research on sexual abuse in children concluded, few studies are undertaken to examine any theory about what causes children to be symptomatic (Kendall-Tackett et al., 1993). The focus is on outcomes rather than the explanation of why particular effects are likely to occur or not. There is an evident gap between wide conceptualizations, such as those offered by the PTSD or traumagenic models, and research documenting effects without much attention to process. In this article, we present a theoretical and testable model that specifies psychological mechanisms related to the traumatic dynamics of stigmatization. Because of our interest in the development of self-conscious emotions and their role in adjustment, we have decided to focus on the stigmatization process. A related interest is how self-evaluations in regard to the abuse are related to subsequent adjustment. Stigmatization is the dynamic in the traumagenic model that most clearly encompasses these interests in self-blame and negative self-regard. In contrast to stigmatization, traumatic sexualization focuses on deviations in sexual behavior, betrayal focuses on disruptions in the capacity to form close relationships and powerlessness on fear, anxiety, and PTSD symptoms.
It is time for the field to move toward constructing middle range theories (Deutsch & Krauss, 1965; Merton, 1957). Such theories have the advantage of providing a deeper understanding of the processes involved in adaptation. They are also more readily operationalized into clear research plans that can result in specific information about particular dynamics of the adaptation to abuse. This article begins with a presentation of a process model to explain stigmatization. It represents an effort to move from the broad conceptualization of multiple dynamics of sexual abuse offered by Finkelhor and Browne (1985) to a more specific consideration of how stigmatization may operate in sexual abuse victims. The model provides both empirically testable hypotheses and offers important clinical insights. We will review the existing literature that supports the model and discuss how the model is grounded both in a developmental psychopathology perspective as well as in current conceptualizations of sexual abuse.

THE MODEL OF STIGMATIZATION

While the empirical work is quite limited, the relation between sexual abuse and stigmatization appears to be a strong one (Finkelhor & Browne, 1986). Our central premise is that sexual abuse is likely to lead to the powerful negative self-evaluative emotion of shame in the victim, and that shame rather than guilt is the core emotion for stigmatization. We believe that attributions about the sexual abuse mediate the influence of the abuse on subsequent feelings of shame. Attribution processes concern causal inferences or the perceived reason(s) an event has occurred (Weiner, 1990). Individuals may use three dimensions to explain the causes of good and bad events: (1) internality (the self is the cause) versus externality (someone or something outside of the self is the cause); (2) stability (the reason will remain the same) versus instability (the reason may change); and, (3) globality (the reason affects my entire self or everything that happens to me) versus specificity (the reason applies to a particular event or aspect of the self). Internal, stable, global attributions for negative events (e.g., "This happened because I am a bad person") are the most likely to lead to shame (Lewis, M., 1992). We also expect that shame influences the child’s adjustment; that is, the more shame experienced, the greater the likelihood of poor adjustment. Recent research suggests that individuals who are shame prone are more likely to evidence poor self-esteem, depression, and dissociation (Lewis, M., 1992; Ross, 1989; Tangney, Wagner, & Gramzow, 1990). Consequently, we believe that an internal, stable, global attribution style for negative events, and the abuse in particular, constitutes a risk factor for shame and subsequent poor adjustment.

Figure 1 presents our conceptual model of the traumagenic dynamics of stigmatization in child and adolescent victims of sexual abuse. On the far left side of the model is the sexual abuse event(s). Sexual abuse leads to shame through the mediation of cognitive attributions about the abuse (a, b) and shame in turn leads to poor adjustment (d). The model also allows
for the sexual abuse to influence shame (c) and adjustment (e) directly, although our central hypothesis is that the outcomes of abuse are mediated by how the child thinks about the event(s).

Examination of three moderating factors, social support, gender, and developmental period, as they influence the basic process described in Figure 1 is also important. Emotional support from parents, siblings, and friends has been shown to mitigate the effects of negative events and promote good adjustment (Brownell & Shumaker, 1984; Conte & Berliner, 1988; Wyatt & Mickey, 1988). Social support should, therefore, operate to buffer against the negative effects of sexual abuse on shame and adjustment. Sex of victim appears related to reported incidence of victimization and type of outcome (Friedrich, 1988; Friedrich et al., 1986; Gold, 1986; Knopp, 1986). Because females are more likely to experience shame in situations where they perceive they have broken a rule, abused girls should be more at-risk for poor adjustment and especially depression, compared to boys (Cutler & Nolen-Hoeksema, 1991). The developmental period during which the abuse occurs can also moderate the stigmatization processes. Some work indicates that the prepubescent period, compared to early childhood or adolescence, may be a particularly vulnerable time (Friedrich, 1988; Tufts, 1984).

In summary, we propose that one process whereby sexual abuse results in poor adjustment is through the mediation of shame. The extent to which shame is experienced following sexual abuse is viewed as primarily determined by the victim's attributions about the event. This process of stigmatization is moderated by the victim's sex, developmental period, and social support.

Sexual Abuse, Shame, and Stigmatization

Theory and available research on normal and atypical samples leads to specific hypotheses about how sexual abuse is related to the experience of shame, stigmatization, and subsequent behavior problems (Browne & Finkelhor, 1986; Kendall-Tackett et al., 1993; Lewis, M., 1992; Tangney, Wagner, & Gramzow, 1990). Stigmatization has been defined as the negative feelings and thoughts about the self that may occur during and following sexual abuse. It is described as the extent to which a victim feels bad and blameworthy. Stigmatization has been associated with shame, guilt, and low self-esteem (Finkelhor & Browne, 1986; Putnam, 1990; Wolfe & Gentile, 1992).

The phenomenological experience of shame is a desire to hide, disappear, or die (Lewis, H. B., 1971; Lewis, M., 1992; Nathanson, 1987). It is a highly negative and painful state that also results in the collapse of bodily posture, the disruption of ongoing behavior, confusion in thought, and an inability to speak, at least briefly. The action accompanying shame is a shrinking of the body, as though to disappear. Because of the intensity of this emotional state, and the fact that the attribution is an attack on the self-system, individuals will act to rid themselves of it. However, since it is a global attack on the self, they have great difficulty in dissipating this emotion. When shamed repeatedly, people develop strategies to rid themselves of this feeling, including depression and/or acting-out behaviors (Lewis, H. B., 1971, 1987).

Shame does not appear to be produced by any specific situation, but rather by an individual's interpretation of an event. Even more important, shame is not related necessarily to whether the event is public or private. Although some hold that shame is a public failure (Lewis, H. B., 1971), this need not be so (Lewis, M., 1992; Tangney, Wagner, & Gramzow, 1990). Failure, attributed to the self-system, can be either public or private. Shame, therefore, may be public, but is as likely to be private.

While shame and guilt have been poorly differentiated in past theory and research, recent work suggests that they are phenomenologically different and involve different cognitive processes (Ferguson, Stegge, & Damhuis, 1991; Lewis, H. B., 1987; Lewis, M., 1992; Tangney, Wagner & Gramzow, 1990; Wicker, Payne, & Morgan, 1983). We believe it is critical to
differentiate shame from guilt because it is shame rather than guilt that should lead to poor adaptation to sexual abuse. Both shame and guilt involve negative affect, but the focus of the negative affect differs. Guilt is an emotion produced when individuals evaluate their behavior as a failure, but focus on the specific features or actions of the self that led to the failure. Unlike the focus on the global self in shame, the focus in guilt is on the self’s actions and behaviors that may repair the failure. From a phenomenological point of view, individuals are pained by their failure, but this pained feeling is directed to the cause of the failure or the object of harm rather than on the self. Because the cognitive-attributional process focuses on action rather than on the total self, the feeling produced is not as intensely negative as shame and does not lead to confusion or to the loss of action. In fact, the emotion of guilt usually is associated with a corrective action that the individual can take to prevent negative experiences.

Although most individuals have the capacity to experience both emotions, there appear to be individual differences in the likelihood of feeling shame compared to guilt when experiencing negative events or outcomes. Across situations some people are consistently more likely to experience shame while others are more likely to respond with guilt (Tangney, Burggraf, & Wagner, 1995). Several studies indicate that proneness to shame versus guilt has different correlates in the interpersonal and intrapersonal adjustment of adults. Shame proneness has been associated with the psychological symptoms of depression, anxiety, low self-esteem, and paranoid ideation (Harder & Lewis, 1986; Hoblitzelle, 1987; Tangney, Wagner, & Gramzow, 1990). Fergusen, Stegge, and Damhuis (1991) provide clear evidence that children and adolescents have distinct concepts of shame compared to guilt and that these conceptions are comparable to adults’ phenomenological descriptions. In studies of children ages 10–12 years, proneness to shame was positively correlated to depressive symptoms and negatively correlated with self-esteem (Burggraf & Tangney, 1989, 1990). In contrast, proneness to guilt independent of shame, was unrelated to depressive symptoms and self-esteem.

From our clinical experience, we have observed that shame is an emotion highly characteristic of victims. In our work with children and adults who were abused as children, we have found that they tend to denigrate themselves and express the desire to hide and avoid exposure. Self-denigration can take the form of such statements as “I am stupid, awful, a bad person, a blob.” In adults, shame is often expressed by the fact that they continue to keep childhood molestation a secret. Both children and adults have been observed to hide themselves when talking about the abuse (e.g., avoiding eye contact, hiding their face, hiding their body behind a pillow or chair). We believe that the experience of shame related to sexual abuse, more so than guilt, is likely to lead to the traumagenics of stigmatization and the subsequent negative outcomes of low self-esteem, depression, and dissociation (Ross, 1989; Tangney, Wagner, & Gramzow, 1990).

Characteristics of Sexual Abuse and Shame

The experience of shame, as a consequence of the sexual abuse, is a central mechanism related to stigmatization and subsequent behavior problems. Shame is likely to be influenced by contextual factors. Unfortunately, the number of studies on the relation between type of abuse and the likelihood of subsequent behavior problems is small, mostly retrospective, and inconsistent (see Browne & Finkelhor, 1986; Kendall-Tackett et al., 1993 for reviews). Furthermore, none of the studies make a direct link between type of sexual abuse, the experience of shame, and subsequent behavior problems. Nevertheless, based on clinical report and some research, it is possible to hypothesize regarding which abuse factors may be related to shame. If the victim is immersed in a social environment where the self is denigrated and humiliated, shame is a likely result (Finkelhor & Browne, 1986; Friedrich, Berliner, Urquiza, & Beilke, 1988; Lewis, M., 1992). Our approach, following the suggestions of Finkelhor and Browne (1986), does not simply classify abuse characteristics as more or less serious, but provides a
specific statement about the potential of these characteristics for producing shame. For example, it makes sense to assume that if the offender blames the victim for the sexual abuse, shame should be higher. Intra-familial abuse, especially with a parent, has been related to greater trauma (Finkelhor, 1979; Friedrich, Urquiza, & Beilke, 1986; McLeer et al., 1988; Russell, 1986; Sirles, Smith, & Kusama, 1989). Sexual abuse by a parent, and in particular a biological parent, may be more related to shame because it represents a violation of a very strong, pervasive social standard which is made public upon disclosure (Lewis, M., 1992). Also, to the extent that such abuse represents a betrayal by a trusted person, in combination with the violation of a social taboo, greater shame would be expected and, hence, greater trauma (Browne & Finkelhor, 1986).

More serious forms of sexual contact have been shown to be related to greater trauma, although the difference between penetration and genital fondling is not always found (Bagley & Ramsey, 1985; Elwell & Ephross, 1987; Friedrich et al., 1986; Kendall-Tackett et al., 1993; Russell, 1986; Seidner & Calhoun, 1984; Tufts, 1984). Repeated incidents of serious forms of contact would be expected to elicit more shame from the victim, as they represent a greater magnitude of transgression from acceptable behavior. Also, the more the victim is forced to play an active compared to a more passive role in the abuse act(s), the more shame would be predicted. Acceptance of bribery is another characteristic that could be expected to be related to more shame because it may heighten a sense of complicity in a taboo relationship. In contrast, being threatened or physically coerced may be associated with less shame because the victim feels less responsible for the abuse. Being discovered, as compared to purposeful telling, may also constitute a higher risk factor for shame. Discovery involves the public exposure of the self which may be more immediately shameful (Lewis, M., 1992; Taska, 1995). Discovery also may leave the question of complicity more uncertain than in those instances of purposeful telling and in addition, may be associated with the victim’s feeling of powerlessness.

At this point, we have specified the class of characteristics that may be more likely to lead to shame and stigmatization. However, it is important to recognize that, while a certain characteristic of the event may be likely to elicit shame, the cognitive evaluation of the event, or attribution style of the victim, should play a central role in whether and the extent to which shame will be experienced (Lewis, M., 1992).

Attribution Style and Shame

Underlying shame is an elaborate set of cognitive processes. First, self-conscious evaluative emotions involve a set of standards that one acquires through culturalization in a particular society. By the second year of life, children show some understanding about appropriate and inappropriate behavior (Heckhausen, 1984; Kagan, 1981). Recent work indicates that by the beginning of the third year of life, children, without adults present, already have standards and seem to show distress when they violate them (Heckhausen, 1984; Lewis, Alessandri, & Sullivan, 1992; Stipek, 1983; Stipek, Recchia, & McClintic, 1992). The acquisition of standards continues across the lifespan (Stipek, Recchia, & McClintic, 1992). Success or failure vis-à-vis a standard is likely to produce a signal that results in self-reflection (see Mandler, 1975). This reflective process gives rise to self-attributions and to the specific emotions accompanying the different types of self-attribution. A good deal of literature has been concerned with the nature of attribution and its importance for behavior especially in achievement situations (e.g., Dweck, 1991; Dweck & Leggett, 1988; Weiner, 1974, 1986) and in understanding depression (Garber & Seligman, 1980; Kaslow, Rehm, Pollack, & Siegel, 1988).

The work of Lewis (1992) is particularly relevant because it is directly concerned with attribution related to self-conscious emotions. Lewis’ structure of self-evaluation/attribution is composed of two dimensions: locus of causality (evaluation of whether cause is internal or
external to the subject, such as ability or luck) and specificity (evaluation of cause as global or specific). These two attribution dimensions give rise to self-conscious evaluative emotions, such as shame, guilt, and pride. If failure is attributed to an internal, global cause, the resulting emotion is shame; if attributed to internal, specific aspects of the self, guilt results; if success is attributed to internal, specific factors, the emotion is pride.

How the victim evaluates the sexual abuse event(s) is a central component of victimization and is thought to mediate subsequent long lasting effects of the abuse (Conte, 1985; Gold, 1986; Janoff-Bulman & Frieze, 1983; Wyatt & Mickey, 1988). The literature suggests that making internal, stable, global attributions for negative events is related to poor adjustment, including shame, low self-esteem, helplessness, psychological distress, and depression (Kasl-Low, Rehm, Pollack, & Siegel, 1988; Lewis, M., 1992; Metalsky, Abramson, Seligman, Semmel, & Peterson, 1982; Peterson & Seligman, 1983; Tangney, Wagner, & Gramzow, 1990; Tangney, Wagner, Fletcher, & Gramzow, 1990).

The work available on the relation between attribution style and sexual abuse in adults who were victimized in childhood supports the idea that attribution style mediates the long-term outcome of sexual abuse (Gold, 1986; Wyatt & Mickey, 1988). One study compared the current functioning of women who had been sexually abused as children to women who did not report being abused (Gold, 1986). There was a strong relation between the victim’s attribution style and her adult functioning. Women who were sexually victimized in childhood, and who reported psychological distress and low self-esteem, were more likely to have an attribution style characterized by internal, stable, global attributions for negative events. Another study of women who reported being sexually abused as children found that a self-blaming attribution style was related to not having disclosed the abuse and more severe forms of abuse (Wyatt & Mickey, 1988). These findings suggest that self-blaming attributions may be related to more shame and hence, unwillingness to disclose the event. One study of adolescent victims found that internal attributions for the sexual abuse, compared to external ones, were related to lower self-esteem and higher depression scores (Morrow, 1991). Adolescent victims who felt “I did something wrong and I am being punished for it” showed poorer adjustment than those who viewed the perpetrator at fault “because he was drinking.”

Shame and Adjustment

A basic premise of our model is that the experience of shame is one primary mechanism by which victims of sexual abuse develop behavior problems. There is some evidence suggesting a relation between self blame and guilt in abuse victims and low self-esteem and depression (German, Habenicht, & Futcher, 1990; Wolfe & Gentile, 1992). However, to our knowledge, the empirical literature on sexual abuse has not examined shame and its relation to adjustment in victims. Theoretically, the traumagenic dynamics of stigmatization have been linked to shame, but the exact processes have not been explored (Finkelhor & Browne, 1986).

The literature on shame indicates how the continued experience of this emotion can lead to poor adjustment. Both the clinical and empirical literature suggest that shame proneness is related to affective disorders, particularly depression (Harder & Lewis, 1986; Hoblitzelle, 1987; Lewis, H. B., 1971, 1987; Lewis, M., 1992; Tangney, Wagner, & Gramzow, 1990). Repeated experiences of shame should make an individual vulnerable to depression (Lewis, H. B., 1987; Lewis, M., 1992). Tangney, Burggraf, and Wagner (1995) argue that shame-prone individuals may be more vulnerable to depression because of persistent situations in which self-functioning is disrupted and because the cognitive/affective experience of shame may contribute to hopelessness. The current model thus conceptualizes depression as an outcome of the attribution-shame process. It is possible that children have the attribution-shame-depression dynamic prior to victimization, in which case depression would mediate the effects of the abuse. However, even when depression operates as a mediator, we argue that it still is
an outcome of the attribution-shame process. To empirically evaluate depression as a mediator would require a prospective study of children prior to victimization.

Problems of dissociation also have been linked to shame. Of particular interest is the suggestion that sexual abuse may lead to dissociative disorders. It is argued that sexual abuse leads to shame in the victim and dissociation is a defense against this powerfully negative state (Lewis, M., 1992; Ross, 1989). Evidence for the relation between sexual abuse, shame, and dissociation comes from clinical case histories of multiple personality disorders in which sexual abuse almost always is evident (Ross, 1989).

MODERATING FACTORS

Social Support

The social support provided by relationships with parents, siblings, extended kin, nonkin adults, and friends is known to influence psychological health and adjustment in children and adolescents (Bryant, 1985; Buhrmester & Furman, 1987; Cochran & Riley, 1987; Feiring & Lewis, 1991a, 1991b; Werner & Smith, 1982). The support network can serve to mitigate the negative effects of stressful events and also may operate to enhance the individual's sense of competence and self-worth (Brownell & Shumaker, 1984; Cohen & McKay, 1984; Crnic, Ragozin, Greenberg, Robinson, & Basham, 1983; Crockenberg, 1981; Sarason & Sarason, 1984). Different sources of support (e.g., parent, friend, teacher, counselor) as well as different types of support (e.g., emotional, educational) can have differential impact on feelings of competence and self-esteem (Brownell, 1982; Feiring, Fox, Jaskir, & Lewis, M., 1987).

Little empirical work is available on whether social support operates as a buffer for child and adolescent victims of sexual abuse. Retrospective data collected on adults who were sexually abused in childhood indicate that social support from adults was associated with better sexual adjustment and more positive attitudes toward men (Gold, 1986; Wyatt & Mickey, 1988). One study with children, aged 4–17 years, found that a supportive relationship with an adult or sibling was associated with fewer negative symptoms, as rated by a social worker (Conte & Berliner, 1988). Another report indicated that the social support networks of sexually abused girls, aged 6–16 years, compared to an age matched control group, differed in the number of satisfactory relationships and support from same sex peers (Helmers, Everett, & Trickett, 1991). Sexually abused preadolescent girls appeared to be the most socially isolated. There is also some evidence that maternal support is related to better prognosis (Everson, Hunter, & Runyan, 1991; Goodman et al., 1992).

While the supportive response of adult caretakers to victimized children has been described as critical to their perceptions of the abuse and adaptation (Adams-Tucker, 1982; Johnson & Kenkel, 1991; Silver & Wortman, 1980), prospective research on support as a buffer is lacking. Social support is viewed as moderating the effects of sexual abuse. Under conditions of greater social support, sexual abuse should have substantially less impact (c.f. Wheaton, 1985). There is no literature to suggest at what point(s) in the stigmatization process the buffering effect may occur. Social support may impact on the relation between abuse and an at-risk attribution style, abuse and shame, and abuse and poor adjustment. First, social support may moderate the victim's attributions about the abuse such that victims with more social support will be less likely to hold internal, global, stable attributions about why the abuse occurred. Second, social support may moderate the experience of shame such that victims with more support are likely to feel less shame. Third, social support may moderate the impact of abuse on adjustment such that those victims with more support are less likely to show poor adjustment.

Emotional support from parents, other family members (e.g., siblings), nonkin adults (e.g., case worker, therapist, teacher), and friends may have differentiated roles to play in adaptation.
Both perceived and received support need to be explored (Eckenrode & Wethington, 1990; Kaniasty, Norris, & Murrell, 1990). Perceived support refers to the noncontext dependent psychological sense of support derived from feeling loved, valued, and part of a reliable, trusted social network. Received support refers to concrete instances of helping from network members. While perceived and received support are likely to be correlated with each other, received support may give us important information regarding mobilization of support resources in response to the abuse disclosure and sequelae. Perceived support may be a more effective buffer of the relation between sexual abuse and attribution style while received support may operate more as a buffer between shame and adjustment.

Developmental Period

Because children’s abilities to understand their experiences both intrapsychically and interpersonally change tremendously during the course of development from infancy through adolescence, it is likely that the effects of sexual abuse vary considerably with developmental period (Bukowski, 1992). Unfortunately, research yields inconsistent results regarding the influence of developmental period. This may be due in part to the confusion between age of onset of the abuse and the developmental period during which the abuse persists (Tufts, 1984). In some studies, neither age of onset (Bagley & Ramsey, 1985; Finkelhor, 1979; Langmade, 1983; Russell, 1986) nor age at assessment (Einbender & Friedrich, 1989; Friedrich, Urquiza, & Beilke, 1986; Kolko, Moser, & Weldy, 1988) show much relation to the impact of the sexual abuse. While some studies show the later the abuse, the more pervasive the effects (Kendall-Tackett, Williams, & Finkelhor, 1993), other work indicates that the prepubescent period may be a particularly vulnerable time, compared to early childhood or adolescence (Courtois, 1979; Friedrich, 1988; Gomes-Schwartz, Horowitz, & Sauzier, 1985; Tufts, 1984). One study found that sexually abused children between the ages of 7 and 13 years showed the highest number of behavior problems and were most like psychiatric patients (Friedrich, 1988). The youngest (4–6) and oldest (13+) groups of sexually abused children showed rates of behavior problems between that of normals and psychiatric patients.

Attribution patterns should also be affected by the developmental period. Research on attribution patterns for school achievement indicates that children’s attributions become more differentiated with age. Preadolescent children may be more likely to make global attributions for success or failure (Miller, 1985; Nicholls, 1984). This suggests that latency aged children will be more at-risk for making internal, global attributions for the sexual abuse, a pattern which should lead to more shame and, therefore, poorer adjustment.

Gender

Gender appears related to sexual abuse and subsequent outcomes. The sexual abuse of females is more likely to be reported, although many investigators now believe the sexual abuse of males is greatly under-reported (Knopp, 1986; Porter, 1986). Thus, most of the available research is on females (Browne & Finkelhor, 1986; Finkelhor, 1979). Females are more likely to experience shame in situations where they perceive they have broken a rule or not lived up to their own or others expectations (Lewis, M., 1992; Tangney, 1991). There is some evidence that shame is more likely in females because they are more likely to make internal, stable, global attributions for failure and negative events (Anderson, Horowitz, & French, 1983; Dweck & Leggett, 1988; Dweck & Reppucci, 1973; Lewis, M., 1992; Nicholls, 1975). Thus, abused girls, compared to boys, may be more at risk for making internal stable global attributions for the abuse, which will lead to more shame and, therefore, poorer adjustment. It also may be the case that girls are more at-risk for experiencing abuse events that lead to shame. For example, incest by a parental figure, compared to extra-familial abuse, may be more likely to happen to females and should be strongly associated with shame. Thus it is
important to determine what types of abuse events elicit shame in females compared to males and whether certain events which may be linked to gender are more likely to predispose the victim to feelings of shame.

Male and female victims may exhibit different responses to the sexual abuse. Girls may show more internalizing problems than boys (Cutler & Nolen-Hoeksema, 1991; Friedrich, 1988; Friedrich et al., 1986). Related to this phenomenon is the finding that adult women who were sexually abused as children are more likely to report depressive symptomatology and low self-esteem than adult women who were not abused as children (Gold, 1986). It has also been suggested that the need to defend the self against prolonged shame leads to depression in females and rage in males (Cutler & Nolen-Hoeksema, 1991; Friedrich, Beilke, & Urquiza, 1988; Lewis, M., 1992; Lewis, H. B., 1971; Retzinger, 1987; Tangney, Wagner, Fletcher, & Gramzow, 1990).

THE MODEL AND DEVELOPMENTAL PSYCHOPATHOLOGY

The model proposed here is developed from the Traumagenics Dynamics model (Finkelhor & Browne, 1986) and provides a specific set of emotional and cognitive processes to explain and predict child and adolescent adaptation to sexual abuse. It expands on the traumagenic model framework by including the victim’s view of the abuse (attribution), specifying shame as the core emotion of stigmatization, and considering sex of victim, social support, and developmental period as moderators of the stigmatization process. It also conceptualizes abuse in terms of children’s adaptation, thus acknowledging the importance of children as active agents in their own adjustment (Friedrich, 1988). The four dynamics of the traumagenic model describe a broad range of behaviors and outcomes, and presumes that within individuals the extent to which each dynamic is characteristic varies. The dynamics were not conceived as mutually exclusive and behaviors said to be associated with each dynamic overlap to some degree. For example, depression is seen as related to betrayal, powerlessness, and stigmatization. While the processes we delineate in our model are hypothesized to be most related to stigmatization, these processes and their outcomes may be related to the other dynamics. While the empirical relations are still to be established, theoretically stigmatization as defined here would be expected to be moderately related to betrayal and powerlessness. Regarding betrayal, the emotion of shame and the desire to isolate or hide oneself should increase an individual’s sense of vulnerability and distrust of others who may discover the denigrated and unlovable self. The shame related attributional style may also play a role in the dynamic of powerlessness, most specifically to the perception of self as victim. It would be of interest in future research to develop process models for the other dynamics in order to define each dynamic more specifically and to examine how the processes involved in each dynamic relate to each other within and across individuals.

In addition to the traumagenic model conceptualization, the current model is grounded in the principles of developmental psychopathology (Sroufe & Rutter, 1984). Sroufe and Rutter defined developmental psychopathology as focused on the origins of maladaptive patterns of behavior relative to normal adaptive patterns and developmental processes. Whereas clinical psychology is often concerned with issues of diagnosis and treatment, developmental psychopathology focuses on how deviant patterns of adjustment are due to perturbations of normal adaptive mechanisms. Consequently, many abnormal behaviors are viewed as the result of normal processes that were distorted by atypical or destructive experiences rather than distortions engendered by abnormal processes. In our model of stigmatization, the normal processes of attribution and self-conscious emotional expression are viewed as at-risk for deviant development as at least in part a function of the abuse experience.

Another important aspect of developmental psychopathology is its emphasis on the under-
standing and study of maladaptation in regard to age related aspects of development. Due to the focus on normal developmental process, this approach requires the recognition that the impact of particular experiences on development will vary according to when they occur during the life cycle. Such variations in impact may be due to a sensitive period type phenomenon in which specific processes may be more easily influenced at certain points in the life cycle (e.g., Bornstein, 1989). Our stigmatization model stipulates the centrality of developmental period in understanding the victims’ adaptation and focuses on the moderating effects of age for cognitive processes. It suggests that latency age may be a sensitive period for the development of attribution patterns and that abuse events occurring during this time period may have particular impact on the solidification of an at-risk shame-prone attribution style.

The developmental psychopathology approach also is conceptualized within a systems framework (Feiring & Lewis, 1978; Lewis, Feiring, & Kotsonis, 1984; Sameroff, 1983) and, as such, emphasizes the importance of considering the interdependence of developmental processes. For example, interdependence of this sort is described by the role of cognitive and emotional factors as mediators between interpersonal interactions and the development of social competence. In our model, both attribution and self-conscious emotions operate as mediators between the experience of sexual abuse and the subsequent adjustment and adaptation. A systems approach also requires the consideration that sexual abuse occurs within the context of other events so that the abuse needs to be viewed as part of a network of experiences. Thus, although sexual abuse may be different from other traumatic experiences it is an important task to think about how its effects may be both unique as well as related to other pre-existing factors of the environment in which the abuse occurs (Clausen & Crittenden, 1991). Focusing on the social support network of the victim is one way of conceptualizing the abuse within a larger social context.

CONCLUDING REMARKS

As documented in recent reviews, the past decade has seen a considerable increase in the number of studies focusing on sexual abuse and its relation to child outcomes (Beitchman et al., 1991; Kendall-Tackett, Williams, & Finkelhor, 1993). Compared to retrospective studies of adults, studies of children provide a firmer foundation for documenting the array of traumatizing factors and the wide range of possible sequelae. As anyone conducting research on children who have been sexually abused and their families is well aware, such work is labor intensive and a difficult task. It involves coordinating a complex set of problems, including gaining access to children and their families, confidentiality, ensuring evaluations are conducted with clinical sensitivity, and child advocacy and referral. Given the herculean effort necessary to conduct such work, the advances made in the last decade are certainly laudable. The field has come far but has far to go. The model presented in this article represents the kind of theory necessary to move the understanding and treatment of children who have been sexually abused to a more precise level. It addresses a number of important issues for the development of middle range theory in this area, such as differentiation of prediction by age and gender, the specification of intervening variables, and the incorporation of developmental theory and clinical knowledge.

Recently we have begun a study designed to operationalize the model for latency-age children and early adolescence. This short term longitudinal study involves information gathered from children/adolescents, their parent/caretaker, caseworkers, and teachers within 6 weeks of disclosure and one year later. It primarily utilizes standardized measures that tap shame, attribution, and social support processes in general and specific to the abuse, in addition to the outcomes of depression, self-esteem, dissociation, and PTSD. While results from the initial assessments will not be available for some time, preliminary findings indicate support for the
idea that shame and attribution are key mediating factors for understanding adaptation following disclosure (Feiring, Taska, & Lewis, 1995). We hope that the model described here will serve as the basis for future research and ideas as well as for other models that may be developed at a similar level but addressing different processes than those proposed as significant for stigmatization. Unless we understand the dynamics and circumstances whereby the experience of sexual abuse leads to poor adjustment, we will not be able to identify those victims most in need of intervention, or the types of intervention likely to be most effective.

REFERENCES


Résumé—Alors que l’abus sexuel au cours de l’enfance place l’individu à risque face à divers problèmes, la recherche indique une grande variabilité de l’adaptation de la victime à cette situation. Les travaux, qui tentent d’expliquer de façon systématique les processus d’adaptation des enfants au traumatisme sont limités. Peu d’études ont été entamées pour examiner en théorie ce qui rend les enfants symptomatiques. Cet article présente un modèle théorique et testable, qui spécifie les processus psychologiques liés à la dynamique de stigmatisation entrainant le traumatisme des victimes d’abus sexuels au cours de l’enfance et de l’adolescence. Ce modèle suggère que l’abus sexuel provoque un sentiment de honte à travers la médiation d’attributions cognitives concernant l’abus et la honte provoque à son tour une mauvaise adaptation. Trois facteurs, le soutien social, le genre et la période de développement sont hypothétiquement proposées pour atténuer le processus de stigmatisation. Les recherches développementales et cliniques soutenant ce modèle sont revues, des hypothèses spécifiques sont avancées et l’importance de la psychopathologie du développement pour de futures théories et recherches est discutée. Sauf si de futures recherches éclairent le processus et les circonstances qui entraînent une mauvaise adaptation, suite à un abus sexuel, peu de progrès seront faits dans l’élaboration de traitements plus efficaces.

Resumen—Aunque el abuso sexual en la infancia coloca a un sujeto en una situación de riesgo para desarrollar diferentes problemas, la investigación indica que existe una amplia variación en el grado de ajuste de las víctimas. Hay escasos trabajos disponibles que intenten explicar de manera sistemática los procesos mediante los cuales los niños/as se ajustan al trauma. Se han llevado a cabo pocos estudios dirigidos a examinar teorías acerca de qué es lo que causa que los niños/as presenten síntomas. Este artículo presenta un modelo teórico y evaluable, que especifica los procesos psicológicos relacionados con la dinámica de la estigmatización generada por el trauma del abuso sexual en niños/as y adolescentes. El modelo propone que el abuso sexual conduce a la culpa a través de la mediación de atribuciones cognitivas sobre el abuso, y que la culpa a su vez conduce a un pobre nivel de ajuste. Se hipotetiza que hay tres factores: apoyo social, género, y estadío evolutivo, que moderan dicho proceso de estigmatización. Se revisa la investigación evolutiva y clínica que apoya el modelo, se formulan hipótesis específicas, y se comenta la relevancia de la psicopatología evolutiva para las futuras formulaciones teóricas e investigaciones. A menos que las investigaciones futuras aclaren el proceso y circunstancias por las cuales una experiencia de abuso sexual conduce a un pobre nivel de ajuste, apenas se podrá avanzar en el desarrollo de tratamientos más eficaces.