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Helpful or Harmful: The Impact of Shame and Guilt on Concealment in Adulthood Following Childhood Trauma

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by

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We the undersigned committee, having examined the submitted doctoral research project, “Helpful or Harmful: The Impact of Shame and Guilt on Concealment in Adulthood Following Childhood Trauma” by Xiomara Senior, M.S. hereby indicate its unanimous approval.

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Abstract

Helpful or Harmful: The Impact of Shame and Guilt on Concealment in Adulthood Following Childhood Trauma

by

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The current study aimed to examine the moderating role of shame and guilt in the associations between types of childhood maltreatment and levels of self-concealment. Childhood maltreatment has been linked to emotions such as shame and guilt that elicit schemas of self-doubt, incompetence, and failure (Cohen et al., (2011). When an individual internalizes these thoughts and emotions, they may act in maladaptive ways such as avoidance, fear, dissociation, and possible concealment within adulthood (Dorahy & Clearwater, 2012, Smetana et al., 2019). De Seve et al. (2020) recently found that shame proved to be a mediator in the relationship between self-concealment and feelings of inferiority, further emphasizing the importance of research on shame and guilt within self-concealment.

A hierarchical regression was utilized to examine if shame and guilt moderates the relationship between various types of childhood maltreatment (e.g., physical abuse, physical neglect, sexual abuse, and emotional abuse) and level of concealment. Participants ranged in age from 19-64 years old and were recruited on a volunteer basis via social media platforms and local organizations and schools. Participants completed the self-report measures of the Childhood Trauma Questionnaire (CTQ), The Test of

Self-Conscious Affect (TOSCA), The Adverse Childhood Experiences Questionnaire (ACE-Q), and The Self Concealment Scale (SCS) through Qualtrics.

The present study utilized the data collected from the CTQ, ACE-Q, TOSCA, and SCS. The study consisted of 68 participants. 50% of participants identified as male (n = 34), 47% identified as female (n = 32). Among this sample 57 of the participants endorsed a history of childhood trauma while 19 participants endorsed no history of childhood trauma. It was hypothesized that participants who scored higher on shame, compared to guilt, would also score significantly higher on level of concealment, and this hypothesis was supported. Significant negative correlations were also found between emotional neglect as well as sexual abuse and concealment, suggesting a relationship between childhood trauma and concealment. It should also be noted that although it was hypothesized that the participants who reported childhood trauma would display higher levels on concealment on the SCS than the control group, a control group was unable to be formed due to the prevalence of childhood trauma in the sample.

While it was hypothesized that shame would moderate the relationship between childhood trauma and level of concealment, as assessed with the CTQ, ACE-Q, and TOSCA-3, a moderated regression analysis found this interaction to be non-significant. These findings suggest that concealment may serve as a barrier to individuals disclosing feelings of shame. Due to a previous confirmed mediation between shame and feelings of inferiority, it can be suggested that the items meant to endorse shame on the TOSCA-3 elicited feelings of inferiority resulting in the individual concealing this information. In addition to clinical implications, these results suggest that future research should incorporate considerations of the role of concealment in participant expression of shame.

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Chapter 1

Helpful or Harmful: The Impact of Shame and Guilt on Concealment in Adulthood Following Childhood Trauma

Unlovable, unworthy, angry, afraid, conditional, worthless, and confused. All of these are words given by children who had reported at least one type of childhood trauma (Cohen et al., 2011, Gupta et al., 2011). These words also reflect the words adults, with a history of childhood trauma used to explain their current emotions in a study by Dorahy & Clearwater (2012). Statistics show that 68% of children and adolescents have experienced a traumatic event before 16 (Wamser-Nanney & Vandenberg, 2013). These traumatic events can include child sexual or physical abuse, neglect, domestic violence, life-threatening illness, school or community violence, unexpected death of a family member or close friend, natural disaster, removal from family, or other serious accidents (Wamser-Nanney & Vandenberg, 2013). Most of these children will likely experience repeated trauma, as most events are not isolated but instead chronic.

The effects of trauma are numerous and persist years after the traumatic experiences have occurred. Many individuals carry their trauma with them throughout life, impacting their mental health, relationships, and identity development. Messina and Burdon (2020) reported that 60% of children and adolescents had been exposed to crime, violence, and abuse either directly or indirectly. Of that sixty percent, fifty percent reported experiencing assault. Many children and adolescents experience severe, repetitive, and prolonged trauma. The Center for Disease Control and Prevention (2019) identified that individuals who reported at least one adverse childhood event were three times more likely to be diagnosed with depression. This same study found that

individuals who reported four or more adverse childhood events were 15 times more likely to attempt suicide within adulthood. These statistics emphasize the lifelong impact even one incident of childhood maltreatment can have on an individual's life. For the purposes of this study, any form of abuse mentioned moving forward will be related to childhood maltreatment specifically.

Childhood maltreatment has been linked to emotions such as shame and guilt that elicit schemas of self-doubt, incompetence, and failure (Cohen et al., (2011). When an individual internalizes these thoughts and emotions, they may act in maladaptive ways such as avoidance, fear, dissociation, and possible concealment within adulthood (Dorahy & Clearwater, 2012, Smetana et al., 2019). Kealy et al. (2018) introduced that shame developed as a "moral defense." Whereas Nathanson (1992) suggested that individuals who experienced feelings of shame may utilize it as a coping skill coining the term "shame coping" (Vagos et al., 2018). While shame coping may appear beneficial in the moment to protect themselves, it may also create a pattern of general self-concealment and avoidance, hindering the individual's growth and development. De Seve et al. (2020) discovered that the feeling of shame mediated the relationship between self-concealment and feelings of inferiority. This finding exemplifies how individuals who experience trauma-related shame may develop self-concealment as perceived resilience. In actuality, this avoidance or reluctance to share may further prolong their trauma response into late adulthood.

Moral Injury

Moral Injury is defined as the negative feelings (e.g., shame, guilt, anger, etc.) that result from a traumatic event in which an individual is forced to contradict their

core values (McEwen et al., 2020). Individuals such as frontline workers, military personnel, and doctors have been found to be more susceptible to moral injury due to having occupations that work directly with other individuals in high risk, life or death decisions, that impact the wellbeing of others.

Although moral injury is not a new concept, it became more prevalent during the recent COVID-19 pandemic (Haller et al., 2020). During this unprecedented time, doctors were more encouraged to approach triage as prioritizing the patients with a more favorable prognosis resulting in a moral conflict of doing no harm. Wang et al. (2022) conducted a study where 3,006 Chinese physicians and nurses were sent the Moral Injury Symptoms Scale–Health Professional version (MISS-HP) to complete following the COVID-19 pandemic. The researchers sought to identify the association between exposure to COVID patients and the presence of moral injury. The analysis of these surveys resulted in strong positive correlations between elevated scores on the MISS-HP and the presence of anxiety, burnout, depression, and low wellbeing (Wang et al., 2022). It was also found that health care providers who provided care to patients with COVID displayed a 28% greater risk for moral injury compared to those who cared for patients without COVID. Haller et al. (2020) stated that when an individual is forced to violate their morals in times of elevated stress it can develop into anger, shame, distrust, and guilt. Moral injury has been linked to maladaptive coping and negative outcomes such as substance use, depression, suicidal ideation, and possible post traumatic stress disorder (Haller et al., 2020). During a meta-analysis on moral injury, McEwen et al., (2020) found moral injury to not only be linked to negative mental health outcomes, but also impact the individual socially, cognitively, spiritually, physically, and behaviorally. This

metanalysis of 59 articles found that there appears to be a conflicting understanding of studying moral injury distinct from PTSD. While PTSD and moral injury may have overlapping symptomology, moral injury is characterized by unresolved guilt and shame that may not be present with PTSD.

Richardson et al. (2022) examined how moral injury plays a role in the military population by having 19 active military and veterans complete self-report measures and an in depth interview. Among these measures were the Patient Health Questionnaire (PHQ), The Moral Injury Symptom Scale-Military Version, and the Functional Assessment of Chronic Illness Therapy- Spirituality Well Being. The results of this study indicated that the overall themes of moral injury within the military population were reflective of betrayal, moral ambivalence (shift in worldview, questioning purpose), soul wounds (guilt and demoralization), and lack of reconciliation (shame and sense of duty). The concept of moral injury reflects the importance of understanding the underlying shame and guilt which may be present following a traumatic event.

Types of Trauma related to Childhood Sexual Abuse

Gupta et al. (2011) found that adults who had experienced childhood sexual abuse reported negative emotions such as fear, sadness, anger, and disgust; more frequently in daily life than adults who had not experienced any childhood maltreatment. Childhood sexual abuse (CSA) is defined as any physical sexual contact that is without the other person's consent or utilizes physical force (Gupta et al., 2011). However, CSA may also be characterized by non-contact forms of sexual abuse in which the individual is exposed to sexual content without consent (i.e., pornography, social media posts, and voyeurism etc.; Jaroenkajornkij et al., 2022). Among these negative emotions (e.g., fear, sadness,

anger, etc.), shame and anger were found to be the most correlated with the presence of childhood trauma (Gupta et al., 2011). Multiple studies also concluded somatization to be a symptom strongly correlated to childhood sexual abuse. Kealy et al. (2018) reported that CSA was strongly correlated with negative attitude towards one's sexuality as well as an overall negative appraisal of one's appearance resulting in a sense of shame. This was previously seen in 1996 when a study was facilitated in which adult women who had experienced CSA and those who had not, were asked to evaluate their experience following a gynecology exam (Kealy et al., 2018). The women who had experienced CSA reported more trauma like responses (i.e., fear, shame, negative self-image) than the control group who had no history of CSA. Although this environment involved several apparent triggers for the CSA due to the victims being physically vulnerable, the literature also provides evidence for victims experiencing maladaptive coping, low self-efficacy, relationship insecurities, increased sexual behaviors, and being less likely to reach out to social support. These characteristics have also made women three times more likely to experience revictimization later in their lives than the general population (MacGinley et al., 2019). Schnur et al. (2017) validated this statistic by finding that only four out of 16 women who reported CSA were not revictimized in adulthood. As previously mentioned, maladaptive coping may result from experiencing CSA. These coping strategies may include internalizing shame or guilt (Russell et al., 2020), somatization avoidance and denial, and concealment (Ashy et al., 2020, Dorahy & Clearwater, 2012, Kealy et al., 2018, Smetana et al., 2019).

Unfortunately, most of the literature on CSA or adult sexual abuse focuses on the female population. While it has been seen that women tend to internalize their traumatic

experiences, men have displayed more externalizing symptoms (Dorahy & Clearwater, 2012). The literature shows that one in six males are sexually abused before the age of 18. However, it has been found that men typically wait an average of 20-25 years before disclosing their sexual trauma. Male CSA survivors have also been shown to be at a greater risk for revictimization than males without a history of CSA (Ellis et al., 2020). Dorahy and Clearwater (2012) interviewed seven adult men who had experienced CSA to assess their level of shame. The men were given The State of Shame and Guilt Scale, a 15-item questionnaire that measures the level of guilt or shame that the participant experiences in the moment (Dorahy & Clearwater, 2012). The results of this study revealed that, unlike women, male victims of CSA displayed more externalized traumatic symptoms such as increased anger, embarrassment, fear of being labeled gay, guilt, and fear of loss of control. This study emphasized the pattern of shame and guilt related to CSA by reporting how male CSA is viewed. The seven victims all appeared to report experiences of gaslighting (i.e., made to think they were crazy), disbelief, and being misunderstood by professionals when they disclosed their CSA experience. Dorahy and Clearwater (2012) utilized a term coined by Spiegel in 2003 to explain their reactions, "pervasive secrecy". It was discovered that due to the responses from sharing their experience, they began to implement a level of concealment by limiting disclosure at a personal level and a social one (Dorahy & Clearwater, 2012). Ellis et al. (2020) supported this finding that the fear of judgement, mislabeling, and shame and guilt male CSA survivors experienced acted as a catalyst for their lower disclosure rates. This same study found that women were 2.4 times more likely to disclose their sexual violence to family or friends than men. Pereda and Segura (2021) further explored these gender differences by studying 38 males who were sexually abused

as children by representatives of the Spanish Catholic Church. The participants were asked to complete a questionnaire including questions from the Juvenile Victimization Questionnaire (JVQ) detailing their CSA. The results of this study indicated that the survivors experienced shame and guilt as well as feelings of betrayal and abandonments due to the church supporting the offenders not the victims of these sexual acts. In contrast to previous examples, this study explored institutional abuse (abuse that includes exploitation of power where disclosure is prohibited). The participants of this study reported that they attempted to disclose their CSA to multiple individuals, but the stigma and consequence of disclosing these incidents was "strictly stressed" resulting in concealment. It was also found that due to the environment and relationship with the church, 45-69% of the participants reported a negative impact on their spiritual beliefs or religion following the disclosure (Pereda and Segura, 2021). This stigma of disclosure of CSA continues to be seen in multiple settings resulting in emotional avoidance and pervasive secrecy. Riviera et al. (2022) found this similar phenomenon within the military culture. They reported that veteran survivors of CSA endorsed a greater tendency to restrict vulnerable emotions (i.e. sadness, guilt, shame) placing them at greater risk for developing mental illness. These studies emphasize the similarities and differences between males and females in coping with CSA while also highlighting the importance of looking further into trauma related shame and guilt.

Child Maltreatment

While the severity of sexual abuse and related symptomology requires a separate category of childhood trauma, the other types of trauma, such as physical abuse, physical neglect, emotional abuse, and verbal abuse should not be minimized. Mojallal et al. (2021)

defines childhood maltreatment (CM) as any form of abuse or neglect that occurs before the age of 18, resulting in potential harm to the child's development, survival, or overall health. Due to this broad range of areas impacted, literature has found links between CM and aggression and violence, poor academic performance, increased mental health disorders, interpersonal issues, and emotional dysregulation (Afifi & MacMillan, 2011, Chang et al., 2018, Kealy et al., 2018). When reviewing the literature on traumatic symptoms due to CM, a pervasive pattern of shame and guilt related feelings was found to be associated with these experiences. However, there was some disagreement about the origin of this shame. Ashy et al. (2020) found that participants in their study reported shame resulting from disclosing their psychiatric symptoms (i.e., depression, anxiety, dissociation). Vallati et al. (2020) further found evidence that among their participants with bipolar disorder, internalized shame displayed a strong correlation among physical abuse, emotional abuse, and neglect. However, some disagreed, arguing that shame was not the result of psychiatric symptoms but rather a general altered cognitive schema. Kealy et al. (2018) introduced the idea that shame developed as a "moral defense" in which the child absorbs the responsibility of the perpetrator. Therefore, they utilize shame to avoid a painful reality. Cohen et al. (2011) also concluded this by relating childhood maltreatment to schemas reflective of failure, incompetence, and worthlessness exacerbating feelings of shame and guilt. Specifically, shame was found to be associated with forms of neglect. Schoenleber et al. (2021) also concluded this positive relationship by discovering a positive correlation between shame proneness, childhood trauma, and maladaptive emotional regulation.

Child Welfare

An area of childhood trauma that is often overlooked is one that makes children more susceptible to physical, sexual, emotional, and mental abuse than any other population, fostered children. Although more focus is being placed on this population, there is still a deficit of research on the extent of trauma these individuals endure and how it affects them throughout their lives. The literature of foster children is comprised of testimonials detailing feelings of abandonment, feeling unloved, and complicated emotions. (Anderson, 2020, Barnett et al.,2019, Hoksbergen et al., 2003, John et al., 2019). Hoksbergen et al. (2003) identifies the removal of children from their home and placed in foster families as cumulative adoption trauma beginning at a young age when the child is separated from their biological parents and then the reinforcement later in adulthood with the realization of a perceived permanent void. It should be noted that this population is included to only enlighten about childhood trauma not to reprimand the action of removing a child from a dangerous environment.

John et al. (2019) expanded upon the trauma of the child welfare system by exploring the case study of an individual 11-year-old girl. Although only 11 years old, the girl detailed traumatic events of being removed from her home, distanced from her brothers, and placed in a total of six foster homes. In conjunction with these circumstances, she also disclosed the presence of sexual abuse by her foster father, witnessing domestic violence, and emotional abuse and neglect. As a result of this trauma, she struggled to cope and was placed in residential treatment as well as hospitalized for suicide attempts.

To emphasize the lifelong impact caused by possible trauma in the child welfare system, in 2020 a 65-year-old male wrote an analytic autoethnography addressing his

struggles. He detailed the lifelong perceived shame these individuals carry throughout their lives for being "given up" multiple times. He explained how he coped with the shame through dissociation from reality, creating a fantasy of his parents being high school sweethearts that could not raise their child (Anderson, 2020). He later disclosed the anger and hostility he manifested when this reality was shattered by learning the truth about his parents. This autoethnography illuminated society on how this population struggles with lifelong shame due to being labeled " a foster kid" and treated as a "second class person" impacting them into late adulthood (Anderson, 2020).

Research in this area has introduced a link between childhood trauma in foster children and attachment difficulties later in adulthood. John et al. (2019) delves into the attachment insecurities of this population by addressing the social, cognitive, and behavioral issues they struggle with. Adults who were in foster homes as children have been shown to display a greater tendency for distrust in relationships, poor boundaries, and maladaptive social skills than those children who were not in the foster care system (John et al., 2019). This was consistent with a study conducted by Cline and Helding (1999) where they found that children who had been placed in an orphanage for 2-3 years were at a greater risk for developing PTSD than those who were not. Additionally, studies have also discovered that this population is at a greater risk for cognitive difficulties such as language delays, inattention, and poor executive functioning due to the exposure of complex trauma (John et al., 2019). This finding is consistent with another study that identified the strongest predictor of psychiatric illness among youth in foster care as the number of adverse life events they had experienced (McMillen et al., 2005).

Due to these discoveries, in 2011 congress implemented the Promoting Safe and Stable Families Program to ensure the trauma of these children was addressed by state child welfare agencies (Barnett et al., 2019). This mandate was also in conjunction with three other trauma related grants issued by the Administration for Children and Families to improve the utilization of trauma informed care, systems, and services for this population. Barnett et al. (2019) conducted a longitudinal study over a five-year span to identify whether trauma informed services moderated the relationship between children's behavioral health needs and parents' satisfaction and commitment. The results of this study indicated that trauma informed mental health services decreased the behavioral health needs within foster families and increased parent satisfaction and commitment (Barnett et al., 2019). This study emphasizes the importance of early intervention of mental health services focused on trauma within foster care.

Factors in the Development of Trauma

Neurology of Childhood Trauma

As previously mentioned, experiencing this level of trauma, whether a single occurrence or chronic, can impact the structure and neurochemistry of the brain. In fact, all types of CM have been linked to later limbic system dysfunction, specifically increased electrical activity within limbic structures such as the amygdala (Ashy et al., 2020). Aleman and Swart (2008) conducted a study in which MRIs of adults who had experienced CM were assessed compared to those who had no history of CM. The results of the scans displayed that the adults who reported a history of CM via physical or emotional abuse, indicated more significant limbic system irritability than the control group without a history

of CM. This was elevated for those individuals who reported more than one CM incident. Ashy et al. (2020) expanded upon this finding by discovering that adults who had experienced CM via verbal abuse from their parents displayed reduced neural integrity associated with increased limbic system irritability.

The Stress Response

Research has also shown that individuals who have experienced childhood trauma may display a dysregulated stress response, placing them at a greater risk for long term symptoms. The body's stress response is comprised of three parts the hypothalamus, pituitary glands, and adrenal glands (Miller et al., 2007). These combined are known as the HPA axis. When an individual is faced with a stressor, the hypothalamus detects whether the individual is experiencing physical or emotional distress. From this area a message is transferred to the pituitary to create adrenocorticotropic releasing hormone (ACTH). ACTH then reports to the adrenal glands to create cortisol, also known as the stress hormone (Miller et al., (2007). In healthy individuals, the hypothalamus can identify whether the body needs to produce more or less cortisol, which results in the individual reacting to the stressor or deescalating. However, individuals who have experienced chronic stress or trauma have been shown to display HPA axis dysfunction, meaning that their HPA axis is overstimulated resulting in excessive production of cortisol and the individual responding to all stressors in "survival mode". HPA axis dysfunction has been linked to immune system suppression, cognitive difficulties, cardiovascular disease, diabetes, and other chronic potential mental and physical conditions (Miller et al., 2007).

Long Term Health Effects

According to the CDC, adverse childhood experiences are associated with an individual having persistent health complications, engaging in risky behaviors, and experiencing greater risk for premature death (Center for Disease Control, 2016). The CDC-Kaiser Permanente study is a landmark body of work in the conversation of how childhood trauma impacts one's overall development and later adulthood. This study consisted of 17,000 respondents from Southern California receiving physical exams. The patients were sent the Adverse Childhood Experiences Questionnaire (ACE-Q) as well as the Behavioral Risk Factor Surveys to assess the individual's medical history. The results of this study displayed a strong positive relationship between exposure to adverse childhood events and increased risk of heart disease, skeletal disease, cancer, liver disease, and chronic lung disease in adulthood (Felitti et al., 1998). The CDC-Kaiser Permanente study was a pioneer in examining the relationship of traumatic experiences and continual development throughout one's life. Specifically, investigators found that those participants who scored 4 of higher in the scale were twice as likely than those who scored less than 4 to develop, for example, alcoholism, possible suicide, depression, and drug abuse.

Since the ACE study, the literature has begun to delve further into various health risks related to childhood trauma. Chiang et al. (2022) completed a meta-analysis of 196 studies to explore the relationship between childhood trauma and inflammation in adulthood. It is important to note that inflammation is defined as the body and immune system's primary defense against harmful bacteria. The study consisted of examining the type of childhood stress, the developmental stage of the participants, and level of

inflammation. Through this exploration it was discovered that not only was childhood stress related to increased inflammation, but this pattern was consistent among all the developmental stages. However, the greatest contribution from this study was the finding that the strength of the childhood stress inflammation relationship increased throughout the lifespan of the individual regardless of the type of childhood trauma they were exposed to (Chiang et al., 2022). The stress response previously mentioned can be attributed to this study in terms that when the body is functioning in "survival mode" due to trauma it overstimulates viewing multiple external stimuli as threats.

Distress Tolerance

Individuals who have experienced childhood trauma demonstrate lower levels of distress tolerance. Distress tolerance is defined as an individual's ability to tolerate or cope with adverse life events or emotional states (Bartlett et al., 2020). Due to the revictimization aspect of complex trauma, these individuals learn to consistently internalize negative events and to expect the worst resulting in a reduced ability to self-regulate. An inability to self-regulate may place the individual at a greater risk for suicidal ideations or behaviors. Unfortunately, this cycle from childhood trauma has been shown to impact an individual's life throughout adulthood. Bartlett et al. (2020) expanded upon this by conducting a study where 94 adult psychiatric patients in a residential facility completed the Childhood Trauma Questionnaire and The Distress Tolerance Scale. The researchers hypothesized that a lower level of perceived distress tolerance would mediate the relationship between childhood maltreatment and suicidal ideations and behaviors in adulthood (Bartlett et al., 2020). The results from the assessments reflected that the severity of childhood

maltreatment demonstrated an indirect association with not only suicidal ideations but prehospitalization suicidality via distress tolerance.

Suicidality

As previously mentioned, childhood trauma bears fatal consequences to an individual's livelihood. 800,000 suicides are committed each year in conjunction with 25 million suicide attempts (O'Connor et al., 2019). The revealed relationship between childhood trauma and adult suicidality has led to an influx of research within this area. As previously mentioned, psychiatric inpatients display a greater risk of suicidality due to 78% of them reporting at least one form of childhood abuse or neglect (Bartlett et al., 2020). To explore the factors that catalyze this relationship, O' Connor et al. (2019) recruited 154 participants aged 18-63 to complete a 7-day study. Following a series of questionnaires, clinical interviews, and the CTQ, individuals were separated into three groups: those who had a history of suicide attempts, those who had suicidal ideations but no attempts, and a control group. Over the span of seven days the participants completed mood tracking as well as provided cortisol samples throughout each day to test stress levels (O'Connor et al., 2019). The results of the assessments revealed that participants within the suicide attempt group displayed the highest scores on the CTQ with 78.8% endorsing moderate to severe childhood trauma (O'Connor et al., 2019). In assessing the impact of cortisol levels, the results reflected diminished levels of cortisol among the suicide attempt and suicidal ideation groups compared to the control group. The surprisingly low levels of cortisol among the suicide attempt and suicidal ideation individuals displays the negative consequence of brain function modification associated with the effects of childhood trauma. These results indicate that childhood trauma may make individuals more

vulnerable to suicide in adulthood as a result of a HPA dysregulation. This finding was consistent with studies that discovered this relationship among adolescent survivors of child abuse and suicide attempts and/or ideations (Read et al., 2001).

A metanalysis was also conducted over 200 patients within The New Zealand Community Mental Health Centre to further explore this finding. The results of this explorative analysis revealed that a history of childhood sexual abuse proved to be a more predictive factor for suicidality than a diagnosis of depression. In fact, it was discovered that some individuals who reported a history of childhood abuse and a high suicide risk displayed no depressive symptoms (Read et al., 2001). This study also exposed a crucial factor that may be contributing to the strength of this relationship, social support. Furthermore, it was discovered that the individuals who reported higher suicidal risks also reported limited social support (Read et al., 2001). Read et al. (2001) concluded that although childhood trauma proved to show a strong relationship to suicidal and self-destructive behaviors, the lack of a social support system maintains this relationship into adulthood (Read et al., 2001).

Thompson and Kingree (2022) conducted a longitudinal study,completed among 10,914 participants, to assess whether exposure to adverse childhood events increased the likelihood of suicidal ideation or suicide attempts. Participants were recruited via US public and private school students within the 7^{th}-12^{th} grade. Students were sent the Adverse Childhood Experiences Questionnaire (ACE-Q) and a questionnaire inquiring about suicidal ideation or attempts. Follow ups were completed in five waves after 1 year, 7 years, 14 years, and 22 years from the initial survey. The results of this study found that an individual being exposed to even one ACE puts them at a greater risk for suicidal ideations.

Individuals who reported 2-3 ACEs were found to be at a greater risk for suicide attempts and sexual victimization 22 years after the incident. This study also identified the types of ACEs which place an individual at a greater risk for suicide attempts from least to greatest as family history of suicide, death of a parent, childhood sexual abuse, physical abuse, incarceration of a parent, family substance abuse, and emotional abuse. It was also found that childhood sexual abuse places the individual at the greatest risk for suicidal ideation throughout the lifespan (Thompson & Kingree, 2022).

Social Support and Attachment

The impact of social support on trauma focused therapy has been consistently confirmed through the treatment outcomes of therapy with family involvement. Allbaugh et al. (2018) conducted a study recruiting 150 African American females institutionalized at a psychiatric hospital in Georgia. The participants included only women who had been hospitalized due to a suicide attempt within the past year. The participants were instructed to complete the CTQ, The Relationship Styles Questionnaire, The Social Support Behaviors Scale, and The Beck Scale for Suicidal Ideation (Allbaugh et al., 2018). The findings of the assessments emphasized the importance of social support indicating that elevated levels of emotional abuse predicted diminished levels of attachment security. These struggles with attachment, proved to be associated with a perceived lack of social support or the tendency to seek support. Attachment difficulties and hesitancy to seek social support have also been linked to an increased risk for suicidal ideation or attempts due to elevated distress and isolating behaviors (Read et al., 2001). This study proved that social support and attachment may mediate the relationship between childhood maltreatment and suicidality.

Resilience

Following a traumatic event, an individual's level of coping is measured by their resilience. While the literature cannot directly define resilience, it can be interpreted that it is the ability to emotionally and mentally process the traumatic event to return to a pre-crisis state of functioning (Afifi & MacMillan, 2011). However, resilience may manifest differently for children compared to adults. In children, resilience is demonstrated when the child exhibits a range of competence behaviorally, emotionally, and academically. In adults, resilience is often measured by social functioning, psychological wellbeing, self-esteem, and the absence of psychopathology (Afifi & MacMillan, 2011). It is important to note that resilience is fluid, changing over time and manifesting differently in each developmental stage. An individual may display resilience in one area of their life but not in another, so it is best to utilize multiple indicators when assessing resilience in children and adults. Among the literature, there is a consensus that the protective factors for resilience include a support system reflective of family stability, nurturance in caregiving, spousal support, and coherence in parent and child relationships (Afifi & MacMillan, 2011). Resilience has also been found to impact the strength of the relationship between childhood trauma and psychiatric symptoms in males and females (Ashy et al., 2020).

Locus Of Control

Individuals have the capacity to internalize or externalize their trauma. Additionally, it has been inferred that an individual's locus of control may predict the individual's attribution style following trauma. Ahlin and Lobo (2015) explained that there are two types of locus of control. The first is an internal locus of control where the individual believes that they are in control of all decisions made in their lives. The second type is called an external locus of control. Individuals with an external locus of control

believe that life is happening to them due to luck, fate, or some force outside their control (Hoksbergen et al., 2003). Although there is not an indicator of one being better than the other, the literature states that an individual who develops an internal locus of control following a traumatic event may result in a decreased risk of revictimization and improved psychological adjustment than those that demonstrate an external locus of control (MacGinley et al., 2019). It has been suggested that this may indicate that the individual having a greater perception of control may result in more proactive behaviors. In contrast, an internalized locus of control has been linked to females internalizing the blame for incidents outside their power, resulting in low self-esteem (MacGinley et al., 2019). However, an external locus of control has also been linked to an increased sense of learned helplessness, where the individual learns through repetition of giving up not to try (Rind et al., 1998). Rind (1998) found that individuals who reported an external locus of control and increased learned helplessness were more likely to demonstrate self-blame for the incident and lack the motivation to resolve related stressors. This same study found that among non-clinical college students with chronic trauma, CSA displayed a stronger relationship with having an external locus of control. MacGinley et al. (2019) also verified this by reporting that an external locus of control and maladaptive coping proved to have a strong relationship within coerced victimization experiences (CSA involving manipulation, begging, or threatening).

Shame and Guilt

Self-Conscious Emotions

Shame and Guilt are considered self-conscious or self-evaluative emotions that surface when an individual experiences perceived failure (Babcock Fenerci & DePrince, 2018, Kealy et al., 2018). Shame and guilt are developed during the preschool years of an individual's life as they begin to explore their self-recognition and form their self-appraisal (Babcock Fenerci & DePrince, 2018). Although typically combined, the difference between shame and guilt lies within their attribution style. Shame and guilt hold characteristics much like locus of control where the individual either internalizes or externalizes the situation. Shame is experienced when the individual negatively evaluates *themselves* internalizing the failure to reflect them as a person. In contrast, guilt, is experienced when the individual negatively evaluates the *behavior,* labeling it as something affected by determinants outside their control (Kealy et al., 2018 and Russell et al., 2020). The feeling of shame can be painful and detrimental, impacting the individual's sense of self, resulting in hopelessness, or a feeling of stagnation. However, guilt demonstrates a feeling of regret due to an action but with a belief that it can be controlled and prevented in the future (Babcock Fenerci & DePrince, 2018). Although most literature identifies shame and guilt separately, some argue that they are quite intertwined with neither presented independently. Aakvaag et al. (2019) claims that an individual who experiences a traumatic event may feel shame due to the guilty feelings such as survivors' guilt and blame themselves for being victimized, ashamed that they should have prevented it.

Impact of Parenting Style

Due to both shame and guilt being developed in the preschool years, it can be questioned whether parenting styles and child maltreatment may play a role in their development. The literature reflects mixed results about exact parenting styles that may contribute to guilt or shame. However, Babcock Fenerci and Deprince (2018) found that emotional abuse and neglect, lack of warmth, and the parent utilizing statements reflective of the child's self, have been associated with shame proneness (the tendency for a child to develop shameful feelings). On the other hand, the development of guilt has been linked to more supportive parenting behavior, nurturance, and methods that address the child's behavior rather than their sense of self (Babcock Fenerci & Deprince, 2018). This same study reported that overall shame and guilt were linked to adverse childhood experiences related to their caregivers. These turbulent parent-child interactions may disrupt the development of realistic limits, independence, appropriate emotional validation, and curiosity. Babcock Fenerci and Deprince (2018) expanded upon this by exploring how generational trauma may affect the development of shame and guilt through parent-child interactions. For this study, 124 mothers who reported childhood maltreatment completed The Trauma Appraisal Questionnaire (TAQ), The Trauma Symptom Checklist (TSC-40), and the Child Behavior Checklist, Preschool version (CBCL/1.5–5). The researchers sought to explore the relationship between maternal shame, alienation, and their child's internalizing or externalizing behaviors. The results demonstrated that maternal post trauma appraisals, consisting of shame, alienation, and self-blame were significantly correlated with their child's internalizing and externalizing behaviors. This same study found that maternal trauma-related distress acted as a mediator between maternal shame

and child externalizing symptoms (Babcock Fenerci & Deprince, 2018). However, it only partially mediated the relationship between shame and internalizing symptoms. This study revealed that generational trauma appraisals such as shame could influence the development of children socially and emotionally, further contributing to the development of shame and guilt through parent-child interactions (Babcock Fenerci & Deprince, 2018). They categorized the development of early maladaptive schemas (EMS) for disconnection and rejection into five areas: difficulties comprehending internalized and externalized boundaries, focusing too much on others' needs, unrealistic internalized expectations, lack of autonomy, and perceived lack of love and safety. This may suggest that any combination of these could contribute to the development of shame or guilt because of childhood maltreatment.

Shame

Famous developmental psychologist Eric Erickson explained that shame might develop within the Autonomy vs Shame and Doubt stage of his psychosocial stages. He explained that the goal of this stage was for a child to gain a sense of control of their world. However, there are mixed results explaining the development of shame among different theories (Leach & Cidam, 2015). Social psychologists claim that shame exists as a motivator to improve the interpersonal relationships disrupted by the shameful action. Functional psychologists argue that shame is more directed at the improving an individual's self-concept and image. Finally, culturally, shame has been viewed as a catalyst to please others and repair any social image which may have been damaged by the shameful act (Leach & Cidam, 2015). Despite the lack of a definitive reasoning for shame, there is a consensus that shame is linked to multiple adverse mental health outcomes (i.e.,

anger, social anxiety, low self-esteem, depression, personality disorders, and interpersonal issues) (Babcock Fenerci & DePrince, 2018 and Sullivan et al., 2020).

Concerning CSE and CM, there is a multitude of jargon to describe shame. The first is *shame proneness*; this refers to the intensity of shame the person experiences across various situations that may elicit these feelings. (Babcock Fenerci & DePrince, 2018, Bhuptani & Messman., 2021, Dorahy & Clearwater., 2012, Hooge et al., 2008, Leach & Cidam., 2015, Pineles et. al, 2006). *General shame* is utilized to address the actual feeling of shame about the behaviors or characteristics of the individual (Bhuptani & Messman, 2021). Finally, *assault-related shame* refers to the feeling of shame directly related to the CSE experience (Bhuptani et al., 2021, Thoresen et al., 2018). For the purpose of this study, shame will be defined as general shame, exploring the specific feelings of shame the individual experiences.

Shame has been shown to have a strong link to childhood trauma by negatively influencing an individual physically, socially, and cognitively. Trauma-related shame has proven to be positively correlated with psychopathology and a greater risk of revictimization (Babcock Fenerci & DePrince, 2018, Cepeda-Benito & Short, 1998 and Hooge et al., 2008). John et al. (2019) discovered that individuals who reported feelings of shame also displayed lower self-efficacy and decreased feelings of empowerment in risky situations. Socially, shame has been found to manifest through loss of trust, social withdrawal, alienation, avoidance, and loneliness (Thoresen et al., 2018). Therefore, chronic shame has been found to be associated with increased social anxiety, increased shyness, less empathy, and an increased risk of depression. Sullivan et al. (2019) suggested that this impact in socialization may be due to the individual's inability to be empathetic

towards others due to a preoccupation with their own painful emotions. However, this level of shame may also hinder their willingness to seek support from others despite the increased distress.

Shame Coping

Vagos et al. (2018) suggested that the true danger of shame may not be in the feeling itself, but rather how an individual copes with it. An individual may cope with shame adaptively or maladaptively. Adaptively coping with shame consists of utilizing self-reassurance, self-soothing techniques, and identifying the shame as part of their humanity to accept it (Vagos et al., 2018). When an individual maladaptively copes with shame, they may approach the feeling by withdrawing, denying, or avoiding, exacerbating the negative emotions. In 1992 Nathanson developed The Compass of Shame, a concept that explains the relationship between shame and loneliness by defining the four ways an individual may socially cope with shame (Elison et al., 2006). He explained that someone who experiences shame may withdrawal, avoid, attack others, or attack themselves (Elison et al., 2006, Thoresen et al., 2018, Wurmser, 2016). The first of the four ways is attack self. In this style, the individual internalizes the shame, viewing it as a factual aspect of the experience and manifests it via inferiority, anger, depressive symptoms, or anxiety (Vagos et al., 2018). In contrast, the second way of coping directs the shame at external factors. Attacking others results in the individual transforming the shame into anger and hostility towards outside forces by minimizing their own role within the shameful event (Vagos et al., 2018). Although the first two coping styles result in the individual directing the shame towards a source (self or external), the last two styles of withdrawal and avoidance adopt a more dissociative approach. Individuals who withdrawal from the shame, comprehend and

accept the negative nature of the feeling and therefore isolate themselves from others who may remind them of these emotions. Vagos et al. (2018) found a positive association between withdrawal and attacking self, as they both involved characteristics of the individual displaying low self-esteem and self-critical ideations. The final style of coping, avoidance, is characterized by a more dismissing quality of denial. Individuals who utilize this style, minimize the shame by distracting not only themselves, but others as well, from entertaining any mention of the shameful event.

In 2006, The Compass of Shame was developed into an assessment tool for shame which is still used today. It is comprised of 48 questions organized among twelve scenarios which may elicit feelings of shame (Vagos et al., 2018). Vagos et al. (2018) utilized The Compass of Shame Scale (CoSS) to determine the difference of shame coping between males and females. This study included 2,420 adolescents, 396 of which were recruited from jails and foster care. The participants completed The CoSS, The Other as Shamer Scale Brief-Adolescent version (OASB-A), and The Forms of Self-Criticizing/Attacking and Self-Reassuring Scale (FSCRS) (Vagos et al., 2018). The results displayed that the females were more likely to cope with shame by attacking themselves or withdrawing. However, it was also discovered that females reported more adaptive ways of coping with shame than the male participants (Vagos et al., 2018). An interesting finding from this study was found among the foster care adolescents. The males recruited from foster care settings displayed more attacking other ways of coping. In fact, overall, the participants from foster care settings, whether male or female, displayed more maladaptive coping such as externalizing anger and hostility (Vagos et al., 2018). It can be suggested that this pattern

may reflect the harsh and shame prone environments foster children endure (Vagos et al., 2018).

Dissociated Shame

Shame has been shown to have a substantial impact on somatic symptoms and an individual's overall health. *Dissociated shame* refers to when an individual is unable to process their feelings of shame mentally or emotionally, so they are somaticized through physical symptoms (e.g., stomachaches, headaches, aches and pains, etc.; Kealy et al., 2018). The overall role of dissociation within shame is to avoid painful thoughts or emotions (Dorahy & Clearwater, 2012). Kealy et al (2018) assessed this relationship by completing a study evaluating 99 adult outpatients from British Columbia utilizing the Somatic Symptom Inventory (SSI), Childhood Trauma Questionnaire (CTQ/6-18), and the Personal Feelings Questionnaire (PFQ). The researchers hypothesized that childhood trauma would elicit an indirect effect on somatization via shame or guilt (Kealy et al., 2018). The results revealed that somatic symptoms positively correlated with both shame and guilt. Concerning childhood trauma, they found that shame showed a significant association with emotional abuse and neglect, whereas guilt only displayed a significant relationship with emotional abuse. Furthermore, it was discovered that feelings of shame mediated the link between emotional abuse and somatic symptoms (Kealy et al., 2018). Therefore, children whose emotional needs are ignored may seek nurturance through physical ailments or injuries, developing somatic tendencies later in adulthood. This explains how shame may act as a catalyst by which childhood trauma contributes to the development of dissociative shame. In a previously mentioned study where seven adult males who had experienced CSA were interviewed, they disclosed that their feelings of

shame were sometimes so severe that they would turn to punishment or self-harm (i.e., cutting, burning with water, hitting etc.) stating, “The pain was nothing compared to the pain felt” (Dorahy & Clearwater, 2012). Another study found that males’ exposure to childhood trauma was only associated with somatic symptoms (Ashy et al., 2020).

Results from some studies were consistent with these findings, showing a significant relationship between shame and guilt and somatic symptoms (Pineles et al., 2006). However, these unveiled an interesting finding discovering that only those studies that utilized The Test of Self Consciousness Affect (TOSCA) as a measurement found the relationship between shame and guilt and somatic symptoms. The TOSCA is an assessment that provides 15 scenarios to evaluate an individual’s response by assessing externalizing behaviors, shame, guilt, or prideful behaviors (Pineles et al., 2006 and Sullivan et al., 2020). It was suggested that measures involving non personalized scenarios may be less likely to evoke defensive biases compared to checklist measures (Pineles et al., 2006). This finding alludes to the idea that shame may play a role in the level of information an individual discloses.

Constructive Shame

Interestingly, a paradox has emerged within the literature on shame claiming that studies emphasize the negative aspects of shame but disregard that it may be a more constructive emotion. Hooge et al. (2008) hypothesized that an individual’s shame could originate from the individual (endogenous) or from their environment (exogenous). They contributed to this hypothesis questioning whether shame is more indicative of one’s response tendencies or elicited by the environment coining this “the inside-outside problem”. To test this hypothesis, the researchers conducted a series of three experiments

to measure prosocial behavior in social dilemmas. The researchers evoked three different types of shame (imagined shame, recalled shame, and experienced shame; Hooge et al., 2008). The first of the three experiments asked 144 undergraduates to imagine a scenario where they were presenting and everything goes wrong (i.e., forgetting words, not knowing answers, people bullying, etc.) to create imagined shame. The second experiment consisted of 147 undergraduate students completing a question in which they were asked to recall and write about a situation they felt ashamed of, evoking recalled shame. Lastly, the third experiment was conducted by placing 163 undergraduate students in a lab study where they were asked to complete an intelligence test. The participants then received false feedback reporting their scores were around 8 or 9 when the average for their peers was 20, creating experienced shame. Following each of these scenarios, the participants were asked to engage in a 10-coin game to measure their prosocial behaviors. For the game, the participants were randomly assigned to the exogenous group, where their partner was unaware of their shameful experience or the endogenous group, where their partner was aware of their shameful experience. In each round the participants had to choose how many coins to wager without knowing the amount their partner would put in. The participant's behaviors were measured via the Triple Dominance Measure of Social Value Orientations, consisting of selfish and prosocial monetary divisions. The results displayed that exogenous shame (where their partner was unaware of their shame) did not appear to influence prosocial behaviors. However, endogenous shame (where their partner was aware of their shame) did appear to influence and elicit more prosocial behaviors. This article introduced the idea that shame may act as a moral emotion that motivates and humbles individuals (Hooge et al., 2008). Consistent with these findings, Leach and Cidam

(2015) reported that shame displayed increased cooperative behaviors in social dilemmas, self-improvement motivation, and prosocial motivation towards making amends to those impacted (Leach & Cidam, 2015). Both articles agreed that this finding was only recently seen due to previous studies focusing soley on the avoidance and negative characteristics of shame rather than exploring the social implications and situational shame (Hooge et al., 2008;Leach & Cidam, 2015).

Guilt

Development of Guilt

Revisiting the Psychosocial Stages, Erick Erickson believed that guilt might develop between the ages of 3 and 5 years-old with the initiative vs guilt stage. Erickson claimed that while the autonomy vs shame and doubt stage helps children form their independence, the third stage expands upon that, implementing the idea that they can exert control over themselves and their world (Steinberg, 2011). This stage challenges the child to begin to understand the value of making choices, so if they cannot successfully complete this stage, they may develop a sense of guilt characterized by fear and self-doubt. Although Erickson states that guilt develops if the stage is not completed, literature has also demonstrated the opposite is true.

As previously mentioned, where shame is a more internalized emotion personalizing the feeling, guilt consists of a greater focus on the behavior separate from the self. Guilt is typically portrayed in the literature as a tendency to accept responsibility and become proactive in preventing the behavior in the future. Therefore, the experience of guilt has been linked to a decrease in hostility and interpersonal anger (Tangney et al., 1996). Sullivan et al. (2019) found that guilt proved to be unrelated to symptoms of anxiety

and depression compared to shame. This same study also found a positive association between guilt and greater life satisfaction (Sullivan et al., 2019). Among the literature two types of guilt are seen. The first is *dispositional guilt* which consists of regret and longing to repair the wrongdoing (Sullivan et al., 2019). The second is referred to as *shame-free guilt*, which is defined as guilt that excludes personalizing factors (Sullivan et al., 2019 and Tangney et al., 1996). Vagos et al. (2018) conducted a longitudinal study displaying those individuals for whom experienced dispositional guilt as a child were less likely to be involved in substance use, risky sexual behaviors, and criminal involvement as adults. However, within the same study, the opposite was found related to shame. Like shame, guilt has been proven to significantly impact the socialization aspects of an individual's functioning. Cohen et al. (2011) expanded upon the idea that it may be considered a target behavior since dispositional guilt evokes this need to repair the relationship. Sullivan et al. (2019) discovered that individuals who experienced shame-free dispositional guilt experienced greater empathy and concern for others. The researchers explained that by the participants taking responsibility for their wrongdoings, they fostered growth and personal development, enhancing their overall life satisfaction. Another study discovered consistent results concluding that individuals who experienced dispositional guilt displayed more regulated behaviors in coping with anger, such as nonhostile discussion and cognitive reappraisals (i.e., the benefit of the doubt, considering their responsibility, etc.) In contrast, this same study also found shame to be associated with maladaptive and aggressive responses to anger. Hooge et al. (2008) expanded upon this constructive quality of guilt, discovering that dispositional guilt acts a relationship-enhancing tool long term by implementing empathy and positive conflict resolution within intimate relationships.

Guilt and Trauma

Although guilt in general is considered a constructive emotion, when combined with childhood maltreatment, it can begin to reflect some of the same negative characteristics, much like shame. Unfortunately, trauma-related guilt and shame have been shown to both display internalizing behaviors following childhood maltreatment, reducing the constructive qualities (Pineles et al., 2006). Trauma-related guilt is characterized by the individual experiencing a negative emotional or cognitive state about the perceived responsibility of the event, a violation of the individual's values, and unrealistic expectations of preventability (Aakvaag et al., 2019). Trauma-related shame and guilt were more frequently reported by individuals who had experienced multiple maltreatment types than those who had only experienced single incidents (Aakvaag et al., 2019). Individuals who report trauma-related guilt typically experience guilt related to how they could have changed the situation by their actions or guilt about surviving (Held et al., 2015). The cognitive symptoms of guilt following CM can even distort into separation anxiety. That is, the child develops a belief that they will harm or damage the family if they become autonomous or take the initiative (Kealy et al., 2018). This type of thinking can hinder an individual's interpersonal relationships and attachment style later in adulthood. Held et al. (2015) found that individuals who had experienced trauma-related guilt from CSA and CM exhibited more significant relationship insecurities and intimacy issues than those who had not.

Concealment

Concealment is defined as an individual's intentional act of keeping intimate information secret (Cepeda-Benito & Short, 1998). Although the literature on

concealment is limited, it is best to approach it through its inverse, disclosure. Disclosure has been considered a complex concept due to researchers arguing if it is a personality trait or simply an interpersonal reaction (Ignatius & Kokkonen., 2007). Studies have found that lack of disclosure (concealment) has been linked to increased depressive symptoms, decreased physical health, interpersonal conflict, lack of social support, and greater risk for psychopathology (Cepeda-Benito & Short, 1998 and Slepian et al., 2020).

Smetana et al. (2019) interpreted that there are two ways to conceal information successfully. The first is avoidance, where the individual deflects the question or completely avoids discussing the information. The second is omission, where the individual explains a partial truth omitting specific details that may elicit a greater reaction (Smetana et al., 2019). Both avoidance and omission have been linked to increased lying and relationship conflict. Although there is no definitive reasoning to explain these behaviors, Ignatius and Kokkonen (2007) conducted a metanalysis to identify factors that have been liked to self-disclosure or concealment. The first factor is flexibility, referring to the individual understanding the boundaries and social norms of what they disclose in everyday conversation. The second is the individual's level of shyness, inferring that more shy individuals are less likely to share intimate details in discussions. The third is low sociability referring to how inclined the individual is to socialize with others in general. The fourth is toughness in males. As previously mentioned, males that disclosed CSA experienced guilt about being labeled gay or weak due to gender stereotypes. They also displayed hesitancy in disclosure due to the fear of being automatically identified as the instigator of the abuse (Dorahy & Clearwater, 2012). Due to these fears, the male participants reported that they developed a tendency to

persistently conceal information at a personal and general level. The fifth and final factor linked to self-disclosure or concealment was neuroticism. Ignatius and Kokkonen (2007) stated that the link between neuroticism and self-disclosure lies in neglecting social norms. They detailed that neurotic individuals display an unawareness or reluctance to appropriate levels of disclosure, exhibiting oversharing behaviors (Ignatius & Kokkonen, 2007). This same study found that neurotic men actually were shown to disclose more than neurotic women.

Concealment and Trauma

Various therapeutic theories have implemented a level of self-disclosure when processing childhood trauma. Since it is known that the act of disclosing and processing trauma in therapy has been associated with a reduction in psychopathology, it is not surprising that those treatments involving disclosure elicited positive outcomes. Individuals who wrote about their trauma displayed reduced physician visits, better work and school performance, and improved immune functioning (Pineles et al., 2006). Cepeda-Benito and Short (1998) tested this theory exploring the role of concealment or self-disclosure in relation to individuals seeking therapeutic services. The researchers recruited 732 Texas University psychology students to complete a survey inquiring about their attitudes towards psychotherapy, psychological distress, social support, likelihood to seek services, and level of self-concealment (Cepeda-Benito & Short, 1998). Their results concluded that individuals reporting higher self-concealment were three times more likely than low self-concealers to report needing services but not seeking them out (Cepeda-Benito & Short, 1998).

Concealment, Shame, and Guilt

As previously discussed, shame and guilt are identified as self-conscious emotions. Therefore, shame and guilt reflect the private self by which individuals typically seek to conceal due to a fear of embarrassment, judgement, or rejection (Slepian et al., 2020). Slepian et al. (2020) suggested that the harm in secrecy does not lie within the action of concealment but rather the mind wandering to the concealed thought evoking intrusive thoughts. For this study, 67 men and 133 females were asked to complete The Common Secrets Questionnaire, consisting of the 38 most common secrets. For each secret, the participant was asked to endorse whether they could personally relate with the identified secret or not. After endorsing a secret, the participants identified three shame thoughts and three guilt thoughts (e.g., I feel like I am a bad person, worthless, regret, etc.) Finally, they rated the level of distress the secret caused them (Slepian et al., 2020). The results suggested that although neither shame nor guilt predicted concealment, both resulted in mind wandering or intrusive thoughts about concealing the secret. It was also found that when the secret elicited feelings of shame, it produced a greater frequency of intrusive thoughts than those that evoked feelings of guilt (Slepian et al., 2020).

Another study sought to explore the impact of concealment and disclosure strategies among adolescents by assessing parent-child interactions and communication styles (Smetana et al., 2019). Developmentally, as adolescents get older, their level of concealment increases, and they limit what they disclose. Elison (2006) identified that there is a difference between disclosure strategies and concealment strategies among adolescents. They claimed that disclosure strategies among parent-child relationships referred to the adolescent telling the entire truth, but only if they are asked. However,

concealment strategies include adolescents telling their parents the truth but omitting details or providing completely false information (Smetana et al., 2019). This study concluded that adolescents were more likely to conceal information when feelings of shame were involved due to fear of punishment or disapproval from parents. This study also found that the level of disclosure or concealment varied by issue, such as adolescents concealing participation in risky behaviors (Smetana et al., 2019).

Self-Concealment

Research has begun to emerge with regards to the concept of self-concealment exploring the relationship between perfectionism, help seeking behaviors, and internalizing problems in relation to concealment (Abdollahi et al., 2020, De'Seve et al., 2020, Edmunds et al., 2020, & Hogge et al., 2020). Self-Concealment is typically viewed in research as a defense mechanism meant to set social boundaries by actively hiding aspects of oneself (Larson & Chastain, 1990). However, there is a self-concealment phenomenon that explains that individuals who opt for this approach are more likely to display negative health outcomes more than those who self-disclose. Pennebaker and Chew (1985) explored this concept by finding that individuals who did not disclose thoughts or emotions related to past trauma, presented with more long-term health concerns when controlling for social support of the individual. The research of self-concealment came to a peak when Larson and Chastain (1990) developed The Self Concealment Scale (SCS) to assess the fear, motivation, and lying behaviors of those who self-conceal. This study reviewed 816 participants for whom were recruited from universities, psychology conferences, and graduate students in counseling programs. The participants were asked to complete the SCS in conjunction with the Self Disclosure

Index and the Social Support and Social Network Measure. The results of this study corroborated previous findings demonstrating the same interaction between self-concealment and physical symptoms controlling for depression and anxiety. This finding was even more significant due to the participants who endorsed elevated levels of trauma and self-concealment reporting greater physical symptoms (Larson & Chastain, 1990). To better understand the reasoning behind self-concealment, Larson and Chastain (1990) conducted an exploratory analysis where they found that participants were more likely to utilize self-concealment when they perceived the concealed information posed a threat to their self-esteem if disclosed.

While Larson and Chastain (1990) concluded that there was a relationship between self-concealment and self-esteem, there was still the question of what was impacting this choice to conceal information. Abdollahi et al. (2020) conducted a study in which 475 Malaysian high school students were recruited to test whether perfectionism played a role in the relationship between self-concealment and seeking psychological services. It was concluded that self-concealment served as a full mediator between social perfectionism and attitudes towards seeking psychological services. This study also concluded that males who endorsed higher levels of perfectionism were more likely to engage in self concealment than females. Feelings of inferiority have also been shown to impact self-concealment strengthening this link between self-concealment and self-esteem (De Seve et al., 2020). This same study found that shame proved to be a mediator in the relationship between self-concealment and feelings of inferiority, further emphasizing the importance of research of shame and guilt on self-concealment.

Edmunds et al. (2020) expanded upon this relationship by exploring the protective factors of self-concealment. They sought to determine whether individuals who practiced mindfulness measured by the The Mindful Attention Awareness Scale (MAAS) displayed any lower levels of self-concealment, depression, anxiety, or somatization. Two hundred forty-nine undergraduate students completed the Brief Symptom Inventory (BSI), Self-Concealment Scale, and The Mindful Attention Awareness Scale. The results of this study showed that elevated levels of self-concealment predicted elevated levels of depression and anxiety above the effects of mindfulness. Interestingly, it was found that lower levels of self-concealment predicted elevated levels of somatization contradicting previous findings. However, this finding was only true for females not males within the study.

While there has been an influx of literature on self-concealment and impacting factors, few studies have included the variable of trauma. Since it has been strongly supported that trauma-related shame and guilt can have a detrimental impact on an individual's functioning and concealment of trauma has been linked to an increase in psychopathology, it leads us to wonder where the association between these two lies. Pineles et al. (2006) sought to reveal if concealment played a role among shame proneness and somatization. This study recruited 156 female undergraduate psychology students who completed the Test of Self Consciousness, Brief Symptom Inventory, The PTSD checklist, The Attributional Style Questionnaire, and the Self Concealment Scale (Pineles et al., 2006). These assessments concluded that both shame proneness and guilt proved to have a significant association with somatic symptoms. In reference to the concealment of adverse events, it was found that shame proneness displayed a positive

relationship, but guilt-proneness did not. Ultimately, this study concluded that concealment significantly mediated the relationship between PTSD symptoms and shame proneness. However, concealment did not significantly mediate the relationship between shame proneness and somatic symptoms (Pineles et al., 2006). This finding explains that even though an individual may experience concealment due to feelings of shame, it does not increase their chances of somatization of this shame.

Chapter 2

Study Purpose and Rationale

The relationship between shame and guilt within childhood trauma is well supported as well as the relationship between shame and guilt in self concealment (Edmunds et al., 2020, Gupta et al., 2011, Kealy et al., 2018, Larson & Chastain, 1990, Russell et al., 2020). Therefore, it would stand to reason that shame and guilt may be impacting the level of concealment in individuals with a history of childhood trauma. Individuals who have experienced childhood trauma may internalize shame or guilt about the incident resulting in an overall negative sense of self (Kealy et al., 2018). As previously indicated, individuals with a history of childhood trauma have been shown to display lower distress tolerance (Bartlett et al., 2020), greater revictimization (MacGinley et al., 2019, Schnur et al., 2017), diminished levels of attachment, increased depressive symptoms, and greater interpersonal conflicts (Allbaugh et al., 2018, Bartlett et al., 2020, MacGinley et al., 2019, Read et al., 2001, Schnur et al., 2017). The diminished level of distress tolerance may lead these individuals to turn to maladaptive coping such as shame coping to protect them from experiencing pain, creating schemas of internalized failure, incompetence, and worthlessness. The low level of distress tolerance is important due to the relationship link to suicidality within the childhood maltreatment population.

Another major factor of importance is the social and interpersonal aspects of shame and guilt. There is extensive research on childhood trauma affecting attachment later in life (Allbaugh et al., 2018, Read et al., 2001). These attachment issues may stem from a lack of trust towards others, impacting relationships later in adulthood for these individuals. In particular, emotional abuse has been linked to diminished levels of attachment in adulthood (Allbaugh et al., 2018). As previously referenced, emotional abuse may reflect a threat to

the individual's self-esteem, self-image, and self-worth. This view may then be projected into their relationships with others creating feelings of inferiority, distrust, and possible isolating behaviors. These cognitive schemas then have the potential to transform into feelings of internalized shame. As previously mentioned, shame may be utilized as a moral defense (Kealy et al., 2018). Therefore, an individual may perceive shame as a type of coping skill. Resilience has been found to impact the strength of the relationship between childhood trauma and symptomology, so individuals may perceive employing shame as a coping skill as being resilient towards their childhood trauma when it may be maintaining maladaptive behaviors instead. Individuals with a history of CSA who reported higher levels of shame displayed lower self-efficacy and empowerment when placed in stressful situations placing them at a greater risk for revictimization (John et al., 2019).

While shame and guilt may have constructive properties, individuals with a history of childhood trauma may be misled on the role it is playing in the maintenance of their trauma by self-concealing (Hooge et al., 2008). Shame and guilt have the potential to elicit cooperative behaviors as well as prosocial behaviors and motivation for self-improvement (Leach & Cidam 2015). However, there may be a reciprocal effect of the shame or guilt acting as a barrier to disclosure and vice versa. Concealment has been linked to a threat to self-esteem, social perfectionism, and feelings of inferiority which replicate those variables linked to internalized shame. Research has also shown the importance of an individual having a support system when coping with trauma. However, concealment prevents these opportunities for social support by the individual not disclosing (Allbaugh et al., 2018).

Therefore, to further identify how shame and guilt may be playing a role in concealment in adulthood, it is first necessary to understand how childhood trauma may be

impacting how these self-evaluative emotions are being processed. The following study will seek to not only explore how individuals perceive shame and guilt following childhood trauma, but to identify how these may manifest as concealment on a personal and general level later in adulthood. As clinicians, this understanding can inform treatments that target the destructive and constructive sides of shame and guilt that may be negatively impacting clients' interpersonal relationships, world view, and attribution style.

Chapter 3

Objectives and Hypotheses

Objective 1: The first objective of the present study was to explore destructive and constructive ways an individual may be processing shame and guilt following the experience of childhood trauma. Elison et al. (2006) explained that an individual may manifest shame through adaptive and maladaptive channels. The individual may internalize the shame, externalize it by lashing out at others, withdraw, or avoid the feeling completely (self-conceal). Shame and guilt may reflect the private self by which individuals typically seek to conceal due to a fear of embarrassment, judgement, or rejection (Slepian et al., 2020). Chronic shame has been found to be associated with increased social anxiety, increased shyness, less empathy, and an increased risk of depression in adulthood (Thoresen et al., 2018). Leach and Cidam (2015) reported that shame also has constructive properties that resulted in increased cooperative behaviors in social dilemmas, self-improvement motivation, and prosocial motivation towards making amends to those affected. Hooge et al. (2008) also found that dispositional guilt acted as a relationship-enhancing tool long term by implementing empathy and positive conflict resolution within intimate relationships. Therefore, it was expected that individuals who reported experiencing greater feelings of shame would also utilize self-concealment more than those who reported higher scores of guilt.

Hypothesis 1.

Individuals who score higher on the shame scale compared to guilt on the Test of Self-

Conscious Affect will endorse higher scores on the Self Concealment Scale

Hypothesis 1.1

Individuals who score higher on the guilt scale compared to individuals who score lower on the Test of Self-Conscious Affect will report lower scores on the Self Concealment Scale.

Objective 2: The second objective of the present study was to determine whether a history of childhood trauma makes individuals more prone to self-conceal than those who have not experienced childhood trauma. Dorahy & Clearwater (2012) found that individuals who had experienced CSA were more likely to self-conceal due to a belief that self-disclosure would result in being misunderstood, being perceived as weak, or disbelief. This resulted in them developing a sense of pervasive secrecy where they implemented concealment on a personal and general level. Cepeda-Benito & Short (1998) reported that individuals who reported higher levels of self-concealment also reported experiencing at least one form of childhood maltreatment. Therefore, it was expected that individuals who endorsed childhood trauma would also score higher on proneness to self-conceal information compared to those who have no history of childhood trauma.

Hypothesis 2.

Individuals who score higher on the Childhood Trauma Questionnaire will display higher scores on the Self Concealment Scale than the control group.

Objective 3: The third objective of the present study was to determine if *trauma-related shame* and/ or *trauma-related guilt* impacted the level of concealment an individual displays when a history of childhood trauma is present. Various studies have linked experiencing CSA to an overall negative appraisal of one's appearance resulting in a sense of shame (Kealy et al., 2018). Maladaptive coping such as somatization, internalizing shame or guilt, avoidance, and concealment have been linked to a history of childhood trauma. Kealy et al. (2018) introduced the idea that shame develops as a "moral defense" in which the individual utilizes shame or guilt as a protective factor to avoid a painful reality such as trauma. Cohen et al. (2011) also concluded this by relating childhood maltreatment to schemas reflective of failure, incompetence, and worthlessness, exacerbating feelings of shame and guilt. Therefore, given the multiple relationships between shame and guilt, childhood maltreatment, and concealment, it was expected that the individuals who endorsed a history of childhood trauma as well as shame or guilt would display a greater proneness to conceal in adulthood.

Hypothesis 3.

Individuals who endorse a history of trauma on the Childhood Trauma Questionnaire (CTQ) as well as elevated shame on the Test of Self Conscious Affect (TOSCA) will also display elevated levels of concealment on the Self Concealment Scale (SCS).

Chapter 4

Method

Participants and Procedures

Participants in this study were recruited volunteers via social media platforms and through universities within Florida and Georgia. Requirements for participation in the study included individuals being 18 years or older and completing the entirety of the demographics section, TOSCA-3, ACE, and the CTQ. The results from the TOSCA-3, ACE, and CTQ created the basis of this study. Therefore, participants with incomplete assessments were excluded from the result and analyses completed.

Measures

The measures were distributed via Qualtrics, an online platform utilized for survey assembly and data analysis. The survey consisted of The Test of Self Conscious Affect- Third Edition (TOSCA-3), Adverse Childhood Experiences Questionnaire (ACE-Q), and The Childhood Trauma Questionnaire (CTQ). The completion of the survey took on average 21 minutes for participants to complete. All measures utilized are presented in the appendices (see Appendix B-E)

Demographics

Demographics Form. Participant demographics were obtained from the Demographics form (see Appendix A). This form was utilized to collect basic information regarding demographic variables including age, gender, marital status, race/ethnicity, and mental health diagnosis.

Childhood Trauma Questionnaire-Short Form (CTQ-SF)

Used in more than 339 studies, the CTQ has become the most widely used self-report assessment to identify the presence and severity of five types of maltreatment: emotional abuse and neglect, physical abuse and neglect, and sexual abuse in childhood (Fink et al., 1995). The CTQ is comprised of 28 questions on a 5-point Likert scale ranging from "Never True" to "Very True". The CTQ has been translated into 12 languages and is easily accessible to the public online. Unlike other trauma questionnaires, the CTQ does not solely focus on physical and sexual abuse, but rather allows exploration of a multitude of childhood maltreatment types which will benefit this study's wider scope on trauma (Spinhoven et al., 2014).

The CTQ (See Appendix B) was employed to measure physical abuse, physical neglect, emotional abuse, emotional neglect, and sexual abuse. Individuals who endorsed a history of physical abuse as evidenced by the following statements were included in the childhood physical abuse category: a) "I got hit so hard by someone in my family that I had to see a doctor or go to the hospital.", b) "People in my family hit me so hard that it left bruises or marks.", c) "I was punished with a belt, board, or some other hard object.", d) "I believe that I was physically abused." Individuals who endorsed a history of physical neglect as evidenced by the following statements were included in the childhood physical neglect category: a) "I didn't have enough to eat.", b) "My parents were too drunk or high to take care of the family.", c) "I had to wear dirty clothes." Individuals who endorsed a history of sexual abuse as evidenced by the following statements were included in the childhood sexual abuse category: a) "Someone tried to touch me in a sexual way or tried to make me touch them.", b) "Someone threatened to hurt me or tell

lies about me unless I did something sexual with them.", c) "Someone molested me." Individuals who endorsed a history of emotional abuse as evidenced by the following statements were included in the childhood emotional abuse category: a) "People in my family called me things like "Stupid", "Lazy", or "Ugly".", b) "I thought my parents wished I had never been born.", c) "People in my family said hurtful or insulting things to me.", d) "I felt that someone in my family hated me.", e) "I believe that I was emotionally abused." Finally, Individuals who endorsed a history of emotional neglect as evidenced by the inverse of the following statements were included in the childhood emotional neglect category: a) "I knew there was someone to take care of me and protect me.", b) "There was someone in my family who helped me feel that I was important or special.", c) " I felt loved." d) "People in my family felt close to each other."

Adverse Childhood Experiences Questionnaire (ACE-Q)

The Adverse Childhood Experiences (See Appendix C) is a 10-item self-report questionnaire used to explore the presence of various forms of trauma including verbal abuse, neglect, sexual abuse, and physical abuse among other forms. This measure was utilized to incorporate adverse events that may have resulted in childhood trauma that are not directly related to child maltreatment (e.g., divorce, parental imprisonment, family mental illness, family substance abuse, and domestic violence). The ACE-Q asks the participant to only identify the experiences that occurred before the individual's 18th birthday pinpointing only trauma resulting from childhood. Including this measure to support the CTQ allowed for a broader scope of childhood trauma to be assessed. The ACE-Q is scored on a scale from 1 to 10. The individual receives a score of 1 for each statement endorsed. An individual who scores a 4 or higher is at a greater risk for

developing chronic, lifelong social, emotional, and physical problems related to trauma. Items on the ACE-Q directly inquired about the adverse event such as: “Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? OR Ever hit you so hard that you had marks or were injured?”

Test of Self-Conscious Affect (TOSCA-3)

The TOSCA-3 (See Appendix E) is comprised of 15 scenarios which could elicit shame or guilt an individual may encounter in everyday life. For each scenario the individual chose from four different reactions. The individual then rates the likelihood of them displaying each of the four reactions on a 5-point scale. The TOSCA results measure the individual’s proneness to guilt, proneness to shame, externalizing behaviors (attacking others or anger), and unconcern (avoidance or withdrawal) (Fontaine et al., 2001). For example, an individual who indicated the likelihood of the response “I’m inconsiderate” to the scenario of “You make plans to meet a friend for lunch. At 5 o’clock, you realize you stood him up.” indicated a score for shame proneness. The TOSCA currently has three versions to identify differences in shame and guilt among various ages ranging from as young as 8 years old to adulthood. (TOSCA-C, TOSCA-A, and TOSCA-3). The TOSCA-A is the most used version being utilized within developmental studies with children and adolescents to assess shame and guilt. However, the most recent version, the TOSCA-3 has been revised to include scenarios more pertinent to the adult population (Fontaine et al., 2001, Watson et al., 2016). The TOSCA-3 may only be accessed through previous studies that utilized it or by contacting the creator June Tangney, as this researcher did. Since shame and guilt have various ways, they can be manifested, it was important to employ an assessment that not only

identified the level of coping utilized, but also the severity elicited by the feelings of shame and guilt. This helped to gauge the level of generalization of shame and guilt the individual was experiencing.

Self-Concealment Scale (SCS)

The SCS(See Appendix D) is a ten-item self-report survey used to explore the level of self-concealment an individual exhibits about secrets they may have such as "There are lots of things about me I keep to myself" (see Appendix; Larson & Chastain, 2016). These statements were assessed by the individual rating each statement on a 5-point Likert scale ranging from "Strongly Disagree" to "Strongly Agree" (Larson & Chastain, 2016). The SCS has been utilized among various special populations (e.g., family, child/adolescent, multicultural, and LGBTQ). The SCS has also been revised to target concealment for a certain concern by adapting the questions to include factors about chronic pain, parenting, or intimate relationships. However, the SCS can only be accessed through obtaining it from the authors Dale Larson or Robert Chastain, which this author did. For the purpose of this study, the original version with general wording created by Larson and Chastain (1990) was utilized to allow a broader exploration of the individual's tendency to self-conceal. The SCS was chosen for this study due to it assessing the individual's conscious and unconscious effort to self-conceal as well as the level of distress the concealment is currently causing them.

Chapter 5

Research Design and Data Analysis

Before data was collected, permission was obtained by the researcher from the Florida Institute of Technology Institutional Review Board (FIT IRB) to conduct the study. The study consisted of a cross-sectional design. Assessments, demographic form, and informed consent were entered into a Qualtrics Survey by the researcher. The participant assessed and completed the survey via a Qualtrics link. All data collected from Qualtrics was de-identified to ensure minimal risk of breaching confidentiality. Descriptive statistics, including assessment of means, standard deviations, and frequencies, were calculated for participant demographic variables, type of childhood trauma, presence of shame or guilt, and concealment level. A series of independent sample t-tests were applied to assess differences between participants on shame, guilt, and level of concealment. This will also include comparing various childhood trauma types (e.g., physical abuse, sexual abuse, emotional abuse, and physical neglect) with shame and guilt. A series of Pearson correlations were employed to examine patterns of relationships between shame or guilt, childhood trauma, and level of concealment. To determine if the presence of shame or guilt moderates the influence of childhood trauma on level of concealment, a moderation analysis was conducted utilizing exploratory analyses and hierarchical multiple regression. To complete this analysis all categorical variables were dummy coded, and all variables were standardized. All outcomes were considered significant at the $p < .05$ level. All analyses were completed using the Statistical Package for the Social Sciences (SPSS) – version 26.0.

Chapter 6

Results

Participants

The sample size consisted of 113 participants. However, after review of the data it was discovered that 45 participants only completed the demographics section excluding them from the analysis. Therefore, 68 participants were utilized in the study. 50% of participants identified as male (*n* = 34), 47% identified as female (*n* = 32), and 2.9% identified as non-binary. The participants included adults 19-64 years old, and the mean age was 33.42 years (*SD* = 10.89). The distribution of ethnicities was as follows: 63.2% identified as Caucasian (*n* = 43), 14.7% identified as Hispanic (*n* = 10),7 10.3% identified as African American (*n* = 7) , 4.4% identified as Asian (*n* = 3), 2.9% identified as Biracial (*n* = 2), and 4.4% identified as "Other"(*n* = 3). Participants endorsed a variety of mental health diagnoses including Depression (*n* = 11), Anxiety (*n* = 10), Post Traumatic Stress Disorder (*n* = 6), Attention Deficit Hyperactivity Disorder (*n* = 6), and Obsessive Compulsive Disorder (*n* = 2). It should be noted that one participant also endorsed a diagnosis of agoraphobia, an eating disorder, and Bipolar Disorder. When reviewing a list of mental health symptoms, participants reported experiencing worry/anxious feelings (*n* = 4), fatigue (*n* = 30), low energy (*n* = 29), poor concentration (*n* = 27), irritability (*n* = 25), and tension (*n* = 25). When inquiring about previous mental health treatment, 50% participants endorsed attending either individual, couples, or family therapy (*n* = 34). Demographics are presented in Table 1.

Statistical Analysis

Childhood Trauma and Shame

An independent samples t-test was conducted to examine whether individuals who scored higher on the shame scale on the TOSCA -3 showed higher levels of concealment on the SCS in comparison to individuals who scored higher on the guilt scale. Assumption tests suggested that there were no outliers in concealment scores for participants with low shame and high shame scores, and concealment was normally distributed. Levene's test results suggested that variances in concealment for participants with low shame or high shame were statistically equivalent, $F(66) = 0.05$, $p = .80$. Results demonstrated that participants who scored high on shame ($M = 30.87$, $SD = 8.71$) were significantly different from those that scored lower on shame ($M = 23.73$, $SD = 9.08$) on their level of concealment, $t(66) = -3.3$, $p < .001$.

A second independent samples t-test was performed to examine whether participants who scored higher on the guilt scale on the TOSCA -3 showed higher levels of concealment on the SCS in comparison to individuals who scored higher on the shame scale. Assumption tests suggested that there were no outliers in concealment scores for participants with low guilt and high guilt scores, and concealment was normally distributed. Levene's test suggested that variances in concealment for participants with low guilt and high guilt were statistically equivalent, $F(66) = 0.05$, $p = 0.82$. Results demonstrated that participants who scored high on guilt ($M = 26.66$, $SD = 9.76$) were not significantly different from those that scored lower on guilt ($M = 27.41$, $SD = 9.40$) on their level of concealment, $t(66) = 0.32$, $p = 0.38$. Therefore, the hypothesis that Individuals who score higher on the shame scale compared to individuals who score

higher on the guilt scale on the TOSCA-3 will report higher levels of concealment on the SCS was supported (H1). TOSCA scores for shame and guilt are presented in Table 3.

Childhood Trauma and Guilt

A Pearson's correlation was conducted to analyze the relationship between guilt on the TOSCA and level of Concealment on the SCS. Although the results displayed a negative correlation as expected, there was no significant relationship found between high scores of guilt and concealment, r (68) = -.06, p = .60; therefore, the results did not support a significant negative correlation as hypothesized (H2).

Gender Differences

An independent samples t-test was conducted to examine whether females or males reported higher scores of shame or guilt on the TOSCA -3. Assumption tests suggested that there were no outliers in shame or guilt scores for male or female participants, and shame and guilt were normally distributed. Levene's test suggested that variances in shame and guilt for male and female participants were statistically equivalent, F(66) = 0.73, p = 0.01. Results demonstrated that females who scored high on shame (M = 0.63 , SD = 0.49) were significantly different from males (M = 0.33, SD = 0.47) that scored high on shame, t(66) = 0.40 , p = 0.01. However, when an independent samples t-test was conducted to examine whether females or males reported higher scores of guilt on the TOSCA -3, results demonstrated that females (M = 0.59 , SD = 0.50) were not significantly different from males (M = 0.56, SD = 0.51) that scored high on guilt, t(66) = 0.31 , p = 0.39.

Childhood Trauma and Control Group

Descriptive statistics were computed, for history of childhood trauma (M = 27.63, SD = 9.91), shame (M = 42.26, SD = 10.04), guilt (M = 60.24, SD = 6.64), and concealment (M = 27.63, SD = 9.91). Frequency statistics revealed that of the 68 total participants, the individuals who reported a history of childhood trauma (n = 57) drastically outnumbered the participants who reported no history of childhood maltreatment (physical abuse, sexual abuse, physical neglect, emotional abuse, emotional neglect) (n = 19). However, when excluding adverse events (e.g., divorce, imprisonment, substance abuse, etc.) the number decreased (n = 11). This significant difference between the groups did not allow for a control group. Therefore, the hypothesis that individuals with a history of childhood trauma would score higher on concealment than the control group could not be assessed and was not supported (H3). Childhood trauma statistics are presented in Table 2.

Shame as a Moderator

A moderated regression analysis showed that the interaction between childhood trauma (M = 36.57, SD = 8.84) and shame (M = .46, SD = 0.50) in predicting concealment was not significant, b = .05, p = 0.84. The pattern of this nonsignificant interaction is shown in Table 4. Thus, the hypothesis that shame moderated the relationship between childhood trauma and concealment was not supported (H4).

Exploratory Analyses

Childhood Trauma Types

Exploratory correlation analyses were conducted to examine potential relationships between the various types of childhood trauma, TOSCA shame scores, TOSCA guilt scores, and concealment. Significant positive correlations within the various childhood trauma types for this included emotional abuse and physical abuse (r = 0.63, p <.001), emotional abuse and sexual abuse (r = 0.27, p = 0.02), emotional abuse and emotional neglect (r = 0.35, p =.004), and emotional abuse and physical neglect (r = 0.41, p <. 001). Significant positive correlations were also found between emotional neglect and sexual abuse (r = 0.29, p = 0.01), emotional neglect and physical neglect (r = 0.47, p <. 001). A significant positive correlation was also found between shame and guilt (r = .56, p < .001) and shame and concealment (r = 0.26, p = 0.03).

However, during these analyses significant negative correlations were found between sexual abuse and concealment (r = -0.25, p = 0.04). A significant negative correlation was also found between emotional neglect and concealment (r = 0.34, p = 0.00).

These significant correlations suggest the possibility that shame, or guilt, may moderate the relationship between childhood trauma and concealment for either sexual abuse or emotional neglect. Correlations are presented in Table 4.

Sexual Abuse as a Predictor

A moderated regression analysis showed that the interaction between sexual abuse (M = 6.06, SD = 2.12) and shame (M = .46, SD = 0.50) in predicting concealment was not significant, b = 1.15, p = 0.30. A second moderated regression analysis showed

that the interaction between sexual abuse (M = 6.06, SD = 2.12) and guilt (M = 0.57, SD = 0.50) in predicting concealment was not significant, b = 0.85, p = 0.44.

Emotional Neglect as a Predictor

Another regression analysis was conducted to assess the potential for shame or guilt to moderate the relationship between emotional neglect and concealment. A moderated regression analysis showed that the interaction between emotional neglect (M = 0.31, SD = 0.47) and shame (M = .46, SD = 0.50) in predicting concealment was not significant, b = 2.78, p = 0.54. A second moderated regression analysis showed that the interaction between emotional neglect (M = 0.31, SD = 0.47) and guilt (M = 0.57, SD = 0.50) in predicting concealment was not significant, b = 1.45, p = 0.77.

Chapter 7

Discussion

Impact of Study

Childhood maltreatment has been linked to emotions such as shame and guilt that elicit schemas of self-doubt, incompetence, and failure (Cohen et al., 2011). These schemas may contribute to the development of the belief that individuals should conceal their trauma to avoid feeling the impact of shame or guilt. De Seve et al. (2020) found that shame is a mediator between concealment and feelings of inferiority. The majority of prior studies have focused solely on the negative aspects of shame and neglected the understanding that shame may be utilized as a coping skill for individuals with childhood trauma.

This study verified that there is a strong positive relationship between shame and concealment. Understanding this correlation, displays a barrier within the study. How do you get individuals with shame who are prone to conceal to disclose their feelings of shame on a measure? Approximately 45.5% of this sample reported high scores on the shame scale on the TOSCA-3, but 54.4% of the sample also reported high scores on level of concealment on the SCS. This statistic displays the overall concealment of the participants may have been influencing their responses on the TOSCA-3 related to shame. When reviewing the items on the TOSCA-3 related to shame examples included, “You would feel incompetent.” or “I am inconsiderate”. Since inferiority has been shown to impact self-concealment strengthening this link between self-concealment and self-esteem, the low self-esteem feelings that would elicit the endorsement of this shameful statement may have been overridden by the shame coping tactic of concealment.

Therefore, to accurately study shame the researchers would need to focus on characteristics that do not trigger the individual's low self-esteem or defense to self-conceal.

It should also be noted that significant correlations were found between emotional neglect as well as sexual abuse and concealment. This suggested that there is a relationship between childhood trauma and concealment, as well as shame and concealment, even if shame does not moderate the relationship between childhood trauma and concealment.

The results of this study were congruent with prior studies in relation to gender differences among shame and guilt. It was found that females who endorsed high shame also scored higher on the SCS than males. However, this result was not found when guilt was assessed demonstrating similar patterns among males and females. This finding was consistent with Ellis et al. (2020) who discovered that women were 2.4 times more likely to report feelings of shame than men. However, unlike Ellis et al. (2020), this study did not find a significant difference between males and females in regard to disclosure of trauma. It can be suggested that with a larger sample size a difference between gender could be found.

Although previous studies have focused on the emotion of shame, this study sought to explore guilt's constructive qualities. Guilt has been linked to more proactive and repairing behaviors (Cohen et al., 2011, Hooge et al., 2008, Sullivan et al., 2019). These behaviors are also seen in guilt as the outcome of more positive parenting styles reflective of nurturance, and methods that address the child's behavior rather than their sense of self (Babcock Fenerci & DePrince, 2018). Therefore, it was hypothesized that

the presence of guilt on the TOSCA would display lower scores on concealment than shame. Even though this study did not discover a significant effect of guilt on concealment, it did display a negative correlation emphasizing that shame and guilt are attributed differently. This is congruent with the results from Slepian et al., 2020 in which individuals were found to conceal secrets more when they elicited feelings of shame rather than guilt.

Results did not reflect a significant relationship between childhood trauma and shame and guilt. However, a series of independent sample t tests revealed that participants who endorsed four or more adverse childhood events scored higher on the shame and guilt scales compared to those who endorsed less than three. This finding is suggestive of a relationship between shame and guilt and childhood trauma. It is also consistent with the Aakvaag et al. (2019) study where they found shame and guilt to be reported more by those who endorsed more than one adverse childhood experience.

Limitations and Areas for Future Research

A major limitation of this study was the reliance on participants to complete all assessments. Upon completing the survey, some participants provided feedback that the TOSCA-3 was “a lot”. This feedback was also reflected in the exclusion of 45 participants due to incompletion of the TOSCA-3, limiting the overall sample size. The intricacy of this assessment for participants may have hindered obtaining an accurate picture of the role shame plays within individuals with childhood trauma on concealment. It may also be considered that the particular scenario presented may not have elicited only shame allowing the participant to respond higher to the other reactions (e.g., externalization, guilt, or detachment). Future research may benefit from utilizing a

measure that focuses solely on shame and guilt as reactions. It may also be beneficial to only utilize the TOSCA-3 when not obtaining data via virtual survey due to its complexity and length.

Another limitation was the absence of a control group to support the third hypothesis that the individuals who reported a history of childhood trauma on the CTQ or ACE-Q would report higher levels of concealment on the SCS. Initially, it was believed that the majority of the sample would produce more individuals without childhood trauma, allowing for an adequate control group. However, the prevalence of childhood trauma radiated through the sample eliminating the control group. While this lack of a control group did not allow for a comparison between groups, it further supports the importance of this study and continued increases in trauma prevalence.

Future research would benefit from obtaining a larger sample from nonclinical locations to ensure a control group may be utilized for comparison. Due to the broad range of trauma that can occur during childhood, prior studies have chosen to specify a specific population or type of childhood maltreatment within their studies. Although this study explored the relationship between shame and guilt among various types of trauma, significance may be found in future studies if specific characteristics of shame and guilt (i.e., low self-esteem, social withdrawal, avoidance, etc.) are explored within one type of childhood maltreatment.

The literature explains that parenting style and social support have been found to have a strong relationship to shame and guilt with shame being linked to more harsh parenting styles and guilt being linked to more nurturing parenting styles. Although this study did not explore parenting styles directly related to shame and guilt, it might be

beneficial for future research to utilize parenting styles to explore whether they could be attributing to the development of trauma related shame or guilt. It would also be interesting to see if social support in adulthood has any positive impact on decreasing shame coping in adults with a history of childhood trauma.

Another limitation of this study was the inclusion of moral injury in relation to shame. While this study focused solely on trauma occurring during childhood, moral injury has been found to elicit symptoms of shame categorized differently than PTSD. McEwen et al., 2020 found moral injury to not only be linked to negative mental health outcomes, but also impact the individual socially, cognitively, spiritually, physically, and behaviorally. On the surface these appear identical to the long-term effects of childhood trauma in adults. However, further research on moral injury might allow for a more defined picture of the impact of shame following trauma.

Conclusion

The results concluded from this study are meaningful in expanding upon the literature on childhood trauma. The significance of the first hypothesis displays how concealment may be acting as a barrier to individuals disclosing feelings of shame. This is impactful to future research to increase awareness that when studying shame, caution should be taken to approach it in subtle ways that do not elicit the defense of concealment. The disqualification of a control group in this study is also revealing of the prevalence of childhood trauma in society and further accentuates the need for research in this area. Finally, shame and guilt have not been studied in terms of acting as a moderator between childhood trauma and concealment. Since the literature has proven relationships between childhood trauma and shame, concealment and shame, and childhood trauma

and concealment, it is suggested that with a larger sample size and utilization of a different shame scale, this moderation could be found to be significant.

Clinical Implications

This study contributes to the importance of early intervention for childhood trauma as well as how concealment may be eliminating treatment opportunities for this population and increases awareness of the role of lack of self-disclosure as a barrier to clinical practice. When individuals are resistant to disclose their trauma in therapy it eliminates their ability to heal. If clinicians are aware of the maladaptive role shame can play in concealment, they can target the shame directly before treating the trauma. Treating the underlying shame and guilt first may allow the client to be more forthcoming with details of their trauma. This approach may prove to be more beneficial in treating trauma rather than attempting to elicit information from the client when shame is acting as a barrier. The results of this study also provide insight on how to approach shame therapeutically. Due to shame being a complex emotion that may manifest in multiple ways, mental health providers working with the trauma population may benefit from administering a shame scale, such as The Shame Compass Scale, to explore how their client may be using shame as a coping skill.

Finally, it is imperative for clinicians to address their clients' feelings of shame and guilt independently. Mental health providers working with the trauma population may prefer to view guilt as a target behavior, and work with the client to reframe their shameful ideations to ideations of guilt where the client is able to produce more proactive and repairing behaviors supportive of post traumatic growth.

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Tables

Table 1.
Descriptive Statistics of Participant Demographics

Variable *(N = 68)*	*Total Sample*	
	Mean	**SD**
Age	33.42	10.89
	n	%
Gender		
Female	32	47.1%
Male	34	50.0%
Non-binary	2	2.9%
Ethnicity		
Caucasian	43	63.2%
Hispanic/Latin Am	10	14.7%
African American	7	10.3%
Asian	3	4.4%
Other	3	4.4%
Biracial	2	2.9%
Symptoms		
Loss of interest	19	27.9%
Feelings of guilt	18	26.5%
Low energy	29	42.6%
Poor Concentration	27	39.7%
Drastic weight gain	7	10.3%
Drastic weight loss	3	4.4%
Suicidal ideations	8	11.8%
Suicide attempts	3	4.4%
Nightmares	8	11.8%
Worry/Anxious	46	67.6%
Restlessness	23	33.8%
Irritability	25	36.8%
Fatigue	30	44.1%
Insomnia	19	27.9%

Table 2.
Descriptive Statistics of Childhood Trauma

Variable	*Total Sample (N = 68)*	
	n	%
Total Childhood Trauma	57	83.8%
No History of Trauma	11	16.2%
Type of Childhood Maltreatment		
Emotional Abuse	25	36.8%
Emotional Neglect	21	30.9%
Sexual Abuse	19	27.9%
Physical Abuse	15	22.1%
Physical Neglect	6	8.8%
Other Adverse Experiences		
Parental Divorce	28	41.2%
Family Mental Illness	25	36.8%
Substance Abuse	20	29.4%
Domestic Violence	7	10.3%
Imprisonment	6	8.8%

Table 3.
Descriptive Statistics of TOSCA-3 scores

Variable *(N =68)*	*Total Sample*	
	n	%
Shame		
High Shame	31	45.6%
Low Shame	37	54.4%
Guilt		
High Guilt	39	57.4%
Low Guilt	29	42.6%

Table 4.
Correlation of Shame, Guilt, Concealment, and Types of Trauma

		EA	PA	SA	EN	PN	C	S	G
Emotional Abuse (EA)									
	Pearson's r	1	**.624***	**.273***	**.349***	**.408***	-.185	-.085	.082
	Sig. (2-tailed)		<.001	.024	.004	<.001	.132	.489	.507
	N	68							
Physical Abuse (PA)									
	Pearson's r	**.624***	1	.222	.028	.210	.055	.033	.182
	Sig. (2-tailed)	<.001		.069	.819	.086	.654	.790	.137
	N	68							
Sexual Abuse (SA)									
	Pearson's r	**.273***	.222	1	**.293***	.037	**-.250**	-.118	.067
	Sig. (2-tailed)	.024	.069		.015	.762	.040	.336	.589
	N	68							
Emotional Neglect (EN)									
	Pearson's r	**.349***	.028	**.293***	1	**.465***	-.344	-.139	-.044
	Sig. (2-tailed)	.004	.819	.015		<.001	.787	.939	.401
	N	68							
Physical Neglect (PN)									
	Pearson's r	**.408***	.210	.037	**.465***	1	-.033	.009	-.104
	Sig. (2-tailed)	<.001	.086	.762	<.001		.787	.939	.401
	N	68							
Concealment (C)									
	Pearson's r	-.185	.055	**-.250***	**-.344***	-.033	1	**.258***	-.065
	Sig. (2-tailed)	.132	.654	.040	.004	.787		.034	.600
	N	68							
Shame (S)									
	Pearson's r	-.085	.033	-.118	-.139	.009	.258	1	**.562***
	Sig. (2-tailed)	.489	.790	.336	.259	.939	.34		<.001
	N	68							
Guilt (G)									
	Pearson's r	.082	.182	.067	-.044	-.104	-.065	**.562***	1
	Sig. (2-tailed)	.507	.137	.589	.721	.401	.600	<.001	
	N	68							

* *Correlation at .05 level*

Appendices

Appendix A

Demographics Form

Age: _____

Gender:

- Male
- Female
- Non-binary
- Prefer Not to Say

What is your ethnicity?

- Hispanic/Latin American
- Caucasian
- Hawaiian
- African American
- Asian
- American Indian
- Native American
- Biracial

What is your employment status?

- Full time
- Part time
- Retired
- Disabled
- Unemployed
- Student

What is your relationship status?

- Single
- Married
- Divorced
- Widowed
- Separated
- Other

Do you have children?

- Yes
- No

What is your highest level of education?

- Some High School
- High School Diploma
- Associates Degree
- Bachelor's Degree
- Graduate School

Have you ever been treated for a mental health diagnosis? If so, please specify primary diagnosis below: _____

Please select any of the following symptoms that apply to you:

- Loss of interest in things you once enjoyed
- Feelings of guilt
- Low energy
- Poor concentration
- Drastic weight gain
- Drastic weight loss
- Suicidal thoughts
- Suicidal attempts
- Homicidal thoughts
- Nightmares
- Worry/anxious
- Restlessness
- Irritability

- Tension
- Fatigue
- Insomnia
- Hypersomnia
- Panic

Please select any type of treatment you have participated in:

- Individual Psychotherapy
- Family Therapy
- Couples Therapy
- Hospitalizations
- I have never participated in therapy or any type of treatment

Would you say that you have a positive self-esteem?
(Display attitudes, thoughts and behaviors of generally liking who you are):

- Yes
- No
- I'm not sure

Appendix B

Childhood Trauma Questionnaire: The following 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. For each question, circle the response that best describes how you feel. Your answers will be kept confidential.

When I was growing up…	Never True	Rarely True	Sometimes True	Often True	Very Often True
1. I didn't have enough to eat.	0	1	2	3	4
2. I knew there was someone to take care of me and protect me.	0	1	2	3	4
3. People in my family called me things like "stupid," "lazy," or "ugly."	0	1	2	3	4
4. My parents were too drunk or high to take care of the family.	0	1	2	3	4
5. There was someone in my family who helped me feel that I was important or special.	0	1	2	3	4
6. I had to wear dirty clothes.	0	1	2	3	4
7. I felt loved.	0	1	2	3	4
8. I thought my parents wished I had never been born.	0	1	2	3	4
9. I got hit so hard by someone in my family that I had to see a doctor or go to the hospital.	0	1	2	3	4
10. There was nothing I wanted to change about my family.	0	1	2	3	4
11. People in my family hit me so hard that it left me with bruises or marks.	0	1	2	3	4
12. I was punished with a belt, a board, a cord, or some other hard object.	0	1	2	3	4
13. People in my family looked out for each other.	0	1	2	3	4
14. People in my family said hurtful or insulting things to me.	0	1	2	3	4
15. I believe that I was physically abused.	0	1	2	3	4
16. I had the perfect childhood.	0	1	2	3	4
17. I got hit or beaten so badly that it was noticed by someone like a teacher, neighbor, or doctor.	0	1	2	3	4
18. I felt that someone in my family hated me.	0	1	2	3	4
19. People in my family felt close to each other.	0	1	2	3	4
20. Someone tried to touch me in a sexual way, or tried to make me touch them.	0	1	2	3	4
21. Someone threatened to hurt me or tell lies about me unless I did something sexual with them.	0	1	2	3	4
22. I had the best family in the world.	0	1	2	3	4
23. Someone tried to make me do sexual things or watch sexual things.	0	1	2	3	4
24. Someone molested me.	0	1	2	3	4
25. I believe that I was emotionally abused.	0	1	2	3	4

Appendix C

Adverse Childhood Experiences Questionnaire (ACE-Q)

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**...
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**...
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**...
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 _____

4. Did you **often or very often** feel that ...
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often or very often** feel that ...
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.

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Appendix D

Self-Concealment Scale (SCS)

Please indicate the extent of your agreement with each of the following statements using the scale below:

---

1 2 3 4 5
Strongly Disagree Neutral Agree Strongly
Disagree Agree

Circle one number for each item.
1 2 3 4 5 I have an important secret that I haven't shared with anyone.
1 2 3 4 5 If I shared all my secrets with my friends, they'd like me less.
1 2 3 4 5 There are lots of things about me that I keep to myself.
1 2 3 4 5 Some of my secrets have really tormented me.
1 2 3 4 5 When something bad happens to me, I tend to keep it to myself.
1 2 3 4 5 I'm often afraid I'll reveal something I don't want to.
1 2 3 4 5 Telling a secret often backfires and I wish I hadn't told it.
1 2 3 4 5 I have a secret that is so private I would lie if anybody asked me about it.
1 2 3 4 5 My secrets are too embarrassing to share with others.
1 2 3 4 5 I have negative thoughts about myself that I never share with anyone.

Larson, D. G., & Chastain, R. L. (1990). Self-concealment: Conceptualization, measurement, and health implications. Journal of Social and Clinical Psychology, 9, 439-455.

Appendix E

The Test of Self-Conscious Affect- Third Edition (TOSCA-3)

TOSCA-3

Below are situations that people are likely to encounter in day-to-day life, followed by several common reactions to those situations.

As you read each scenario, try to imagine yourself in that situation. Then indicate how likely you would be to react in each of the ways described. We ask you to rate all responses because people may feel or react more than one way to the same situation, or they may react different ways at different times.

For example:

A. You wake up early one Saturday morning. It is cold and rainy outside.

a) You would telephone a friend to catch up on news. 1---2---3---4---5
not likely very likely

b) You would take the extra time to read the paper. 1---2---3---4---5
not likely very likely

c) You would feel disappointed that it's raining. 1---2---3---4---5
not likely very likely

d) You would wonder why you woke up so early. 1---2---3---4---5
not likely very likely

In the above example, I've rated ALL of the answers by circling a number. I circled a "1" for answer (a) because I wouldn't want to wake up a friend very early on a Saturday morning -- so it's not at all likely that I would do that. I circled a "5" for answer (b) because I almost always read the paper if I have time in the morning (very likely). I circled a "3" for answer (c) because for me it's about half and half. Sometimes I would be disappointed about the rain and sometimes I wouldn't -- it would depend on what I had planned. And I circled a "4" for answer (d) because I would probably wonder why I had awakened so early.

Please do not skip any items -- rate all responses.

1. You make plans to meet a friend for lunch. At 5 o'clock, you realize you stood him up.

a) You would think: "I'm inconsiderate." 1---2---3---4---5
not likely very likely

b) You would think: "Well, they'll understand." 1---2---3---4---5
not likely very likely

c) You'd think you should make it up to him as soon as possible. 1---2---3---4---5
not likely very likely

d) You would think: "My boss distracted me just before lunch." 1---2---3---4---5
not likely very likely

2. You break something at work and then hide it.

a) You would think: "This is making me anxious. I need to either fix it or get someone else to." 1---2---3---4---5
not likely very likely

b) You would think about quitting. 1---2---3---4---5
not likely very likely

c) You would think: "A lot of things aren't made very well these days." 1---2---3---4---5
not likely very likely

d) You would think: "It was only an accident." 1---2---3---4---5
not likely very likely

3. You are out with friends one evening, and you're feeling especially witty and attractive. Your best friend's spouse seems to particularly enjoy your company.

a) You would think: "I should have been aware of what my best friend is feeling." 1---2---3---4---5
not likely very likely

b) You would feel happy with your appearance and personality. 1---2---3---4---5
not likely very likely

c) You would feel pleased to have made such a good impression. 1---2---3---4---5
not likely very likely

d) You would think your best friend should pay attention to his/her spouse. 1---2---3---4---5
not likely very likely

e) You would probably avoid eye-contact for a long time. 1---2---3---4---5
not likely very likely

4. At work, you wait until the last minute to plan a project, and it turns out badly.

a) You would feel incompetent. 1---2---3---4---5
not likely very likely

b) You would think: "There are never enough hours in the day." 1---2---3---4---5 not likely very likely

c) You would feel: "I deserve to be reprimanded for mismanaging the project." 1---2---3---4---5 not likely very likely

d) You would think: "What's done is done." 1---2---3---4---5 not likely very likely

5. You make a mistake at work and find out a co-worker is blamed for the error.

a) You would think the company did not like the co-worker. 1---2---3---4---5 not likely very likely

b) You would think: "Life is not fair." 1---2---3---4---5 not likely very likely

c) You would keep quiet and avoid the co-worker. 1---2---3---4---5 not likely very likely

d) You would feel unhappy and eager to correct the situation. 1---2---3---4---5 not likely very likely

6. For several days you put off making a difficult phone call. At the last minute you make the call and are able to manipulate the conversation so that all goes well.

a) You would think: "I guess I'm more persuasive than I thought." 1---2---3---4---5 not likely very likely

b) You would regret that you put it off. 1---2---3---4---5 not likely very likely

c) You would feel like a coward. 1---2---3---4---5 not likely very likely

d) You would think: "I did a good job." 1---2---3---4---5 not likely very likely

e) You would think you shouldn't have to make calls you feel pressured into. 1---2---3---4---5 not likely very likely

7. While playing around, you throw a ball and it hits your friend in the face.

a) You would feel inadequate that you can't even throw a ball. 1---2---3---4---5 not likely very likely

b) You would think maybe your friend needs more practice at catching. 1---2---3---4---5 not likely very likely

c) You would think: "It was just an accident." 1---2---3---4---5 not likely very likely

d) You would apologize and make sure your friend feels better. 1---2---3---4---5 not likely very likely

8. You have recently moved away from your family, and everyone has been very helpful. A few times you needed to borrow money, but you paid it back as soon as you could.

a) You would feel immature. 1---2---3---4---5
not likely very likely

b) You would think: "I sure ran into some bad luck." 1---2---3---4---5
not likely very likely

c) You would return the favor as quickly as you could. 1---2---3---4---5
not likely very likely

d) You would think: "I am a trustworthy person." 1---2---3---4---5
not likely very likely

e) You would be proud that you repaid your debts. 1---2---3---4---5
not likely very likely

9. You are driving down the road, and you hit a small animal.

a) You would think the animal shouldn't have been on the road. 1---2---3---4---5
not likely very likely

b) You would think: "I'm terrible." 1---2---3---4---5
not likely very likely

c) You would feel: "Well, it was an accident." 1---2---3---4---5
not likely very likely

d) You'd feel bad you hadn't been more alert driving down the road. 1---2---3---4---5
not likely very likely

10. You walk out of an exam thinking you did extremely well. Then you find out you did poorly.

a) You would think: "Well, it's just a test." 1---2---3---4---5
not likely very likely

b) You would think: "The instructor doesn't like me." 1---2---3---4---5
not likely very likely

c) You would think: "I should have studied harder." 1---2---3---4---5
not likely very likely

d) You would feel stupid. 1---2---3---4---5
not likely very likely

11. You and a group of co-workers worked very hard on a project.Your boss singles you out for a bonus because the project was such a success.

a) You would feel the boss is rather short-sighted. 1---2---3---4---5
not likely very likely

b) You would feel alone and apart from your 1---2---3---4---5

colleagues. not likely very likely

c) You would feel your hard work had paid off. 1---2---3---4---5
not likely very likely

d) You would feel competent and proud of yourself. 1---2---3---4---5
not likely very likely

e) You would feel you should not accept it. 1---2---3---4---5
not likely very likely

12. While out with a group of friends, you make fun of a friend who's not there.

a) You would think: "It was all in fun; it's harmless." 1---2---3---4---5
not likely very likely

b) You would feel small...like a rat. 1---2---3---4---5
not likely very likely

c) You would think that perhaps that friend should have been there to defend himself/herself. 1---2---3---4---5
not likely very likely

d) You would apologize and talk about that person's good points. 1---2---3---4---5
not likely very likely

13. You make a big mistake on an important project at work. People were depending on you, and your boss criticizes you.

a) You would think your boss should have been more clear about what was expected of you. 1---2---3---4---5
not likely very likely

b) You would feel like you wanted to hide. 1---2---3---4---5
not likely very likely

c) You would think: "I should have recognized the problem and done a better job." 1---2---3---4---5
not likely very likely

d) You would think: "Well, nobody's perfect." 1---2---3---4---5
not likely very likely

14. You volunteer to help with the local Special Olympics for handicapped children. It turns out to be frustrating and time-consuming work.You think seriously about quitting, but then you see how happy the kids are.

a) You would feel selfish and you'd think you are basically lazy. 1---2---3---4---5
not likely very likely

b) You would feel you were forced into doing something you did not want to do. 1---2---3---4---5
not likely very likely

c) You would think: "I should be more concerned about people who are less fortunate." 1---2---3---4---5
not likely very likely

d) You would feel great that you had helped others. 1---2---3---4---5
not likely very likely

e) You would feel very satisfied with yourself. 1---2---3---4---5
not likely very likely

15. You are taking care of your friend's dog while they are on vacation and the dog runs away.

a) You would think, "I am irresponsible and incompetent." 1---2---3---4---5
not likely very likely

b) You would think your friend must not take very good care of their dog or it wouldn't have run away. 1---2---3---4---5
not likely very likely

c) You would vow to be more careful next time. 1---2---3---4---5
not likely very likely

d) You would think your friend could just get a new dog. 1---2---3---4---5
not likely very likely

16. You attend your co-worker's housewarming party and you spill red wine on their new cream-colored carpet, but you think no one notices.

a) You think your co-worker should have expected some accidents at such a big party. 1---2---3---4---5
not likely very likely

b) You would stay late to help clean up the stain after the party. 1---2---3---4---5
not likely very likely

c) You would wish you were anywhere but at the party. 1---2---3---4---5
not likely very likely

d) You would wonder why your co-worker chose to serve red wine with the new light carpet. 1---2---3---4---5
not likely very likely