IDENTIFICATION AND TREATMANT OF SEXUAL SHAME: DEVELOPMENT OF A MEASUREMENT TOOL AND GROUP THERAPY PROTOCOL

A Dissertation

Submitted to the faculty of The American Academy of Clinical Sexologists in partial fulfillment of the requirements of the degree of Doctor of Philosophy in Clinical Sexology

By

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DISSERTATION APPROVAL

This dissertation submitted by Sarah E. Kyle, LCSW has been read and approved by three faculty members of the American Academy of Clinical Sexologists.

The final copies have been examined by the Dissertation Committee and the signatures which appear here verify the fact that any necessary changes have been incorporated and that the dissertation is now given final approval with reference to content, form, and mechanical accuracy.

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VITA

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ABSTRACT

This dissertation proposes a model for assessing and treating clients' sexual shame using a new measurement instrument, the Kyle Inventory of Sexual Shame, along with a six-session group therapy model. Researchers have documented the prevalence of shame underlying a range of psychological problems, and are now becoming aware of the need for domain-specific instruments to assess clients' needs in order to direct them to proper treatment. Despite the wealth of shame research in the past several decades, the literature reflects little attention to sexual shame. Sexuality is an often-avoided subject due to its stigma and our society's cultural mores. Shame has been described as a silent epidemic; epidemic because of its ubiquitous nature, and silent because most people are afraid or unwilling to discuss it. Very little research has been documented on these two topics in combination. The purpose of the current quantitative research was to determine the efficacy of an evaluation tool and treatment model for sexual shame. Since domain-specific measures related to sexual shame were not readily available, the Kyle Inventory of Sexual Shame (KISS) was developed and evaluated with a sample of 102 individuals. Results of a pilot test showed the KISS had a Cronbach's alpha of .929, indicating an excellent level of internal consistency reliability. The efficacy of the six-session group therapy protocol with five participants was also evaluated. Although the difference on the pre- (M = 80; SD = 13.9) and post-test (M = 56.3; SD = 16) were not significantly different, KISS scores were found to be practically significant, and all participants' raw scores were lower (by a minimum of 6 points, maximum of 53 points) on the post-test KISS than on the pre-test KISS, indicating the group therapy was effective in reducing

sexual shame for all participants. Study limitations, recommendations, and conclusions are discussed.

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Chapter 1: The Problem

Introduction and Background of Problem

Shame has been described as an intensely painful, universal feeling that one is inherently flawed, lacking, unacceptable, or unlovable (Brown, 2007; Rizvi, 2010; Tangney & Dearing, 2003). Sexual shame is the experience of these emotions in response to one's current or past sexual thoughts, behaviors, or experiences. Researchers have documented the prevalence of shame along a range of issues, and are now becoming aware of the need for domain-specific instruments to assess clients' needs in order to direct them to proper treatment (Rizvi, 2010). Despite the wealth of shame research in the past several decades, the literature reflects little attention to sexual shame. Sexuality is an often-avoided subject due to its stigma and our society's cultural mores. Shame has been described as a silent epidemic; epidemic because of its ubiquitous nature, and silent because most people are afraid or unwilling to discuss it. When these topics are combined, it seems even researchers have shied away. This paper provides information on the phenomenon of sexual shame and its treatment.

The current research fills a gap in the literature on sexual shame and may create an opportunity to bring evaluation and treatment for sexual shame into mainstream academic conversation. A strategy to identify and ameliorate sexual shame using a group therapy model was explored. Participants in the research completed the Kyle Inventory of Sexual Shame and received a six-session group therapy intervention designed to reduce sexual shame. The results from the current investigation add to the limited literature on sexual shame by determining the efficacy of a group therapy intervention on

reducing sexual shame, and the validity and reliability of a newly developed tool for measuring sexual shame.

Shame. The impact of shame on clients' emotional well-being has recently been investigated by numerous researchers. "Research on the experience, expression and consequences of shame has increased in the past two decades, calling attention to the potentially deleterious effects of this emotion" (Rizvi, 2010, p. 438). Shame has been shown to wreak havoc on its bearers. Research consistently links shame to poor interpersonal skills, an impaired capacity for empathy, feelings of anger and hostility, and maladaptive strategies for managing anger (Tangney & Dearing, 2003). Individuals even risk death or serious injury to avoid feeling shame (Tangney, 2007). Although researchers agreed on its negative ramifications, the lack of reliable and descriptive research on shame as well as the uncertainty of treatment efficacy precluded researchers from solving shame problems in clients. Additionally, therapists may have hesitated to address shame in their clients because it has been poorly understood and addressed in themselves (Morrison, 1998). "In psychotherapy, the emergence of shame tends to generate a *collusion* of avoidance between therapist and patient; both 'avert the eyes' in embarrassment as they turn away from shame" (Morrison, 1998, p.78).

Sexuality. In the United States, sexuality is rarely discussed, even between therapists and clients. Conversations about sexuality are frequently precluded by religious and cultural prohibitions. Despite attempts by educators and mental health practitioners to bring this topic to the forefront, "the erotic still arouses acute moral anxiety and confusion. This is not because sex is intrinsically 'naughty,' but because it is a focus for powerful feelings" (Weeks, 1989, p.18). Individual responses to the subject

of sexuality vary widely. Some may find sexuality elicits feelings of warmth or arousal, while for others it evokes fear or anger. In cultures worldwide, sexuality has been the focus of intense social, religious, ethical, and political divisions. Societal norms have deemed sexuality a matter to be avoided, except in the bedroom or medical setting.

Sexual shame. This cultural ambivalence, particularly acute in North America, is likely at the root of sexual shame. Humans are naturally inquisitive about sexuality, but in our culture they are taught at a young age that it is forbidden. Normal sexual exploration and curiosity are pathologized by parents, religious leaders, and other authority figures. This creates an excited tension around the taboo, which is often met with disapproval, thereby activating sexual shame. Other factors have been shown to contribute to sexual shame, including childhood sexual abuse, growing up in an extremely religious environment, looking at pornography, engaging in same-sex sexual activity, sexual assault, non-consensual sexual activity, and promiscuity (Hastings, 1998; Lichtenberg, 2007; Weeks, 1989).

Group therapy to treat shame. Group therapy was demonstrated to be a highly effective form of psychotherapy that provides participants with meaningful benefits (Yalom, 2005). “Therapeutic change is an enormously complex process that occurs through an intricate interplay of human experiences” (Yalom, 2005, p. 273). The group therapy modality allows clients to be hopeful they can feel better. They experience universality, gaining awareness their situations and feelings are not terminally unique. Group members are able to give and receive care, learn from one another, and make emotional connections with fellow participants. Research indicated that shame can be isolating, but clients who reach out to others experiencing shame have higher levels of

shame resilience (Brown, 2009). These factors render group therapy an ideal treatment modality for shame, especially since shame is typically an overwhelmingly isolating emotion.

Significance of the Study

Despite the considerable amount of research in the individual areas of shame and sexuality, very little is known about the phenomenon of sexual shame, which combines the two. There is also a paucity of empirical evidence on the actual number of clients presenting with particular kinds of shame. Researchers are becoming aware of the need for domain-specific assessment tools that measure shame "in response to specific, idiographic experiences" (Rizvi, 2010, p.439). Due to the lack of research literature describing and mapping the territory of sexual shame, this study offers a preliminary, cutting-edge investigation into a topic that is rarely addressed in depth, but colors a broad segment of sexual treatment.

The information obtained in this study is intended to provide a method for evaluating and treating sexual shame. It will allow mental health providers to utilize more effective interventions when clients present with this issue. The data from this research can be utilized to assist clinicians with developing a better understanding of sexual shame, how it affects clients, and utilizing a specific protocol for alleviating it.

Sexuality is a taboo topic that begets physical and emotional vulnerability, making it particularly disposed to shame. Shame stemming from sexual thoughts or experiences is linked to a range of psychological symptoms, and can be crippling for the individual client (Hastings, 1998; Morrison, 1998). Additionally, within a relationship, sexual shame can provoke other-directed anger, hostility, and even aggression (Tangney,

2007). It often inhibits empathic responses, as well as sexual activity between partners. The possible impact of sexual shame was considered substantially significant to warrant further research on its assessment and management.

Purpose of the Study

The purpose of this study was to evaluate the effectiveness of a group therapy approach for treating sexual shame, develop an instrument to measure sexual shame, and establish the reliability of this instrument, in order to further the body of knowledge about measuring and treating sexual shame. Because no measure of sexual shame had been published, a researcher-created instrument, the Kyle Inventory of Sexual Shame, was developed and validated. This measure was then utilized to determine the effectiveness of a group therapy protocol for treating sexual shame in individuals from a variety of backgrounds.

Limitations of the Study

This study explored a manner of assessing and treating sexual shame. There were several limitations to the research that should be kept in mind. The first of these pertained to the researcher-developed measurement instrument, the Kyle Inventory of Sexual Shame. While the assessment tool was modeled after psychometrically sound measures of shame, it was validated as a part of this study and may require further evaluation for reliability and validity. Additionally, the proposed sample was small and therefore may not represent the general population with regard to diversity of ethnicity, sexual orientation, and socio-economic status. Because participation in the study was voluntary, it was not known whether subjects who opted not to participate had different experiences of sexual shame from those who did participate. Finally, one of the original

participants dropped out of the treatment prior to its completion and was unable to complete the post-group inventory and it was impossible to determine whether there were any systematic differences between the participant who dropped-out and the participants who remained for the duration of the treatment.

Chapter 2: Literature Review

Introduction

The purpose of this study was to evaluate the effectiveness of a group therapy approach for treating sexual shame and to establish the reliability of an instrument to measure sexual shame. The prevalence of shame related to a wide range of issues (e.g. poor interpersonal skills, limited capacity for empathy, feelings of hostility) has been documented, and psychologists have identified the need for domain-specific instruments to assess clients' needs in order to augment treatment outcomes (Rizvi, 2010). Although there is adequate research on shame and other issues, there is a paucity of research on sexual shame. The current research fills a gap in the literature on sexual shame and may bring evaluation and treatment for sexual shame into mainstream academic conversation.

This literature review was conducted using various academic databases, including Dissertations and Theses, Gender Studies Database, Google Scholar, Lexis Nexis, Mental Measurements Yearbook, OED, PsycARTICLES, PsycCRITIQUES, Psychology and Behavioral Sciences Collection, PsycINFO, Social Services Abstracts, and the University of Texas Library Catalog. Search terms included various combinations of the following words: *shame, sexual, sexuality, treat, treating, treatment, group, therapy, effect(s), definition, women, measure, measurement, instrument, tools, and adaptive functions*. The research pertinent to shame, sexual shame, and group therapy was reviewed, and gaps in the literature were identified providing the rationale for the current study.

Shame

Defining shame. According to the Oxford English Dictionary (2010), shame was defined as:

> The painful emotion arising from the consciousness of something dishonouring, ridiculous, or indecorous in one's own conduct or circumstances (or in those of others whose honour or disgrace one regards as one's own), or of being in a situation which offends one's sense of modesty or decency.

Similarly, the Merriam-Webster Dictionary (2008) defined shame as, "a painful emotion caused by consciousness of guilt, shortcoming, or impropriety," "a condition of humiliating disgrace or disrepute," and "something that brings censure or reproach." Social researchers, however, have struggled to find an actual or operational definition of shame that presents it as a measurable concept distinct from other emotions, such as guilt, regret, or embarrassment. Despite the fact that these terms are all commonly used interchangeably, each term represented a distinct emotion associated with unique behaviors, urges, and expressions (Rizvi, 2010). When attempting to differentiate between shame and guilt, researchers have used one of the following three criteria: (1) the type of event that brings about the emotion, (2) whether the transgression was a private or public event, and (3) whether the person views the event as a bad behavior or a failure of the self (Tangney, 2007). The distinction most supported by social psychological research is whether a person attributes an act of wrongdoing to a problem with the *self* or a problem with that particular *behavior*. The experience of shame is directly about the *self*, which is the focus of evaluation. In guilt, the self is not the central object of negative evaluation, but rather the *thing* done or undone is the focus" (Lewis, 1971, p. 30, emphasis in original). In other words, this view of shame involved the belief that the entire self is bad following a transgression, while guilt involved the belief that only the transgression is bad. Lewis (1971) described shame as an acutely painful

emotion that is typically accompanied by a sense of shrinking, worthlessness, and powerlessness. According to Tangney and Dearing (2003), shame was generally more painful than guilt, and it involved global negative evaluations of the self. Morrison (1998) described shame as, “a sharp and searing *feeling* of failure and defectiveness about oneself” (p. 40, emphasis in original). Shame researcher Brené Brown developed this definition: “Shame is the intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging” (2007, p. 5). Pajaczkowska and Ward (2008) wrote that shame “begins precisely where words fail us and where the difference between self and not-self ceases to exist” (p. 3); in other words, the concept is elusive and difficult to define. Despite these varied definitions, researchers tend to agree that shame is a negative and intensely painful evaluation of the self. For the purpose of this study, shame was defined according to Lewis’ (1971) distinction that the *self* rather than a *behavior* is deemed unacceptable.

The effects of shame. Shame is universally manifested by the sufferer’s behavior and physical appearance with symptoms such as “brows furrowed, eyelids drooping, and gaze cast downward, the head characteristically hangs forward. The body posture is stooped, shoulders are slack, and the gait is slow and shuffling” (Morrison, p.7). Shame motivates the hiding of misdeeds, or even of the self, from others. An individual experiencing shame will often deny responsibility for the transgression and exhibit blame and anger toward others (Tangney, 2007). Shame has been shown to precipitate feeling inferior, defective, unworthy, incompetent, weak, unlovable, despairing, and feeling like a failure (Morrison, 1998). Additionally, shame has been shown to have negative immunological effects on its sufferers, causing proinflammatory cytokine activity, which

reduces ability to fight infection (Dickerson, Kemeny, Aziz, Kim, & Fahey, 2004). Research also demonstrated that shame is powerfully detrimental to students' ability to learn, and is an impediment to their academic performance (Bond, 2009; Johnson, 2012; Thompson, Altman, & Davidson, 2004). Shame has been linked to inhibited creativity because it impedes the brain from the presentation of new or unusual ideas (Womack, 1999). Shame has been clinically linked with the formation and maintenance of various forms of psychopathology, including depression, anxiety, stress, eating disorders, sub-clinical sociopathy, low self esteem, paranoid ideation, suicidality, self-injury, and compulsive behaviors (Cirhinlioglu & Guvenc, 2011; Harder, Cutler, & Rockart, 1992; Pinto-Gouveia & Matos, 2011; Rizvi, 2004; Tangney & Dearing, 2003; Tangney, Wagner, & Gramzow, 1992). Empirical data indicated that people experiencing shame tended to be more angry and distressed than those who were less shame-prone (Tangney & Dearing, 2003). This anger was thought to be initially directed inward toward the self, but when it became too distasteful it quickly shifted outward and became other-directed, which led to relational conflict or aggressive behavior (Retzinger, 1985). Extreme shame was shown to lead to violence, ethnic conflict, international strife, and even genocide (Tangney, 2007).

Despite these negative effects, some researchers posited that shame can actually serve a useful purpose at times. Emotions are generally thought to have an adaptive function, so it naturally followed that the emotion of shame might have some value. Shame was initially conceptualized as a deterrent from wrongdoing that would decrease impropriety. However, further research demonstrated the purported inhibitory function was non-existent (Tangney & Dearing, 2003). Tomkins (1962) suggested that shame was

helpful in regulating children's experiences of excessive interest and excitement by helping them disengage when it is appropriate to do so (such as when a bid for attention is rebuffed by a distracted adult caregiver). For some individuals with a solid sense of self, private self-generated experiences of shame may prompt productive soul-searching, introspection, and self-repair. Indeed, Tangney and Dearing (2003) suggested, "Shame and embarrassment are also thought to be a means of communicating one's acknowledgment of wrongdoing, this diffusing anger and aggression" (p. 127). Overall, however, the few adaptive functions of shame do not mitigate its many detrimental effects.

Treatment of shame. Although recent research developments have led to more effective treatments for shame, it remains a major concern in clinical settings and presents a need for more empirically supported interventions. Perhaps because it is not a specific diagnostic category in the DSM-IV-TR (American Psychological Association, 2004), there have been very few empirical studies on the outcome of treatments for shame (Rizvi, 2004; 2010). The goal of this section is to examine past efforts in treating shame in order to determine what has been effective thus far.

Group therapy. Group therapy has proven to be a successful modality in treating individuals who suffer from shame. Adams and Robinson (2001) developed a group protocol for reducing shame as a way of treating sexual addiction. The treatment focused on teaching expressive techniques, changing negative core beliefs, and regulating affect. Milliken (2004) described a successful program implemented to treat the shame of female inmates at the Montgomery County Correctional Facility in Boyds, Maryland. The overall goal of this group treatment program was to create a safe environment in which

the women could develop trust with one another and with the facilitators. This enabled the participants to feel more empowered and thus take more responsibility for themselves, preparing them to address their shame in the group setting. Kim (1997) utilized group therapy to decrease the intensity of internalized shame in a group of 75 adolescents who were exhibiting behavioral problems. This treatment was focused on bringing participants' unconscious shame into awareness, and strengthening the real self through empathy and acknowledgment. Kaufman (1996) also developed a group curriculum to treat shame-based difficulties. The program gave participants information about affect management, interpersonal competence techniques, improving the relationship with the self, and releasing shame to overcome feelings of powerlessness. Kinsman (1997) conducted a pilot study to test the effectiveness of a short-term group psychotherapy experience in reducing internalized shame. Results indicated a significant reduction of shame using this treatment modality. Brown (2009) developed Connections, a group therapy protocol aimed at helping participants become more informed about and resilient to shame.

Individual therapy. Individual therapy has also been utilized to successfully treat shame. However, reports are usually confined to individual case studies, and/or treatments that combined both individual and group therapies. For example, Raps (2009) completed a case study in which a Vietnam veteran's shame about sexually abusing his daughter was successfully treated using a combination of individual and group therapy. Sweezy (2011) also documented a case study of a suicidal woman whose shame was addressed and alleviated using an Internal Family Systems model of individual therapy. Hahn (2000) described a concern about treating shame in individual therapy. Because

shame is a universal emotion, the individual therapist may resonate with the client's shame and the therapist "may inadvertently collude with patients' desire to hide or to release aggression, thereby interfering with the therapeutic process" (p. 13).

Sexual Shame

Defining sexual shame. Although sexuality is regularly addressed in magazines and even shown on prime-time television, it is still difficult for most people to discuss comfortably because of the reluctance and stigma that are attached to the subject on a cultural level (Hastings, 1998). Additionally, individuals are often introduced to sexual shame at a young age via avenues such as sexual secrecy, sexual abuse, exposure to pornography, religious shaming, being dressed to hide the body, or being shamed for masturbation or promiscuity (Hastings, 1998). In North America, parental discomfort in discussing such topics as menstruation, genitals, erections, or nocturnal emissions conveys to the child at a young age that these things are shameful (Hastings, 1998). Few researchers have written about the subject of sexual shame, therefore no singular definition exists for the term. For the purpose of this study, sexual shame was defined using an adaptation of the definition of shame proposed by Brené Brown (2007): the intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging due to our current or past sexual thoughts, experiences, or behaviors.

History of research. Little has been written about the subject of sexual shame. The predominant work on this topic, *Treating Sexual Shame: A New Map for Overcoming Dysfunction, Abuse, and Addiction*, was written by Anne Stirling Hastings in 1998. Although this book appears poorly researched and unsupported by clinical

literature, it is one of very few pieces of work on the subject. In the book, Hastings provided guidelines for therapists who work with clients experiencing sexual shame. She divided sexual shame into three distinct categories: sexual dysfunction, sexual abuse, and sexual addiction, although she offered no specific justification for choosing these divisions. Hastings (1998) referred to examples from her own monogamous heterosexual marriage as a model to be upheld, which may not be effective in reducing shame for clients whose lives fall outside this framework. She used the terms "healthy sex" and "unhealthy sex" throughout the book, and referred to paraphilias as "cross-wired sexuality."

Hastings made affirming statements about homosexuality, then seemingly negated them with assertions such as, "Almost all gay men who have not engaged in sexual recovery have a difficult time being monogamous" (p. 131), and, "In this unaccepting culture, sexual expression between men and between women is seen as deviant" (p. 160), without backing them up with specific references. Hastings recommended asking clients questions such as, "You look like you're feeling sexual. Are you?" "Are you looking at me like I'm a sex object?" "Are you flirting with me? I noticed that you seem to be flirting with me" (pp. 256-257). The above examples may reflect an attitude likely to further clients' sexual shame rather than alleviate it. The author did not offer empirical data to prove nor disprove her treatment methods. Despite these potentially damaging ideas, Hastings recommended (throughout the book) the use of empathy and compassion when addressing sexual shame issues, which corroborates others' findings on treating shame.

Three other works have been written about sexual shame, all from a psychoanalytic perspective. Mollon (2005) stated that a common source of sexual shame originating in childhood was the negative reaction of a parent who looked disapprovingly at the child engaging in genital exploration or play, thereby associating the child's pleasurable body sensations with a feeling of shame. These body sensations, both pleasurable and puzzling, are often banned from discussions with parents, other adults, and even other children. Mollon (2005) explored Freud's writings about repressed sexuality and the role this plays in development of sexual shame. He determined that sexuality in our culture is expressed in ways that are suggestive rather than explicit. This banishment from language was representative of Freud's theories about repression of sexuality and how this is one of the things that fosters sexual shame (Freud, 1975).

Lichtenburg (2007) took a similar view about how shame developed during childhood. He posited that children inherently seek pleasurable bodily sensations through actions such as sucking, mushing food, touching genitals, or playing with feces. These actions are often met with rebukes, interruptions, or prohibition by parents or caregivers, thereby invoking shame in the child. Lichtenburg believed this led to further shame when, during therapy in adulthood, the patient described particular sexual practices that evoked revulsion from the therapist.

Pajaczkowska and Ward (2008) explored the depths of sexual shame and its profound effects on individuals in our society. They investigated people's reluctance to explore shame, likely due to the humiliation and narcissistic wounding attached to it. The first section of the book, *Psychoanalysis*, consisted of a collection of essays on the links between shame and sexuality. It was comprised primarily of works published more than

20 years ago, which supported the editors' claim that the connection between these two subjects was largely ignored by current research. While these three psychoanalytic works offered an understanding of the origins of sexual shame and its role in the unconscious, little effort was expended to explore the practical effects of this malady, and none offered an option for treating it.

Effects of sexual shame. While a great deal has been written about the powerful impact of shame, little empirical data has been collected on the effects of sexual shame. Hastings (1998) stated there are many ways sexual shame created difficulty for couples. One of the ways this happens was through what she called the "goddess-whore dichotomy" (p.33) in which a man's feelings of sexual shame prevent him from having intimate sex with a woman he loves. Instead, he prefers a sexual partner who can join him in the shame of being lustful, talking dirty, using drugs or alcohol, and engaging in taboo sex acts. Hastings contended that in our society, "men who don't have sex aren't men" (p. 36). Women, on the other hand, are culturally allowed to avoid having sex in order to fend off feelings of shame. She stated the belief that women are often "sexually bonded" (p. 36) with their children. While this rarely involves actual sexual contact, it creates a monogamous bond between mother and child that is exclusive of the father. Repercussions of this include fathers' difficulty bonding with their children, and decreased or non-existent sexual energy between partners. Another effect of sexual shame is the manner in which male acculturation around sexuality and masculinity is traumatizing to men. Hastings (1998) believed men should be treated as if they are victims of sexual abuse, even if they were not touched sexually. She explored the ways sex is shamed for men, what their first masturbation and sexual contact were like, and

how these demeaning messages are akin to actual abuse. The effects of sexual shame on women was also explored via a cultural lens, looking at ways women are affected by magazine articles and other media messages, which may not be congruent with their views of themselves. Hastings frequently referenced sexual addiction as an all-encompassing phenomenon that stems from sexual shame. She believed flirting, paraphilias, non-monogamy, and looking at pornography are all manifestations of sexual addiction or unhealthy sexuality caused by sexual shame. Although Hastings' views may be somewhat dated, there is no more current research or theoretical information published about the effects of sexual shame.

Group Therapy

History of group therapy. Group work emerged in American society in the late 1800s and early 1900s (Garvin, 1996). Immigration and industrialization left many people in overcrowded, unhealthy, and deteriorating conditions, which led to the creation of organizations whose aim was the amelioration of such circumstances. The YMCA, YWCA, and Boys' Clubs of America all utilized group work to help those affected by post-Civil War industrialization (NASW, 1987). The Settlement Movement that occurred around the turn of the 20th century helped the poor by forming group-oriented activities, including preschools, adult education, cultural arts groups, social action committees, and neighborhood councils (Garvin, 1996). This community-based method for providing group services continued into the mid-20th century, when theoretical developments on group work began to propel it into such settings as psychiatric clinics, hospitals, family agencies, correctional institutions, rehabilitation settings, and schools (Brabender, Fallon, & Smolar, 2004; Garvin, 1996). The American Group Psychotherapy Association was

formed in 1943, and today includes members from all mental health disciplines (Brabender et al., 2004). In the 1960s and 1970s, the War on Poverty and the Civil Rights Movement provided opportunities to use group work in solving problems such as delinquency, poverty, and mental illness. In 1970, Irvin Yalom published the first edition of *The Theory and Practice of Group Psychotherapy*, still considered by many to be the bible of group treatment. The Council on Social Work Education recognized the value of group work and in the 1970s began mandating the education of social work students in group practice (Garvin, 1996). In the 1980s, managed healthcare attempted to place controls on reimbursement for healthcare services. Group therapy was positively regarded in this movement because of its success at providing cost-effective mental health treatment (Brabender et al., 2004). Subsequently, the accountability of managed care in the 1990s mandated that group therapists use validated approaches, clearly detailed methods, and explicitly identified outcomes. Presently, a wide range of theoretical orientations are accepted as effective means of providing group treatment. The group therapy community is showing increased attention to training and credentialing of group therapists, ethical and legal issues, and topics of diversity, making this a preferred modality for many practitioners (Brabender et al., 2004).

Effectiveness of group therapy. Today, group therapy is widely accepted as an effective treatment method for a broad range of psychological and emotional concerns (Brabender et al., 2004; Corey, 2011). However, although research has shown that group treatment is associated with clients' improvement in a variety of settings and situations, little is known about why this is so. The *Practice Guidelines for Group Psychotherapy of the American Group Psychotherapy Association* (2007) identified cultural variables,

group member values, and the group therapist's expertise as factors that can affect the efficacy of any group. Yalom (2005), considered by many to be the predominant authority on group therapy, conducted extensive research on what elemental dynamics accompany positive change in a group setting. He divided them into eleven therapeutic factors: (1) instillation of hope; (2) universality; (3) imparting information; (4) altruism; (5) the corrective recapitulation of the primary family group; (6) development of socializing techniques; (7) imitative behavior; (8) interpersonal learning; (9) group cohesiveness; (10) catharsis; and (11) existential factors. Yalom's (2005) research demonstrated group therapy has specific benefits that make it superior to individual therapy, including the provision of social learning, developing social support, and improving social networks. Group therapy has been shown to be more effective than individual therapy in treating substance use disorders, obesity, psychological distress due to medical illness, and childhood sexual abuse (Yalom, 2005). Shulman (2010) stated there is "something very distinct, unusual, emotionally moving, and powerful about helping when it takes place in a group. This is *mutual aid*, defined as the process in which members are helpful to each other in a way that is different and supplemental to the help provided by the leader" (p. xxxi). He believed when group members provide help to another member, they also help themselves. Efficiency, commonality, a greater variety of viewpoints, sense of belonging, an opportunity to practice skills and receive feedback, vicarious learning, real-life approximation, and commitment are demonstrated advantages of group therapy versus an individual model (Jacobs, Masson, Harvill, & Schimmel, 2011). Group is considered to be a social microcosm that provides members with a sample of reality. Struggles and conflicts that occur in the group are similar to

those that members experience outside of it; then they receive feedback from other participants, which allows them to see themselves through the eyes of a wide range of people (Corey, 2011; Yalom, 2005;). In group therapy, group participants are able to achieve a sense of belonging. Once this occurs, members learn new avenues of emotional intimacy as well as learning to care for and challenge others. Participants learn and practice new ways of behaving, which they are then able to bring to their life outside the group (Corey, 2011; Jacobs et al., 2011; Yalom, 2005).

Summary

As evidenced in the literature review, there are large bodies of research about shame and about group therapy; however little has been written about sexual shame, and this review revealed no evidence of research about using group therapy to treat sexual shame. The purpose of the current research was to fill this gap in the literature, and provide clinicians with information and options about identifying and treating sexual shame. An evaluation tool for measuring sexual shame was developed, along with a group therapy protocol for treating this specific issue. The measurement instrument was validated and used to evaluate the efficacy of a 6-session therapy group model to treat sexual shame.

Chapter 3: Methodology

The purpose of this study was to evaluate the effectiveness of a group therapy approach for treating sexual shame, develop an instrument to measure sexual shame, and establish the reliability of this instrument. The results from the current investigation extended the research literature on measuring and treating sexual shame. Because there was previously no particular measure of sexual shame, this research informed the development of a new instrument, the Kyle Inventory of Sexual Shame. This measure was tested and then utilized to determine the effectiveness of a group therapy protocol for treating sexual shame in individuals from a variety of backgrounds.

Research Approach and Design

Quantitative approach. A quantitative research approach was used in the study. Quantitative research was selected for this study due to the employment of a measurement instrument used to quantify participants' sexual shame before and after a specific group intervention protocol. Quantitative research refers to approaches to empirical inquiry that collect, analyze, and display data in numerical rather than narrative form (Given, 2008). Quantitative research employs the concepts of reliability and validity. Reliability is a property of the measurement instruments used in the research, and is demonstrated when the instrument consistently produces the same results when administered to the same or comparable individuals (Given, 2008). The internal validity of an instrument is gauged by whether it measures what it is intended to measure. External validity refers to the likelihood that a study's findings will apply to the larger population represented by the study's sample (Given, 2008). Measurement is a fundamental process in quantitative research, because it provides the connection between

empirical observation and the mathematical expression of quantitative relationships (Given, 2008).

Design. A quasi-experimental one-group pretest-posttest design was utilized to address the research question of the study to determine if group therapy is effective in reducing sexual shame. Research designs that include an experimental group being evaluated on a specific measure before and after application of a treatment are considered one-group pretest-posttest quasi-experimental designs. This design is depicted in Figure 1, where 0 represents the pretest and posttest and the x represents the treatment.

Treatment Group 0---------- x ----------0

Figure 1

The design included a pretest used to garner initial information about the sample and to measure participants' initial state on the dependent variable. This design allowed for the assessment of changes that occurred in participants during the time the intervention took place, and provided evidence that the intervention produced these changes. A limitation of the one-group design is that it fails to control for the effects of history, maturation, testing, or statistical regression. However, the short duration of this particular study may have minimized some of the threats to internal validity.

The lack of random selection of participants makes this study quasi-experimental in nature. Quasi-experimental designs are used when randomization is unethical, impractical, or impossible (Kirk, 2012). With a quasi-experimental design, threats to external validity are minimized because the study is conducted in a natural environment, which is not subject to the artificiality of a laboratory experiment. This allows for the

findings to be generalized to other subjects and settings. One limitation of the quasi-experimental design is that the deficiency in randomization makes it difficult to rule out confounding variables, introducing new threats to internal validity and making causality difficult to determine (Kirk, 2012).

Study Variables

Dependent variable. The dependent variable in any experiment is the event studied and expected to change whenever the independent variable is altered. In this research, the dependent variable was sexual shame as measured by scaled scores on the Kyle Inventory of Sexual Shame (KISS). Sexual shame scores were expected to decrease following application of the treatment.

Independent variable. In an experiment, the independent variable is the event that is varied, controlled, or manipulated by the researcher. The independent variable in this study was the participation in a 6-session therapy group designed to treat subjects' sexual shame (see Appendix A for group therapy protocol).

Participants

Five participants were selected for the treatment group. This sample size was selected because therapy delivered in a small group setting produces more intimacy than in larger groups and is likely to compel more member participation (Corey, 2011; Garvin, 1996; Shulman, 2010), which was necessary for success in alleviating sexual shame. One participant dropped out of the group after session 4 due to unforeseen family circumstances. As a result, this member did not complete the post-test; therefore her pretest score was not used during calculation of results.

Instrumentation

This study reflected the first use of the Kyle Inventory of Sexual Shame (KISS). This instrument was designed to assess participants' feelings about their current and past sexual thoughts and behaviors (see Appendix B for instrument). This questionnaire consists of the following 25 items: 20 items that address various aspects of the sexual self in order to evaluate levels of shame which may be attached to them; three demographic questions to determine age, sex, and ethnicity of participants; one item regarding whether subjects have talked to a therapist about their problems, and a final question that looks at whether participants have experienced certain factors which may contribute to sexual shame. Respondents are asked to indicate their level of agreement with the initial 20 items by selecting a correlate from the following scale: (0) Strongly disagree; (1) Disagree; (2) Somewhat Disagree; (3) Somewhat agree; (4) Agree; and (5) Strongly agree. The remaining five items have multiple-choice answers.

As the KISS was developed for utilization in the current study, no reliability information had been previously established for the measure. The internal consistency reliability of the instrument was evaluated in a pilot study of 102 individuals not affiliated with the treatment group. These individuals completed the inventory prior to its implementation with the experimental group. From the scores resulting from this pilot, an internal consistency reliability coefficient (Cronbach's Alpha) was calculated. This calculation estimated the reliability of the inventory based on the average correlation among items within the instrument. The coefficient Alpha was used to measure the degree to which each item is homogeneous, and if all items reflect the same core

construct. Cronbach's Alpha values are generally measured from 0 to 1, and a score of .6 or less indicates inadequate internal consistency reliability.

A Principal Component Analysis (PCA), or Exploratory Factor Analysis was conducted and interpreted using a Varimax rotation, making the data output cleaner and easier to understand. Any significant subscales emerging from this analysis were evaluated for future administration of the measurement instrument.

Validity of the KISS was established by determining whether participants in the study had reduced scores on this measure following the treatment. Their improvement upon receipt of treatment for sexual shame indicated they did in fact have this condition prior to starting the therapy, thereby establishing the validity of the instrument.

Procedures

Data collection procedure. Following approval from the American Academy of Clinical Sexologists' IRB, participants for the pilot study were recruited in order to evaluate the validity and internal consistency reliability of the measurement instrument. Pilot study participants were solicited via email and social media. Once the pilot study was completed and it was determined there were no necessary modifications to be made to the KISS, participants for the treatment group were recruited. Participants were recruited from the client population of the researcher's private therapy practice, as well as a list-serve representing therapists in the Austin area. Participants were provided with study information including an informed consent form. Individuals who agreed to participate, provided informed consent (see Appendix C for informed consent form), and completed a pre-group screening process made up the therapy group.

The treatment group took the pretest (KISS) during their screening interviews, and then attended a 6-session therapy group. Upon completion of the 6th group session, subjects completed the posttest (KISS). All pretests, posttests, and group therapy sessions took place in the therapy office of the researcher.

Data analysis procedure. An inferential data analysis was conducted using a paired *t*-test. This test is used to compare two small sets of quantitative data when there is a definite relationship between data points in each sample. The paired *t*-test is generally used when measurements are taken from the same subjects before and after some manipulation, such as treatment, is applied. The results of the paired *t*-test were analyzed to determine the difference between pretest and posttest scores. A Cohen's *d* calculation was also conducted to determine the effect-size correlation between the pretest and post-test scores.

Ethical Treatment of Participants

This research was conducted in accordance with the APA Ethical Guidelines for Research with Human Subjects (Hastings, 1998; Lichtenberg, 2007; Weeks, 1989), encompassed by the following:

1. Research proposals submitted to institutional review boards (IRB) must contain accurate information. Upon approval, researchers cannot make changes without seeking approval from the IRB.
2. Informed consent is usually required and includes: (a) the purpose of the research, expected duration, and procedures; (b) the right to decline to participate and to withdraw once the study has begun; (c) the potential consequences of declining or withdrawing; (d) any potential risks, discomfort, or adverse effects; (e) any potential research benefits; (f) the limits of confidentiality; (g) incentives for participation; (h) whom to contact for questions about the research and participants' rights. Researchers provide opportunity for the participants to ask questions and receive answers.
3. When research is conducted that includes experimental treatments, participants shall be so informed at the beginning of the study of (a) the experimental nature

of the treatment, (b) the services that will or will not be available to the control group(s) if appropriate; (c) the means by which assignment to treatment or control group is made; (d) available treatment alternative if the person does not want to participate or withdraws after the study has begun; (e) compensation for costs of participating.

4. Informed consent shall be obtained when voices or images are recorded as data unless (a) the research consists only of naturalistic observations taking place in public places and the recording is not anticipated to cause harm; or (b) the research design includes deception, and consent for the use of the recording is obtained during debriefing.
5. When psychologists conduct research with clients/patients, students, or subordinates as participants, steps must be taken to protect the participants from adverse consequences of declining or withdrawing from participation. When research participation is a course requirement, or an opportunity to earn extra credit, an alternative choice of activity is available.
6. Informed consent may not be required where (a) research would not be reasonably expected to cause distress or harm and (b) involves (i) the study of normal educational practices, curricula, or classroom management methods in educational settings; (ii) only anonymous questionnaires, archival research, or naturalistic observations that would not place participants at risk of civil or criminal liability nor damage financial standing, employability, or reputation, and confidentiality is protected; or (iii) the study of organizational factors conducted in the workplace poses no risk to participants' employability and confidentiality is preserved.
7. Psychologists make reasonable efforts to avoid offering excessive or inappropriate financial or other inducement for research participation that would result in coercion.
8. Deception in research shall be used only if it is justified by the study's significant prospective scientific value and nondeceptive alternatives are not feasible. Deception shall not be used if it will cause physical pain or severe emotional distress.
9. (a) Participants shall be offered promptly supplied information about the outcome of the study; (b) if delay or withholding of the study outcome is necessary, reasonable measures must be taken to reduce the risk of harm; (c) when researchers realize that research procedures have harmed a participant, they take reasonable steps to minimize the harm (Lavrakas, p. 632).

Summary

A quantitative one-group pretest posttest quasi-experimental design was utilized to evaluate the effectiveness of a group therapy approach for treating sexual shame and

establish the validity of an instrument to measure sexual shame. Five individuals participated in the investigation by experiencing a 6-week group therapy setting focused on sexual shame. Pre and posttest measures of sexual shame were obtained by the participants' responses on the KISS. The reliability of the KISS was established and the effects of group therapy on sexual shame were reported. The results from the current investigation extend the research literature on measuring and treating sexual shame.

Chapter 4: Results

The purpose of this study was to evaluate the effectiveness of a group therapy approach for treating sexual shame, develop an instrument to measure sexual shame, and establish the reliability of this instrument. The results from the current investigation extended the research literature on measuring and treating sexual shame. This chapter will address the findings of the pilot study, the efficacy of the group therapy treatment and the reliability of the KISS, an exploratory measure for evaluating sexual shame.

Pilot Study

The internal consistency reliability of the KISS was assessed using the data collected from 102 individuals sampled from social media websites as well as from two therapist list-serves. Three items on the KISS were worded in a way that measured respondents' positive feelings about sexual aspects of themselves, unlike the other 17 items that measured negative feelings. These three items were reverse-coded for the data reliability analysis.

It was hypothesized that the KISS would be a reliable measure of sexual shame, since it was modeled after other widely tested measures of shame that were not domain-specific (Andrews, Qian, & Valentine, 2002; Cook, 1987; Rizvi, 2010). Results showed the KISS had a Cronbach's alpha of .929, indicating an excellent level of internal consistency reliability.

Additionally, a Principal Component Analysis (PCA) with Varimax rotation was conducted to identify whether latent factors existed within the 20 non-demographic items in the measure. In the PCA, eigenvalues over 1.0 were used to identify the number of factors in the measure, and rotated component matrix values greater than 0.4 were used to

identify items that loaded onto the factors. Cronbach's alphas were also calculated with the subscales in order to assess the reliability of the factors.

Results indicated a four-factor solution; however, a number of complex loadings emerged within the solution (e.g. items which loaded onto more than a single factor). Therefore, 12 items were removed from the scale and the PCA was rerun with the remaining eight items. Results of the final PCA showed a two-factor solution. Factor1, which accounted for 36.22% of the variance, related predominantly to respondents' feelings about their past sexual choices (α=.797). Factor 2 accounted for 23.8% of the variance, and stemmed from responses about kinky fantasies and same-sex attraction (α=.685).

Group Therapy

A six-session therapy group treatment was conducted to determine the efficacy of this treatment modality for reducing sexual shame. The group consisted of 5 members, all females ranging in age from 30 to 40. Four of the women identified as heterosexual, one as bisexual. Three of the women were partnered with men, two were single and casually dating men. Two were Latina, three were Caucasian. Participants' precursors to sexual shame were reported as follows: All five reported looking at pornography. Four out of five reported they had experienced promiscuity. Four out of five reported they had experienced non-consensual sexual activity or sexual assault. Two out of five reported they had experienced childhood sexual abuse. Two out of five reported they had grown up in an extremely religious environment. Two out of five reported they had experienced sexual activity with someone of the same sex. All five participants verbally reported feeling sexual shame prior to the administration of the pretest KISS.

The first group meeting consisted of introductions to other members and to the topic of sexual shame. Participants were informed about confidentiality and other group norms, such as talking in the first person, refraining from advice-giving, asking open ended questions, remaining curious rather than judgmental, and speaking in a respectful manner to one another. Members stated the reasons they had come to the group, and began telling their stories.

During the second group, participants, some for the first time, were able to identify and disclose the sources of their sexual shame. They reported these as experiences such as sexual abuse; sexual assault; being raised in an extremely religious environment; being shamed by caregivers about sexuality; promiscuity; body shame; and relationship infidelity. Members discussed ways they were impacted by cultural ambivalence about women as both mothers and sexual objects, and how this contributed to their feelings of sexual shame.

Group three offered members an opportunity to explore present-day triggers that induced feelings of sexual shame. These were reported as remembering or discussing past abuse; remembering negative family messages about sex; discussing sexual proclivities with partner; initiating sex with partner; having sex with a new partner; and not feeling sexually attracted to partner. The group also explored participants' beliefs that may have exacerbated shameful feelings. These included the belief they were somehow flawed, the belief they were to blame for past sexual situations, the belief it was not okay for women to be sexual, and the belief they were being judged by others for their past sexual experiences.

During the fourth group, participants looked at the present-day impact sexual shame had on their lives. They identified things such as low-libido, fear of being nude in front of others (including sexual partners), hesitancy to express physical or verbal affection, reluctance to wear revealing clothing or behave in a way that might portray them as a sexual being, low self-acceptance, hypersexuality, avoidance of sexual activity, and fear of entering romantic or sexual relationships.

The fifth group offered members tools for combating sexual shame. Participants discussed the concepts of compassion and empathy, and looked at ways they could potentially utilize these tools with themselves and others. Several members expressed difficulty understanding the concept of being compassionate with themselves. All members reported feeling fearful that if they were "easy" on themselves (e.g., compassionate) it would result in being out of control in some way. When asked for clarification, members reported fear they would eat uncontrollably, have uncontrolled sex with multiple partners, refuse indefinitely to have sex, never be nude in front of a partner, or generally let themselves go. They were asked to role-play various situations in which they might start out with a judgment about themselves or others then they practiced curiosity, which eventually led them to empathy and compassion.

In group six, the final session, members were encouraged to create a vision for moving into the future with less sexual shame. They discussed ways they imagined their sexual selves in the future, including feeling "less heavy" around sexual issues, feeling more free about stating their sexual desires, being more comfortable talking about their past sexual experiences, feeling more open about being nude, and feeling more confident about saying either "yes" or "no" to sexual activity. Members made "Vision Candles" as

a vehicle to create the future they wanted, and glued words and images onto glass candleholders as a visual reminder to practice compassion, empathy, curiosity, self-acceptance, and keeping their own power.

After the group was over, members were surveyed regarding what they found most helpful about the group experience. The following are quotes from this survey:

- "Learning sexual shame is not just my own private nightmare."
- "Recognizing myself in others' experiences. This normalized everything for me."
- "Knowing everyone has felt sexual shame and I'm not an outsider."
- "Being able to share my story out loud and talk openly about the shame."
- "The sense I might be helping someone else by sharing my experiences."
- "Seeing women at all different places and phases in life, yet realizing our commonalities."
- "Hearing others ask questions I was too afraid to ask."
- "Saying out loud what has always been closeted, and knowing I wasn't going to be judged for it."
- "Reframing that what I used to consider shameful is really okay and normal."
- "I liked the emphasis on compassion and learning to be easier on myself."

KISS Administration

Members were given the pretest KISS during their initial screening session, and the posttest KISS at the end of the final group meeting. Using results from the two testing situations, a paired sample *t*-test was used to determine whether the group therapy intervention was effective in reducing participants' levels of sexual shame. Results of this

examination of differences between pre- ($M = 80$; $SD = 13.9$) and post-test ($M = 56.3$; $SD = 16$) scores showed a slight mean difference ($t = 2.4$, $df = 3$, $p = .10$). Although the difference was not statistically significant, the effect size ($d = 1.59$) was found to exceed Cohen's (1988) convention for a large effect ($d = .80$), and the difference was deemed practically significant. Further analysis revealed that all participants' raw scores were lower (by a minimum of 6 points, maximum of 53 points) on the post-test KISS than on the pre-test KISS, indicating the group therapy was effective in reducing sexual shame for all participants.

Summary

In summary, the pilot study of 102 individuals completing the KISS demonstrated this instrument had excellent internal consistency reliability. Validity of the KISS was established by determining that participants in the therapy group had reduced scores on this measure following administration of the treatment. Participants in the therapy group designed to treat sexual shame verbally reported significant reduction in their symptoms following completion of the group. Additionally, raw scores on the pre and post-test KISS indicated that group therapy was an effective treatment for reducing all participants' sexual shame.

Chapter 5: Recommendations and Conclusions

Despite the considerable amount of research in the individual areas of shame and sexuality, very little is known about the phenomenon of sexual shame. There is also a paucity of empirical evidence on the actual number of clients presenting with particular kinds of shame, and researchers are becoming aware of the need for domain-specific assessment tools that measure shame (Rizvi, 2010). The purpose of this study was to evaluate the effectiveness of a group therapy approach for treating sexual shame, develop an instrument to measure sexual shame, and establish the reliability of this instrument, in order to further the body of knowledge about measuring and treating sexual shame.

Because no measure of sexual shame had been published, a researcher-created instrument, the Kyle Inventory of Sexual Shame, was developed and validated. This measure was then utilized to determine the effectiveness of a group therapy protocol for treating sexual shame in individuals from a variety of backgrounds. Results of a pilot test with 102 individuals showed the KISS had an excellent level of internal consistency reliability.

The efficacy of the six-session group therapy protocol with five participants was also evaluated. Although the difference on the pre- and post-test questionnaires were not significantly different, KISS scores were found to be practically significant, and all participants' raw scores were lower (by a minimum of 6 points, maximum of 53 points) on the post-test KISS than on the pre-test KISS, indicating the group therapy was effective in reducing sexual shame for all participants. Study recommendations and conclusions are discussed in this chapter.

Recommendations

Based on the findings from the current study several recommendations can be made for clinicians as well as future researchers.

Clinicians. It is recommended that clinicians familiarize themselves with patients' presenting symptoms of sexual shame, including low sexual energy, low self-acceptance, avoidance of intimacy, hypersexuality, or sexual avoidance. Practitioners should also be aware of clients' potential precursors to sexual shame, including looking at pornography, experiencing childhood sexual abuse, growing up in an extremely religions environment, same-sex attractions or activity, non-consensual sexual activity, sexual assault, or promiscuity. If patients present with these symptoms or precursors, clinicians should administer the Kyle Inventory of Sexual Shame to assess whether specific treatment for this issue is recommended. If KISS scores indicate treatment is necessary, clients would be well-served by participating in a treatment group following the protocol developed and outlined in this study.

Future research. While research on sexual shame is sparse, the topic is becoming more visible and discussed in clinical and academic settings. Additional analyses should be conducted to understand more about the causes of sexual shame and ways to alleviate it. Further research should seek to identify ways of preventing sexual shame, thereby making its treatment unnecessary. Until this happens, however, opportunities exist to expand the work of the current study. The pilot study testing the internal consistency reliability of the KISS could be replicated with a larger, more

controlled sample. Researchers could control for or evaluate differences in responses due to age, gender, sexual orientation, socioeconomic status, race, or religion. Additionally, there is opportunity to replicate the treatment protocol using samples that are larger and/or more diverse with regard to gender, sexual orientation, race, or socioeconomic status.

Conclusions

In summary, as sexual shame becomes a more visible concern within mainstream culture, clinicians are faced with the challenge of identifying, measuring, and treating it. As we individually and collectively gain more awareness about this construct and its potential detriment to human relationships, it is increasingly important for treatment providers to increase their competence in working with patients who present with sexual shame. By expanding cultural conversations around this topic, new avenues of healing become available for those suffering from the effects of this condition.

One purpose of this study was to evaluate the efficacy of a measurement tool developed to help clinicians identify and assess sexual shame. The Kyle Inventory of Sexual Shame was the resultant instrument. The reliability and validity of this assessment tool have been examined, and the instrument has proved to be both reliable and valid for the population on which it was tested during this research.

Another purpose of the current research was to evaluate the efficacy of a six-session group therapy protocol for treating sexual shame. Five adult females participated in the six-group treatment regimen, with four completing all six sessions. All members who completed the group reported a significant reduction in their feelings of sexual shame after completing the therapy group, indicating the treatment was successful in

alleviating this condition. These research findings are intended to inform future studies and to assist in the development of future salient interventions for identifying and treating sexual shame.

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Appendix A:

Letting Go of Sexual Shame
Group Therapy Protocol

Introduction

This protocol outlines the goals for each group session, the therapist's tasks, and topics to be covered, giving facilitators a platform from which to begin. However, the wounds of shame are interpersonal and relational in nature, and are therefore healed via connections made in the group rather than strictly through the material. Traditional therapist training programs focus almost exclusively on techniques and methods of therapy. This model proposes that the therapist's state of being and the relationships formed among the members and facilitator(s) are of utmost importance, with the content being secondary. The following are some practical steps facilitators can take toward this end.

Personal work. Before forming the group, facilitators can check in with themselves about their personal triggers for sexual shame. If there are unresolved issues, facilitators are strongly encouraged to seek their own therapy so they can be emotionally available to assist their clients.

Presence. One of the most important factors in making connections with others is the ability to be present and free from distractions. Facilitators can accomplish this by practicing mindfulness and staying warmly attentive at all times to what is happening in the group session.

Curiosity. A group about sexual shame will inevitably bring up sensitive topics, and may also evoke some acting-out behaviors. Facilitators should remain curious with participants about what is coming up, rather than being critical of their current or past behaviors. In order to create safety, facilitators must set and maintain boundaries while remaining curious about the origin of members' behaviors.

Session 1: Introduction, Overview, and Defining Sexual Shame

Goal: This session emphasizes the supportive, confidential nature of the group. Participants will begin to understand group norms such as self-disclosure, positive regard, confrontation, and empathic listening. They will gain awareness about the definition of sexual shame as differentiated from guilt, regret, or other self-conscious emotions.

Therapist's tasks:

- Facilitate introductions
- Discuss group guidelines
- Stay conscious of modeling positive group norms

Topics to be covered:

- Introductions
- Confidentiality and other group norms
- Definition of sexual shame
- Universality: participants' circumstances may be different but the underlying feelings of shame are similar

Session 2: Origins of Sexual Shame and the Resulting Vulnerabilities

Goal: This session helps participants identify potential sources of their sexual shame. Members will explore ways they feel vulnerable, and how this has impacted the intimacy in their subsequent relationships.

Therapist's tasks:

- Inform members about factors which precipitate sexual shame, including promiscuity, pornography, sexual abuse, sexual assault/non-consensual sexual activity, growing up in an extremely religious environment, or same-sex sexual activity
- Support participants in managing their vulnerabilities while discussing these topics in group

Topics to be covered:

- Members' experiences which may have precipitated their sexual shame
- What it is like to feel vulnerable in the group setting
- Ways members feel vulnerable in sexual and/or intimate relationships as a result of their sexual shame

Session 3: Identifying Triggers

Goal: This session guides participants in looking at present-day triggers that rekindle their feelings of sexual shame. They will identify situations and behaviors that elicit these feelings, as well as beliefs that perpetuate them. Members will explore the idea of shifting their beliefs and/or behaviors to alleviate feeling sexual shame.

Therapist's tasks:

- Guide members in identifying what triggers their feelings of sexual shame (i.e. talking or thinking about past sexual activity, engaging in sexual behavior, masturbation, looking at pornography, attending religious services, media attention to sexual matters, etc.)
- Explore the idea of changing beliefs rather than changing behaviors
- Discuss which behaviors, if any, need to be modified in members' present-day behaviors in order to alleviate sexual shame

Topics to be covered:

- Triggers for sexual shame
- Situations and behaviors that elicit sexual shame
- Beliefs that perpetuate feelings of sexual shame
- Determining whether beliefs, behaviors, or both need to be shifted in order to reduce present-day sexual shame

Session 4: Effects of Sexual Shame

Goal: This session will help participants identify ways sexual shame has affected them, including its impact on self-acceptance, libido, intimacy, and relationships.

Therapist's tasks:

- Inform members about effects of sexual shame
- Guide participants in exploring ways sexual shame has impacted them in the past
- Discuss ways to minimize the effects of sexual shame in present and future relationships

Topics to be covered:

- Effects of sexual shame
- Ways of minimizing this

Session 5: Tools for Combating Sexual Shame

Goal: This session will help members look at ways empathy and compassion help in eliminating feelings of sexual shame. Participants will learn concrete ways of practicing these concepts with others. Participants will learn and practice the skill of accepting themselves and others just as they are.

Therapist's tasks:

- Define empathy and compassion. Give and elicit concrete examples
- Explore the idea that human behavior makes sense; we may need more information in order to help us understand it
- Help members differentiate between self-esteem and self-acceptance
- Discuss differences between tolerance and acceptance
- Introduce role plays to help participants understand these concepts

Topics to be covered:

- Empathy and compassion
- Making sense of human behavior
- Self and other acceptance
- Internal adjustments needed in order to achieve acceptance of self and others
- Maintaining boundaries

Session 6: Creating a Vision for your Future

Goals: This session sets the stage for members to make a regular practice of releasing their sexual shame. They will be able to formulate a vision of how they will move into the future without the burden of sexual shame.

Therapist's tasks:

- Provide members with candles (commonly known as prayer candles), scissors, glue sticks, and plenty of magazines from which to find images and words.
- Observe and comment on members' progress.
- Provide members with posttests to assess progress.

Topics to be covered:

- Members will discuss their visions for a future without sexual shame.
- Members will create vision candles depicting ways they can move into the future without being held back by sexual shame.
- Participants will recap their progress in the group, and discuss their projects with the group.
- Posttests will be administered.

Appendix B

Kyle Inventory of Sexual Shame

Shame has been described as an "excruciating painful and contagious emotion". It is different than feeling bad or upset about a behavior, because it relates to how you feel about *yourself* as a person. You might notice feelings of wanting to hide parts of yourself, or even isolate from others at times. The following are some statements related to sexual shame that may or may not describe how you are feeling right now. Please rate your agreement with each statement using the 6-point scale below.

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

1. I think people would look down on me if they knew about my sexual experiences.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

2. I scold myself and put myself down when I think of myself in past sexual situations.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

3. Overall, I feel satisfied with my current and past sexual choices and experiences.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

4. When I think of my sexual past, I feel defective as a person, like something is inherently wrong with me.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

5. I feel ashamed about having sex with someone when I didn't want to.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

6. I feel like I am never quite good enough when it comes to sexuality.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

7. I sometimes try to conceal the kind of person I am with regard to sexuality.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

8. I feel ashamed of my sexual abilities.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

9. I feel ashamed about having sexual or kinky fantasies.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

10. I feel ashamed of something about my body when I am in a sexual situation.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

11. I sometimes avoid certain people because of my past sexual choices or experiences.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

12. I feel good about myself with regard to my sexual choices and experiences.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

13. I replay painful events from my sexual past over and over in my mind.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

14. I have an overpowering dread that my sexual past will be revealed in front of others.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

15. I feel ashamed about a time when I had sex that was not totally consensual.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

16. When it comes to sexuality, I feel like I am a worthy person who is at least equal to others.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

17. I feel ashamed about having an affair/being unfaithful/being sexually promiscuous.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

18. I feel afraid other people will find out about my sexual defects.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

19. I feel ashamed about having same-sex attractions.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

20. I feel empty and unfulfilled when I think of my current or past sexual experiences.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

21. How old are you? _______

22. Do you identify as:
- ☐ Male
- ☐ Female

23. Do you identify as:
- ☐ Asian/Pacific Islander
- ☐ Black
- ☐ Latino
- ☐ White
- ☐ Other

24. Have you ever talked to a therapist about your problems?
- ☐ Yes
- ☐ No

25. Have you experienced any of the following (check all that apply):
- ☐ Looking at pornography
- ☐ Childhood sexual abuse
- ☐ Growing up in an extremely religious household
- ☐ Sexual activity with someone of the same sex
- ☐ Non-consensual sexual activity/sexual assault
- ☐ Promiscuity

Appendix C: Informed Consent Form

Title of Research: The Efficacy of Group Therapy in Treating Sexual Shame
Name of Principal Investigator/Primary Researcher: Sarah E. Kyle, LCSW
Phone Number of Principal Investigator/Primary Researcher: 512-441-5953
Name and Phone Number of Committee Members:

A. PURPOSE AND BACKGROUND

Under the supervision of Dr. William Granzig, Professor of Clinical Sexology at the American Academy of Clinical Sexologists (AACS), Sarah Kyle, a Ph.D. student at AACS, is conducting research on sexual shame. The purpose of this research is to help further the body of knowledge about treating sexual shame.

B. PROCEDURES

If I agree to participate in this research study, the following will occur:

1. I will be asked to participate in a therapy group consisting of 6 sessions, each lasting 1.5 hours.
2. I will be asked to discuss my past experiences with regard to shame (including sexual shame), and I will be asked to identify and assess my support systems.
3. I will also be asked my age, gender, race, sexual orientation, socio-economic status, and educational background.

C. RISKS

If I agree to participate in this research study, I understand the following are potential associated risks:

1. I will be asked to talk about issues of a personal nature and I might feel uncomfortable talking about some things. I am free to decline to answer any questions that I don't wish to answer.
2. Self-disclosure in any kind of group setting (therapeutic, social, educational, etc.) carries the risk of violation of confidentiality. There is the possibility that someone within the group may reveal your secrets outside the group, which could cause emotional or even economic damage. Additionally, if you reveal another member's secrets outside the group, that member might have legal grounds to sue you for money. If you violate the confidentiality rules of the group, you may be asked to leave the group.
3. As with any therapeutic setting, if you reveal any type of child or elder abuse (physical, emotional, or sexual), or if you express intent to harm yourself or another person, the researcher is required by law to notify the appropriate authorities.
4. Regarding confidentiality of data, records from this study will be kept as confidential as possible. No individual identities will be used in any reports or publications resulting from the study. All pretest and posttest surveys will be given codes and stored separately from any names or other direct identification of participants. Only the researcher will have access to the demographic information for each participant, and no other indication of identity will be necessary for this study. After the study is completed and all data has been analyzed, the list linking names of participants with their pretests and posttests will be held for one year and then destroyed.
5. If at any time the researcher deems my participation is no longer in my best interest, said participation may be terminated by the investigator without regard to my consent.

D. DIRECT BENEFITS

The anticipated benefit of participating in this study is a better understanding of the causes and effects of sexual shame. It is reasonably expected that my level of sexual shame may be reduced by participating.

E. ALTERNATIVES

I am free to choose not to participate in this research study.

F. COSTS

There will be no costs to me as a result of taking part in this research study.

G. COMPENSATION

There will be no monetary compensation to me for participating in this study. However, I will receive 6 no-cost group therapy sessions as a part of my participation.

H. QUESTIONS

I have spoken with Sarah E. Kyle, LCSW about this study and have had my questions answered. If I have any further questions about the study, I can contact Dr. William Granzig by calling (407) 645-1641, or Sarah Kyle by calling (512) 441-5953 or write to them at the American Academy of Clinical Sexologists, 3202 Lawton Road, Suite 170; Orlando, FL 32803.

I. CONSENT

I have been given a copy of this consent form to keep.

PARTICIPATION IN THIS RESEARCH STUDY IS VOLUNTARY. I am free to decline to participate in this research study, or I may withdraw my participation at any point without penalty. If I choose to withdraw, I will give written or verbal notice to the investigator at least 24 hours before the first scheduled group session I am to miss.

Signature ________________________________ Date ________________
Research Participant

Signature ________________________________ Date ________________
Interviewer

Appendix D: Data Analysis for Pilot Study

Descriptive Statistics

	N	Mean	Std. Deviation	Skewness		Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Std. Error
I scold myself and put myself down when I think of myself in past sexual situations.	102	3.03	1.396	.214	.239	-.843	.474
I think people would look down on me if they knew about my sexual experiences.	102	3.55	1.533	.057	.239	-1.170	.474
Overall, I feel satisfied with my current and past sexual choices and experiences.	102	3.94	1.311	-.346	.239	-.631	.474
When I think of my sexual past, I feel defective as a person, like something is inherently wrong with me.	102	2.45	1.487	.770	.239	-.521	.474
I feel ashamed about having sex with someone when I didn't want to.	101	2.99	1.603	.254	.240	-1.245	.476
I feel like I am never quite good enough when it comes to sexuality.	102	3.14	1.548	.256	.239	-1.078	.474
I sometimes try to conceal the kind of person I am with regard to sexuality.	102	2.92	1.539	.449	.239	-.925	.474
I feel ashamed of my sexual abilities.	102	2.54	1.279	.750	.239	.180	.474

I feel ashamed about having sexual or kinky fantasies.	102	2.46	1.376	.862	.239	-.074	.474
I feel ashamed of something about my body when I am in a sexual situation.	102	3.64	1.591	-.166	.239	-1.093	.474
I sometimes avoid certain people because of my past sexual choices or experiences.	102	2.64	1.434	.705	.239	-.539	.474
I feel good about myself with regard to my sexual choices and experiences.	102	4.03	1.190	-.490	.239	-.153	.474
I replay painful events from my sexual past over and over in my mind.	102	2.51	1.494	.962	.239	-.027	.474
I have an overpowering dread that my sexual past will be revealed in front of others.	102	2.35	1.310	.962	.239	.266	.474
I feel ashamed about a time when I had sex that was not totally consensual.	102	2.37	1.528	.875	.239	-.550	.474
When it comes to sexuality, I feel like I am a worthy person who is at least equal to others.	102	4.66	1.121	-.875	.239	.659	.474
I feel ashamed about having an affair/being unfaithful/being sexually promiscuous.	102	3.16	1.716	.111	.239	-1.341	.474
I feel afraid other people will find out about my sexual defects.	102	2.63	1.364	.395	.239	-1.015	.474

I feel ashamed about having same-sex attractions.	102	1.94	.983	1.267	.239	1.540	.474
I feel empty and unfulfilled when I think of my current or past sexual experiences.	102	2.90	1.499	.386	.239	-.942	.474
Valid N (listwise)	101						

++

Scold I scold myself and put myself down when I think of myself in past sexual situations.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	15	14.7	14.7	14.7
	Disagree	30	29.4	29.4	44.1
	Somewhat Disagree	11	10.8	10.8	54.9
	Somewhat agree	34	33.3	33.3	88.2
	Agree	7	6.9	6.9	95.1
	Strongly agree	5	4.9	4.9	100.0
	Total	102	100.0	100.0	

Lookdown I think people would look down on me if they knew about my sexual experiences.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	7	6.9	6.9	6.9
	Disagree	29	28.4	28.4	35.3
	Somewhat Disagree	10	9.8	9.8	45.1
	Somewhat agree	26	25.5	25.5	70.6
	Agree	17	16.7	16.7	87.3
	Strongly agree	13	12.7	12.7	100.0
	Total	102	100.0	100.0	

Sexchoices Overall, I feel satisfied with my current and past sexual choices and experiences.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	4	3.9	3.9	3.9
	Disagree	11	10.8	10.8	14.7
	Somewhat Disagree	23	22.5	22.5	37.3
	Somewhat agree	23	22.5	22.5	59.8
	Agree	31	30.4	30.4	90.2
	Strongly agree	10	9.8	9.8	100.0
	Total	102	100.0	100.0	

Defective When I think of my sexual past, I feel defective as a person, like something is inherently wrong with me.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	36	35.3	35.3	35.3
	Disagree	28	27.5	27.5	62.7
	Somewhat Disagree	9	8.8	8.8	71.6
	Somewhat agree	18	17.6	17.6	89.2
	Agree	7	6.9	6.9	96.1
	Strongly agree	4	3.9	3.9	100.0
	Total	102	100.0	100.0	

Ashamed I feel ashamed about having sex with someone when I didn't want to.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	23	22.5	22.8	22.8
	Disagree	27	26.5	26.7	49.5
	Somewhat Disagree	6	5.9	5.9	55.4
	Somewhat agree	24	23.5	23.8	79.2
	Agree	15	14.7	14.9	94.1
	Strongly agree	6	5.9	5.9	100.0
	Total	101	99.0	100.0	
Missing	System	1	1.0		
Total		102	100.0		

Goodenough I feel like I am never quite good enough when it comes to sexuality.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	16	15.7	15.7	15.7
	Disagree	29	28.4	28.4	44.1
	Somewhat Disagree	12	11.8	11.8	55.9
	Somewhat agree	23	22.5	22.5	78.4
	Agree	14	13.7	13.7	92.2
	Strongly agree	8	7.8	7.8	100.0
	Total	102	100.0	100.0	

Conceal I sometimes try to conceal the kind of person I am with regard to sexuality.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	20	19.6	19.6	19.6
	Disagree	32	31.4	31.4	51.0
	Somewhat Disagree	11	10.8	10.8	61.8
	Somewhat agree	21	20.6	20.6	82.4
	Agree	11	10.8	10.8	93.1
	Strongly agree	7	6.9	6.9	100.0
	Total	102	100.0	100.0	

Sexability I feel ashamed of my sexual abilities.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	23	22.5	22.5	22.5
	Disagree	35	34.3	34.3	56.9
	Somewhat Disagree	19	18.6	18.6	75.5
	Somewhat agree	20	19.6	19.6	95.1
	Agree	1	1.0	1.0	96.1
	Strongly agree	4	3.9	3.9	100.0
	Total	102	100.0	100.0	

Kinky I feel ashamed about having sexual or kinky fantasies.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	28	27.5	27.5	27.5
	Disagree	38	37.3	37.3	64.7
	Somewhat Disagree	9	8.8	8.8	73.5
	Somewhat agree	19	18.6	18.6	92.2
	Agree	4	3.9	3.9	96.1
	Strongly agree	4	3.9	3.9	100.0
	Total	102	100.0	100.0	

Body I feel ashamed of something about my body when I am in a sexual situation.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	12	11.8	11.8	11.8
	Disagree	18	17.6	17.6	29.4
	Somewhat Disagree	13	12.7	12.7	42.2
	Somewhat agree	25	24.5	24.5	66.7
	Agree	20	19.6	19.6	86.3
	Strongly agree	14	13.7	13.7	100.0
	Total	102	100.0	100.0	

Pastsex I sometimes avoid certain people because of my past sexual choices or experiences.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	23	22.5	22.5	22.5
	Disagree	39	38.2	38.2	60.8
	Somewhat Disagree	9	8.8	8.8	69.6
	Somewhat agree	18	17.6	17.6	87.3
	Agree	9	8.8	8.8	96.1
	Strongly agree	4	3.9	3.9	100.0
	Total	102	100.0	100.0	

Feelgood I feel good about myself with regard to my sexual choices and experiences.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	3	2.9	2.9	2.9
	Disagree	8	7.8	7.8	10.8
	Somewhat Disagree	20	19.6	19.6	30.4
	Somewhat agree	31	30.4	30.4	60.8
	Agree	32	31.4	31.4	92.2
	Strongly agree	8	7.8	7.8	100.0
	Total	102	100.0	100.0	

Painevents I replay painful events from my sexual past over and over in my mind.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	29	28.4	28.4	28.4
	Disagree	37	36.3	36.3	64.7
	Somewhat Disagree	10	9.8	9.8	74.5
	Somewhat agree	14	13.7	13.7	88.2
	Agree	5	4.9	4.9	93.1
	Strongly agree	7	6.9	6.9	100.0
	Total	102	100.0	100.0	

Dread I have an overpowering dread that my sexual past will be revealed in front of others.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	30	29.4	29.4	29.4
	Disagree	38	37.3	37.3	66.7
	Somewhat Disagree	12	11.8	11.8	78.4
	Somewhat agree	15	14.7	14.7	93.1
	Agree	4	3.9	3.9	97.1
	Strongly agree	3	2.9	2.9	100.0
	Total	102	100.0	100.0	

Consensual I feel ashamed about a time when I had sex that was not totally consensual.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	40	39.2	39.2	39.2
	Disagree	29	28.4	28.4	67.6
	Somewhat Disagree	6	5.9	5.9	73.5
	Somewhat agree	12	11.8	11.8	85.3
	Agree	12	11.8	11.8	97.1
	Strongly agree	3	2.9	2.9	100.0
	Total	102	100.0	100.0	

Worthy When it comes to sexuality, I feel like I am a worthy person who is at least equal to others.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	1	1.0	1.0	1.0
	Disagree	5	4.9	4.9	5.9
	Somewhat Disagree	7	6.9	6.9	12.7
	Somewhat agree	26	25.5	25.5	38.2
	Agree	39	38.2	38.2	76.5
	Strongly agree	24	23.5	23.5	100.0
	Total	102	100.0	100.0	

Affair I feel ashamed about having an affair/being unfaithful/being sexually promiscuous.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	26	25.5	25.5	25.5
	Disagree	18	17.6	17.6	43.1
	Somewhat Disagree	8	7.8	7.8	51.0
	Somewhat agree	24	23.5	23.5	74.5
	Agree	16	15.7	15.7	90.2
	Strongly agree	10	9.8	9.8	100.0
	Total	102	100.0	100.0	

Sexdefects I feel afraid other people will find out about my sexual defects.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	26	25.5	25.5	25.5
	Disagree	30	29.4	29.4	54.9
	Somewhat Disagree	13	12.7	12.7	67.6
	Somewhat agree	23	22.5	22.5	90.2
	Agree	9	8.8	8.8	99.0
	Strongly agree	1	1.0	1.0	100.0
	Total	102	100.0	100.0	

Samesex I feel ashamed about having same-sex attractions.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	37	36.3	36.3	36.3
	Disagree	46	45.1	45.1	81.4
	Somewhat Disagree	10	9.8	9.8	91.2
	Somewhat agree	6	5.9	5.9	97.1
	Agree	3	2.9	2.9	100.0
	Total	102	100.0	100.0	

Unfulfilled I feel empty and unfulfilled when I think of my current or past sexual experiences.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	20	19.6	19.6	19.6
	Disagree	33	32.4	32.4	52.0
	Somewhat Disagree	6	5.9	5.9	57.8
	Somewhat agree	29	28.4	28.4	86.3
	Agree	8	7.8	7.8	94.1
	Strongly agree	6	5.9	5.9	100.0
	Total	102	100.0	100.0	

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Alpha for the 20 items (three items needed to be reverse coded to because of negative loadings, the names of those items were: Sexchoices, Feelgood, Worthy).

Case Processing Summary

		N	%
Cases	Valid	101	99.0
	Excluded[a]	1	1.0
	Total	102	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.929	20

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Results of Principal Component Analysis (PCA)

Factor Analysis

Communalities

	Initial	Extraction
I scold myself and put myself down when I think of myself in past sexual situations.	1.000	.694
I think people would look down on me if they knew about my sexual experiences.	1.000	.623
Overall, I feel satisfied with my current and past sexual choices and experiences.	1.000	.571
When I think of my sexual past, I feel defective as a person, like something is inherently wrong with me.	1.000	.690

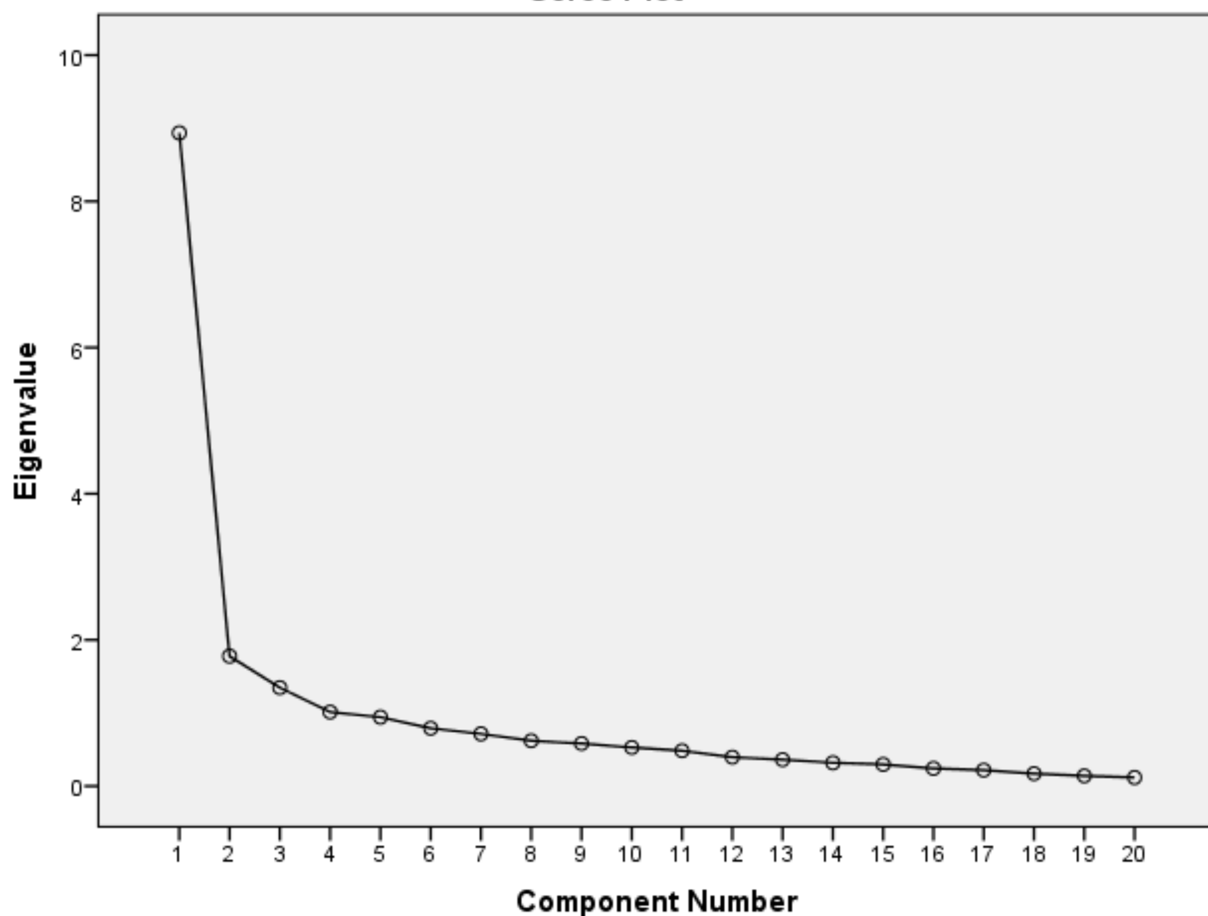
I feel ashamed about having sex with someone when I didn't want to.	1.000	.439
I feel like I am never quite good enough when it comes to sexuality.	1.000	.823
I sometimes try to conceal the kind of person I am with regard to sexuality.	1.000	.609
I feel ashamed of my sexual abilities.	1.000	.710
I feel ashamed about having sexual or kinky fantasies.	1.000	.688
I feel ashamed of something about my body when I am in a sexual situation.	1.000	.509
I sometimes avoid certain people because of my past sexual choices or experiences.	1.000	.513
I feel good about myself with regard to my sexual choices and experiences.	1.000	.673
I replay painful events from my sexual past over and over in my mind.	1.000	.790
I have an overpowering dread that my sexual past will be revealed in front of others.	1.000	.682
I feel ashamed about a time when I had sex that was not totally consensual.	1.000	.654
When it comes to sexuality, I feel like I am a worthy person who is at least equal to others.	1.000	.731
I feel ashamed about having an affair/being unfaithful/being sexually promiscuous.	1.000	.722
I feel afraid other people will find out about my sexual defects.	1.000	.682

I feel ashamed about having same-sex attractions.	1.000	.572
I feel empty and unfulfilled when I think of my current or past sexual experiences.	1.000	.700

Extraction Method: Principal Component Analysis.

Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	8.936	44.681	44.681	8.936	44.681	44.681	5.215	26.075	26.075
2	1.778	8.890	53.572	1.778	8.890	53.572	3.688	18.440	44.515
3	1.346	6.732	60.304	1.346	6.732	60.304	2.162	10.810	55.325
4	1.013	5.067	65.371	1.013	5.067	65.371	2.009	10.046	65.371
5	.943	4.715	70.086						
6	.791	3.955	74.041						
7	.715	3.574	77.615						
8	.620	3.099	80.714						
9	.582	2.912	83.626						
10	.528	2.638	86.264						
11	.484	2.420	88.685						
12	.396	1.979	90.664						
13	.363	1.813	92.477						
14	.319	1.595	94.072						
15	.297	1.483	95.555						
16	.242	1.210	96.765						
17	.218	1.092	97.857						
18	.171	.855	98.711						
19	.140	.700	99.411						
20	.118	.589	100.000						



Component Matrix[a]

	Component			
	1	2	3	4
I scold myself and put myself down when I think of myself in past sexual situations.	.729	.094	-.390	-.047
I think people would look down on me if they knew about my sexual experiences.	.608	.420	.161	-.227
Overall, I feel satisfied with my current and past sexual choices and experiences.	-.667	.056	.242	.254

When I think of my sexual past, I feel defective as a person, like something is inherently wrong with me.	.809	.073	-.160	.067
I feel ashamed about having sex with someone when I didn't want to.	.514	.245	-.288	.181
I feel like I am never quite good enough when it comes to sexuality.	.825	-.375	.041	-.019
I sometimes try to conceal the kind of person I am with regard to sexuality.	.684	-.059	.305	.212
I feel ashamed of my sexual abilities.	.655	-.522	.083	.027
I feel ashamed about having sexual or kinky fantasies.	.726	-.094	.377	-.100
I feel ashamed of something about my body when I am in a sexual situation.	.611	-.311	.042	-.192
I sometimes avoid certain people because of my past sexual choices or experiences.	.632	.336	.001	.014
I feel good about myself with regard to my sexual choices and experiences.	-.713	-.004	.279	.295
I replay painful events from my sexual past over and over in my mind.	.710	.178	-.184	.470
I have an overpowering dread that my sexual past will be revealed in front of others.	.620	.412	.308	.184
I feel ashamed about a time when I had sex that was not totally consensual.	.589	.424	-.271	.229
When it comes to sexuality, I feel like I am a worthy person who is at least equal to others.	-.783	.340	-.045	.017

I feel ashamed about having an affair/being unfaithful/being sexually promiscuous.	.295	.533	.381	-.453
I feel afraid other people will find out about my sexual defects.	.798	.023	.166	-.132
I feel ashamed about having same-sex attractions.	.385	-.130	.511	.381
I feel empty and unfulfilled when I think of my current or past sexual experiences.	.753	-.302	-.199	-.049

Extraction Method: Principal Component Analysis.

a. 4 components extracted.

Rotated Component Matrix[a]

	Component			
	1	2	3	4
I scold myself and put myself down when I think of myself in past sexual situations.	.516	.633	.145	-.085
I think people would look down on me if they knew about my sexual experiences.	.230	.361	.651	.126
Overall, I feel satisfied with my current and past sexual choices and experiences.	-.619	-.359	-.218	.107
When I think of my sexual past, I feel defective as a person, like something is inherently wrong with me.	.519	.594	.193	.177
I feel ashamed about having sex with someone when I didn't want to.	.182	.631	.081	.041
I feel like I am never quite good enough when it comes to sexuality.	.810	.239	.063	.324
I sometimes try to conceal the kind of person I am with regard to sexuality.	.408	.276	.193	.573

I feel ashamed of my sexual abilities.	.761	.070	-.089	.343
I feel ashamed about having sexual or kinky fantasies.	.559	.112	.397	.453
I feel ashamed of something about my body when I am in a sexual situation.	.681	.080	.134	.144
I sometimes avoid certain people because of my past sexual choices or experiences.	.234	.519	.398	.175
I feel good about myself with regard to my sexual choices and experiences.	-.632	-.416	-.277	.152
I replay painful events from my sexual past over and over in my mind.	.248	.773	-.018	.361
I have an overpowering dread that my sexual past will be revealed in front of others.	.085	.459	.477	.486
I feel ashamed about a time when I had sex that was not totally consensual.	.107	.773	.194	.086
When it comes to sexuality, I feel like I am a worthy person who is at least equal to others.	-.759	-.232	-.071	-.311
I feel ashamed about having an affair/being unfaithful/being sexually promiscuous.	-.005	.034	.848	.034
I feel afraid other people will find out about my sexual defects.	.573	.307	.417	.292
I feel ashamed about having same-sex attractions.	.159	.039	.047	.737
I feel empty and unfulfilled when I think of my current or past sexual experiences.	.753	.349	-.004	.102

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.

a. Rotation converged in 8 iterations.

Component Transformation Matrix

Component	1	2	3	4
1	.703	.550	.318	.321
2	-.611	.493	.609	-.110
3	-.115	-.526	.440	.718
4	-.346	.421	-.578	.607

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.

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Factor Analysis

Communalities

	Initial	Extraction
I scold myself and put myself down when I think of myself in past sexual situations.	1.000	.669
Overall, I feel satisfied with my current and past sexual choices and experiences.	1.000	.615
I feel ashamed about having sex with someone when I didn't want to.	1.000	.405
I sometimes try to conceal the kind of person I am with regard to sexuality.	1.000	.633
I feel ashamed about having sexual or kinky fantasies.	1.000	.628
I sometimes avoid certain people because of my past sexual choices or experiences.	1.000	.458
I feel good about myself with regard to my sexual choices and experiences.	1.000	.698
I feel ashamed about having same-sex attractions.	1.000	.696

Extraction Method: Principal Component Analysis.

Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	3.648	45.595	45.595	3.648	45.595	45.595	2.897	36.213	36.213
2	1.155	14.437	60.032	1.155	14.437	60.032	1.906	23.819	60.032
3	.852	10.650	70.682						
4	.662	8.279	78.960						
5	.584	7.306	86.266						
6	.453	5.662	91.928						
7	.359	4.486	96.414						
8	.287	3.586	100.000						

Extraction Method: Principal Component Analysis.

Component Matrix[a]

	Component	
	1	2
I scold myself and put myself down when I think of myself in past sexual situations.	.732	-.366
Overall, I feel satisfied with my current and past sexual choices and experiences.	-.764	.179
I feel ashamed about having sex with someone when I didn't want to.	.564	-.294
I sometimes try to conceal the kind of person I am with regard to sexuality.	.692	.393
I feel ashamed about having sexual or kinky fantasies.	.701	.369
I sometimes avoid certain people because of my past sexual choices or experiences.	.675	-.053

I feel good about myself with regard to my sexual choices and experiences.	-.787	.281
I feel ashamed about having same-sex attractions.	.407	.729

Extraction Method: Principal Component Analysis.

a. 2 components extracted.

Rotated Component Matrix[a]

	Component	
	1	2
I scold myself and put myself down when I think of myself in past sexual situations.	**.812**	.096
Overall, I feel satisfied with my current and past sexual choices and experiences.	**-.737**	-.270
I feel ashamed about having sex with someone when I didn't want to.	**.633**	.064
I sometimes try to conceal the kind of person I am with regard to sexuality.	.363	**.708**
I feel ashamed about having sexual or kinky fantasies.	.384	**.693**
I sometimes avoid certain people because of my past sexual choices or experiences.	**.593**	.326
I feel good about myself with regard to my sexual choices and experiences.	**-.812**	-.197
I feel ashamed about having same-sex attractions.	-.060	**.832**

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.

a. Rotation converged in 3 iterations.

Component Transformation Matrix

Component	1	2
1	.836	.549
2	-.549	.836

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.

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Alpha for Factor 1

Reliability

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	101	99.0
	Excluded[a]	1	1.0
	Total	102	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.797	5

Alpha for Factor 2:

Case Processing Summary

		N	%
Cases	Valid	102	100.0
	Excluded[a]	0	.0
	Total	102	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.685	3

Appendix E: Results of Paired *t*-Test

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness		Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Std. Error
Time1	4	62.00	94.00	80.0000	13.88044	-.691	1.014	-.401	2.619
Time2	4	41.00	71.00	56.2500	15.94522	-.017	1.014	-5.746	2.619
Valid N (listwise)	4								

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Time1	80.0000	4	13.88044	6.94022
	Time2	56.2500	4	15.94522	7.97261

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
					95% Confidence Interval of the Difference				
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper			
Pair 1	Time1 - Time2	23.75000	20.30394	10.15197	-8.55810	56.05810	2.339	3	.101