Development of the Sexual Shame Inventory

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A dissertation submitted in partial fulfillment
of the requirements for the degree of

Doctor of Philosophy

In

Clinical Psychology

Seattle Pacific University

School of Psychology, Family, and Community

March 1st, 2020

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Abstract

Researchers have speculated about the existence of sexual shame, both theoretically and clinically. It has been suggested that sexual shame is maladaptive and influences implications and treatment for shame. However, no valid measure existed to assess these claims. As such, I designed and tested the Sexual Shame Inventory (SSI)—a measure that assesses the domain-specific construct of sexual shame. An initial pool of 35 items were informed through a deductive approach. The scale was completed by a sample of individuals 18 years and older (N = 281). The majority of the sample identified as female, white, heterosexual, and married from the United States. The hypothesized factor structure of the SSI was examined using exploratory factor analysis (EFA). The revised factor structure consists of 10 items and three subscales that assess sexual shame: internalized sexual shame, relational sexual shame, and sexual inferiority. Individuals can acquire a total scale score for overall reported sexual shame and/or subscale scores. Reliability of the final 10-item scale and its three subscales was supported by internal consistency parent scale and subscale alphas ranging from .76 to .86. The SSI was also compared using zero-order and partial correlations to a measure of depression, anxiety, intimacy fear, and self-forgiveness. Results suggest sexual shame contributes to the variance between sexual shame and various outcomes when controlling for the overarching domain of shame. The results of this study support further development of the SSI as a measure of sexual shame with clinical and research utility. With further research, the SSI has the potential to be a useful inventory and screener of sexual shame.

Keywords: sexual shame, internalized sexual shame, relational sexual shame, sexual inferiority, shame, guilt.
Chapter I: Introduction

Purpose

The purpose of this study is to develop an inventory to measure sexual shame. Specifically, I designed and tested a measure that assesses sexual shame to be used in both empirical psychological research and clinical practice. Very little empirical evidence exists highlighting specific areas of shame. In fact, researchers are becoming aware of the need for domain-specific instruments that measure shame “in response to specific, idiographic experiences” that help guide proper treatment (Rizvi, 2010b, p. 439). One of these domain-specific areas is sexual shame.

Researchers have demonstrated the overarching construct of shame to be particularly damaging. Experiences of shame have been linked to poor interpersonal skills, impaired capacity for empathy, anger and hostility, and even serious injury and death in order to escape or avoid feeling shame (Tangney & Dearing, 2002; Tangney, Stuewig, & Mashek, 2007). Additionally, shame-proneness has been linked to clinical outcomes such as the formation and maintenance of depression, anxiety, stress, eating disorders, sociopathy, low self-esteem, paranoid ideation, suicidality, self-injury, and compulsive behaviors (Cirhinlioğlu & Güvenç, 2011; Harder, Cutler, & Rockart, 1992; Pinto-Gouveia & Matos, 2011; Rizvi, 2004; Tangney & Dearing, 2002; Tangney, Wagner, & Gramzow, 1992). Further, experiences of shame has been shown to be related to poor adjustment, including PTSD symptoms (Andrews, 1995; Ferguson, Stegge, Miller, & Olsen, 1999; M. Lewis, Alessandri, & Sullivan, 1992; Tangney, 1995).

Much has also been written about the messages women receive about sexuality. One researcher suggested that messages that stigmatize expressions of female sexuality may contribute to negative outcomes such as depression, anxiety, and other mental distress (Poole,
One form of stigmatization exists in the term “slut shaming,” which refers to the types of messages that restrict female sexuality. Researchers suggest that slut shaming conveys a double standard in which women are stigmatized for overt sexuality, while men are praised for similar behaviors or mocked for not engaging in such behaviors (Ringrose & Harvey, 2015).

Despite there being considerable amount of research in the individual areas of shame and sexuality, little is known about sexual shame. In the United States, sexuality is rarely discussed. Sexuality and sex are perceived as improper to discuss in American homes (Kyle, 2013; McClintock, 2001; Pinto-Gouveia & Matos, 2011). This prohibited discourse around sex keeps damaging events hidden, such as childhood sexual abuse (Carnes & Adams, 2013; Hastings, 1998; Laaser, 1991; Morrison & Ferris, 2009). As a result, researchers suggest sexual shame has been positively linked to familial backgrounds and early life experiences (Lichtenberg, 2011).

Additionally, research suggests that consequences, such as self-hostility, from engaging in sexual behaviors become predictors of sexual shame (Reid, 2010). Further, researchers claim sexual shame is related to narcissism, relational dysfunction, aggression and violence, body-shaming, dissociation, impaired development, sexual dysfunction, hypersexuality and paraphilias, sexual addiction, and low self-esteem (Volk et al., 2016). As such, sexual shame has the potential of being highly maladaptive. However, these claims have not been empirically validated since, prior to this study, sexual shame had not yet been empirically defined, nor has a validated measure existed to assess for domain-specific sexual shame based on an empirically defined construct.

Clark (2017) suggested sexual shame is not merely shame related to sexual acts, but may include meaning attributed to trust and openness in romantic relationships, bodily shame related to aesthetics and function, fear and uncertainty related to power to make decisions related to
sexual encounters, and internalized judgment toward sexual desire, self-worth in relationships, and disgust at oneself as a sexual being. As such, sexual shame has since been defined as:

a visceral feeling of humiliation and disgust toward one’s own body and identity as a sexual being and a belief of being abnormal and inferior; this feeling can be internalized but also manifests in interpersonal relationships having a negative impact on trust, communication, and physical and emotional intimacy (2017, p. 87).

Given this newly defined construct, past research on sexual shame has not been accurately or thoroughly assessed. Therefore, in order to assess the full scope of sexual shame, there is a need to develop a psychometrically sound measure that is domain-specific. To date, no published, empirically supported measure of sexual shame exists. As such, the purpose of this study is to create a valid measure to assess sexual shame.
Chapter II: Literature Review

Defining Shame and Guilt

It is not uncommon to see the terms *shame* and *guilt* used interchangeably. The distinction between these terms is often unclear, but a growing body of literature has highlighted vital differences between this emotional dyad. Shame and guilt belong to a group of emotions labeled the “self-conscious emotions” (Tangney & Fischer, 1995). In contrast to the basic emotions (e.g., anger, fear, joy, etc.) that emerge early in life and are assumed to be universal, the self-conscious emotions have been described as “secondary,” “derived,” or “complex” emotions, because they emerge later in development as part of several critical cognitive abilities, and may be uniquely human (Fischer & Tangney, 1995; M. Lewis et al., 1989). These emotions require the development of a set of standards against which the self is evaluated (Tangney & Salovey, 2010). For instance, one must have a sense of what constitutes “good” and “bad,” “right” and “wrong” as a precursor to experiencing shame and guilt. Additionally, shame and guilt are often evoked by failures or transgressions. As such, shame and guilt are referred to as “moral emotions” because they likely inhibit hurtful, socially undesirable behaviors (Damon, 1988; Eisenberg, 2000; Harris, 2008).

Theories of Shame and Guilt

Often, there is no clear differentiation between shame and guilt (Tangney & Dearing, 2002). Usually, *guilt* is used as a nonspecific term to refer to aspects of both emotions. Additionally, “shame and guilt” are sometimes used together as an inseparable pair of emotion terms (Tangney & Salovey, 2010). However, empirical evidence heavily supports Lewis’s (1971) distinction between these two emotions. It is widely accepted that three theories of shame and guilt primarily exist: the internal/external distinction, the act/person distinction, and the
horizontal/vertical distinction. While each of these distinctions largely overlap, each theory holds its own value. Due to the complexity of guilt and shame, each of these self-conscious emotions serve two different functions within social self-regulation. Adding to the complexity, guilt and shame are not just indicators of our own transgressions, but also signals of our own desires to repair them in others (Giner-Sorolla, 2012).

**Internal Guilt, External Shame.** One theory posits that the expression of shame is fundamentally an interpersonal one, demonstrating submission and avoidance, exhibited by lowered gaze, stooped posture, and hiding of the face, whereas guilt is experienced more intrapersonally (Giner-Sorolla, 2012). This indicates that shame is associated with public exposure. As such, the effects are more intense since one’s transgressions are openly shown. However, one study showed that not only are the effects of shame felt in public conditions, but also felt in private when others empathize with the exposure others experience (Smith et al., 2002). In other words, when one imagines the shameful event that another person publicly experiences, that individual also experiences an intense amount of shame. Consequently, it is unlikely that shame is only experienced due to public exposure. Furthermore, it is also unlikely that guilt is only experienced internally. To highlight this, one study found that nearly all guilt episodes have another person as their target (Baumeister et al., 1995). Therefore, it is unlikely that shame is more interpersonal than guilt, and both emotions can, in fact, be experienced interpersonally as well as intrapersonally.

**Shame as a Focus on the Person, Guilt as a Focus on the Act.** Lewis (1971) first suggested that shame is a negative evaluation of the whole self, whereas guilt is a negative judgment of one’s acts. Because shame elicits focus on oneself as a person, these feelings can be particularly painful and overwhelming, creating a sense that the *self is* unworthy, incompetent, or
bad. Oftentimes, individuals experiencing shame report a sense of shrinking and feeling “small,” describing feelings of worthlessness, powerlessness, and being “exposed.” Individuals tend to imagine how their defective self would appear to others. While these feelings of shame arise from a specific behavior, the implications are more enduring and are seen as a reflection of a defective self (Tangney & Salovey, 2010). Consequently, in shame, the individual interprets negative events as caused by internal, stable, and uncontrollable factors (Giner-Sorolla, 2012). In guilt, the perceived causes of negative events are still internal, but are viewed as unstable yet controllable (Giner-Sorolla, 2012). In other words, guilt is perceived as more about the situation than the individual. Therefore, when an individual feels shame, they tend to focus on the self (“I did that terrible thing”), whereas when one feels guilt, the tendency is to focus on a particular behavior (“I did that terrible thing”).

As such, this differentiation in focus between self and behavior elicits very distinct emotional experiences. Thus, guilt is defined as behavior-focused negative affect relating to an eliciting event, which then results in reproach and repair outcomes (Robins, Noftle, & Tracy, 2007; Tangney & Dearing, 2002; Tangney et al., 2007). On the other hand, shame is defined as self-focused negative affect relating to an eliciting event, which then leads to withdrawal and avoidance outcomes (Robins et al., 2007; Tangney & Dearing, 2002; Tangney et al., 2007). As such, shame contains a clear social component. During a shame experience, individuals compare themselves with others (de Hooge, 2014). As a result, individuals are more sensitive to others’ words and opinions, individuals are worried about how they are judged by others, and they feel inferior to others (de Hooge, 2014). Shame therefore motivates individuals to undertake actions that will protect themselves from further harm and that will improve their damaged or threatened self (de Hooge, 2014). Consequently, shame may be an internalization of anticipated social
judgments. That is, an individual’s view of themselves may stem from the social world. Conversely, when individuals experience guilt, they feel remorse and regret for their actions.

These distinctions in the etiology of shame and guilt are most notable through the varying outcomes associated with guilt and shame (Sheikh & Janoff-Bulman, 2010). For instance, when one experiences shame, it is the global, stable flaws in the self that cause this experience of shame, therefore the tendency is to hide and withdraw. However, if the fault is a single act that you had control over, it is easier to approach and repair the fault (Giner-Sorolla, 2012). Although, recent research has argued that shame does not always motivate withdrawal behaviors and guilt does not always motivate restorative behaviors. In fact, for some, shame may motivate approach behavior, affiliation with others, and prosocial behavior with the main goal of restoring and protecting the threatened or damaged self from further harm (de Hooge, 2014).

**Shame as Hierarchical, Guilt as Reciprocal.** Lastly, there is an evolutionary approach to shame which proposes a form of social hierarchy similar to the submission seen in animals (Fessler, 2007). For instance, physical signs of shame are similar to behaviors exhibited by one animal acknowledging another’s dominance, such as gaze aversion and diminished stature. While establishing this social hierarchy is beneficial to the group in that it reduces conflict and promotes chance of survival, some individuals are forced into a less privileged position (Giner-Sorolla, 2012). As such, this theorized hierarchical social system allows shame to help the system cope and function. It is suggested that shame takes on an appeasement function, which serves to smooth over relations “by boosting the relative worth of another at the individual’s own expense,” (Giner-Sorolla, 2012, p. 107). While shame regulates hierarchical social relations, guilt works to enforce mutual altruism (Trivers, 1971). Guilt does this by causing someone who fails to provide mutual aid to feel unpleasant emotions. As such, guilt regulates reciprocal
interactions between peers. Consequently, guilt has the ability to smooth inequalities within the greater social system.

**Defining Sexual Shame**

While definitions of sexual shame are limited within empirical literature, some conceptual articles and books have discussed the topic (Balsam, 2009; Elise, 2008; Jaffe, 2009; Mollon, 2005; Shadbolt, 2009). Although it has been discussed, up until recently authors have not explicitly stated how sexual shame differs from the general experience of shame. Further, few have suggested definitions for the construct. Kyle stated, “Sexual shame is 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” (2013, p. 13). From this definition the Kyle Inventory of Sexual Shame (KISS) was created. However, this definition was not empirically derived and may not accurately reflect the etiology of sexual shame. Furthermore, this inventory was never published or validated; as such, it is unknown if it accurately assesses the construct of sexual shame. Additionally, Gordon created the Male Sexual Shame Scale (MSSS), defining sexual shame as “caused by negative evaluations of one’s sexual identity, behaviors, attractions, thoughts, or feelings” (2018, p. 107). This definition and consequent items were constructed through deliberation and observation of a panel, and a review of online discussions related to men’s sexuality. Consequently, it is unlikely that items were derived empirically, making it difficult to accurately assess for sexual shame. These definitions, like other definitions mainly rooted in sexual experiences, are limiting and do not accurately reflect the etiology of sexual shame. Women’s developmental processes around sexuality and expectations are heavily rooted in a cultural context and many contradictory messages exist
related to female sexuality. As such, simply because a woman grows up in American culture, sexual shame can develop independent of personal experience (Clark, 2017).

Recently, Clark (2017) provided the only empirically derived definition for the construct of sexual shame that exists to date, and this is the definition of sexual shame that will be used throughout the current study. As such, sexual shame exists as a domain-specific construct within the larger umbrella construct of shame. In other words, sexual shame is not entirely separate from the global experience of shame, although there are specific aspects unique to sexual shame that differ from shame as a whole. Therefore, the dynamics of this definition suggest sexual shame exists within oneself to highlight the intrapersonal nature of sexual shame as well as interpersonal sexual shame.

**Intrapersonal Sexual Shame**

Recent research suggests that there is an overlap between sexual shame and a global experience of shame. For instance, individuals internalize messages of sexual shame that endure above and beyond the context of those relationships in which the shameful events occurred (Clark, 2017), similar to that of a more general sense of shame (Tangney & Salovey, 2010). Clark (2017) also found that participants’ descriptions of sexual shame reported feelings of inferiority, inadequacy, and helplessness leading to interpret themselves as defective and flawed. Further, participants emphasized a feeling of disgust towards themselves, using words like “gross” and “filthy,” unique descriptors of sexual shame rather than general shame. As such, it is likely that this emphasis on internalized disgust may indicate intrapersonal sexual shame rather than a global experience of shame.
Interpersonal Sexual Shame

It is likely that sexual shame develops around the same timeframe as the self-conscious emotions. Through early interpersonal interactions, individuals develop self-appraisals of sexuality. Experiences of shame have been linked to poor interpersonal skills, impaired capacity for empathy, anger and hostility, injury, and death (Gordon, 2018; Tangney & Dearing, 2002; Tangney et al., 2007). Similar to intrapersonal shame, there are facets of interpersonal shame that overlap with descriptions of shame related to romantic relationships. Clark (2017) confirmed previous findings (Lansky, 2005; Morrison, 1989) that those who experience shame often want to avoid intimacy within relationships due to fear that their shortcomings would be exposed and lead to further rejection. Partnered relational shame also evidenced insecure attachment styles (Gross & Hansen, 2000; Karavasilis Karos, 2007; Wells & Hansen, 2003) and interpersonal isolation (Dorahy, 2010; Stafford, 2007). Further, distressed couple relationships were evident in highlighting interpersonal sexual shame (Clark, 2017). As such, the unique challenges accompanying interpersonal relationships, such as communication and trust, are clearly impacted and may be better explained by sexual shame.

Sexual Shame and Sexual Guilt

Although research on sexual shame and guilt is almost non-existent, it is likely that the theories of shame and guilt are applicable to sexual shame and guilt, especially since sexual shame is likely a domain-specific construct under the overarching theory of shame. As such, applying shame and guilt theory, it is likely that sexual shame and sexual guilt largely overlap. However, these two concepts are likely distinct in that sexual shame is a focus on one’s whole self, whereas sexual guilt focuses on the behavior, which thereby leads to approach and repair behaviors. While both guilt and shame can be experienced intrapersonally and interpersonally,
the outcomes of the experience of sexual shame and sexual guilt likely differ. Research consistently suggests that guilt is healthier and more adaptive than shame because guilt is more likely to lead individuals to seek opportunities to correct transgressions. Conversely, shame is more likely to lead to avoidant and withdrawal behaviors (Cohen, Wolf, Panter, & Insko, 2011; Tangney & Dearing, 2002). However, the empirical evidence for this view is debatable as measurement of shame has not been consistent across studies. For instance, some studies have used shame-proneness as a proxy for shame, while others have examined experiences of shame to represent shame. Shame-proneness is the general tendency to experience shame and is considered a personality trait. High shame-prone individuals tend to experience shame very often and in situations others may not experience feelings of shame. These chronic experiences of shame are linked to mostly negative interpersonal and psychological consequences (de Hooge, 2014). As such, the interpersonal consequences of shame-proneness cannot presume similar consequences from situational experiences of shame. Similar problems can be argued for experiences of guilt and guilt-proneness. Consequently, it is imperative that both sexual shame and sexual guilt be treated as distinct in order to highlight these potential differences in outcomes and behaviors.

Sexual Shame and Psychopathology

Although there is a lack of empirical research related specifically to sexual shame, several studies have been conducted looking at various mental health outcomes associated with the global construct of shame. As previously mentioned, shame involves negative evaluation of the self. As such, evidence shows shame is associated with psychopathology. For instance, shame has been associated with engagement in suicidal and non-suicidal self-injury, substance abuse, risky behavior such as unprotected sex, depression, anxiety disorders, eating disorders,
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and borderline personality disorder (Andrews et al., 2002; Cândea & Szentagotai-Tătar, 2018; Cassiello-Robbins et al., 2019). Conversely, some researchers have shown that while shame-proneness was related to psychopathology, situational experiences of shame were only related to feelings of inferiority, anger, and a state of anxiety (de Hooge, 2014).

With regards to depression specifically, both shame and depression involve feelings of being small and insignificant, worthless, and helpless. Further, shame and depressive symptoms both involve activation of the hypothalamic-pituitary-adrenal axis and proinflammatory immune processes (Dickerson et al., 2004; Holsboer, 2000; Schiepers et al., 2005). Also, the focus on the self as “bad” inherent in shame is likely to elicit ruminative processes that has been linked to depressive symptoms (Kim et al., 2011). Moreover, this focus on the “bad self” in shame has been demonstrated as a similar attribution pattern in depressed mood (Abramson et al., 2002). In a recent meta-analysis, researchers consistently showed robust links between shame and depressive symptoms with a medium effect size (Kim et al., 2011). As such, there is abundant evidence that determinants of shame show strong ties to depressed affect.

Additionally, shame is relevant for generalized anxiety disorder (GAD). In GAD, some theorists suggest worry might be used as a strategy to reduce negative emotions such as shame (Schoenleber et al., 2014). Further, individuals suffering from GAD may believe worry is helpful as it may prevent or prepare them for facing feared outcomes, thereby lessening the shame because they tried to prevent or were at least more prepared for the aftermath. In fact, a recent meta-analysis showed shame was significantly associated with overall anxiety symptoms with a medium effect size (Cândea & Szentagotai-Tătar, 2018). Shame was significantly associated (medium effect sizes) with all but one type of anxiety symptoms investigated, and the strongest correlations were with GAD, social anxiety, and separation anxiety (although, only one study
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was available regarding separation anxiety and therefore, may not have yielded reliable results; Cândea & Szentagotai-Tătar, 2018).

Along similar lines as social anxiety is fear of intimacy, a specific concept of anxiety regarding self-disclosure and social intimacy in close relationships. Intimacy in relationships fosters acceptance, value, and affection between partners (Frost, 2012) and shame may play a key role in thwarting attempts at intimacy (Goldberg, 1991). “Fear of intimacy” has been defined as perceived intimacy as a fearful situation due to the damage suffered by people in their life background and the length of their relationship (Yeganehfarzand et al., 2019). This fear is formed through the influence of childhood experiences and adult relationships and has been associated with feelings of pain, suffering, and failure (Yeganehfarzand et al., 2019). Research has shown a strong association between intimacy and various measures of adjustment. For instance, fear of intimacy has been correlated positively with loneliness and difficulty with interpersonal relationships, and negatively correlated with social intimacy and social desirability (Lutwak et al., 2003). Further, shame has shown to be associated with exhibiting high fears of intimacy, supporting Goldberg’s theory (1991) that “shame plays a fundamental role in intimacy fears” (Lutwak et al., 2003, p. 914). With the strong associations between psychopathology and shame, further investigation of the association between the domain-specific construct of sexual shame and depression, anxiety, and intimacy fear is needed.

Review of Current Shame Measures

Previous researchers have speculated that sexual shame exists as its own construct, distinctively separate from the predominant concept of shame (Balsam, 2009; Elise, 2008; Jaffe, 2009; Mollon, 2005; Shadbolt, 2009). However, due to a lack of extant measures of sexual shame specifically, researchers tend to choose measures of the overarching construct of shame
with varying results. Nevertheless, it is clear that none of these measures relate directly to sexuality.

*The Shame Inventory*

The Shame Inventory (SI; Rizvi, 2010) is a self-report measure designed to assess an individual’s propensity to experience shame both globally and in response to specific life events. The measure includes a definition of shame and three general items about the experience of shame. These three questions use a 5-point Likert scale to assess the frequency, intensity, and negative effects of shame. After these three items, a list of 50 potential shame cues is presented to participants. Participants are asked to rate each cue on a 0-4 (0-no shame to 4-extreme shame) scale to indicate the intensity of their current levels of shame about that event or characteristic, or to indicate if they have never experienced the event/behavior/characteristic. Examples of items included, “Was laughed at in front of others,” “Was sexually harassed,” “Had sexual/kinky fantasies,” and “Being gay/lesbian/bisexual.” Seven out of the 50 potential shame cues relate to sexuality, including cues regarding sexual abuse or bodily satisfaction.

*The Test of Self-Conscious Affect*

The Test of Self-Conscious Affect (TOSCA-3; Tangney & Dearing, 2002) is a self-report measure composed of 11 negative and five positive scenarios yielding indices of Shame Proneness, Guilt Proneness, Externalization, Detachment/Unconcern, Alpha Pride, and Beta Pride. For each of these scenarios, there are four 5-point Likert scale items (1-not likely to 5-very likely) that yield the indices aforementioned. A short version of the TOSCA-3 may be created by dropping the positive scenarios thereby eliminating the Pride scales. A shortened version of the TOSCA-3 shame and guilt scales correlated .94 and .93 respectively with their corresponding full-length versions, thus supporting the utility of the abbreviated version. An example of a
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scenario is “You attend your coworker’s housewarming party and you spill red wine on a new cream-colored carpet, but you think no one notices,” with examples of items being, “You think your coworker should have expected some accidents at such a big party,” and “You would wish you were anywhere but at the party.” Most of the research on the associations between shame and psychological symptoms are measuring shame proneness (Cândea & Szentagotai-Tátar, 2018).

The Experience of Shame Scale

The Experience of Shame Scale (ESS; Andrews, Qian, & Valentine, 2002) is a self-report measure consisting of 25 items designed to assess four areas of characterological shame: (1) shame of personal habits, (2) manner with others, (3) sort of person, and (4) personal ability. The ESS also assesses three areas of behavioral shame: (5) shame about doing something wrong, (6) saying something stupid, and (7) failure in competitive situations. Further, the ESS assesses (8) bodily shame, or feeling ashamed of your body or any part of it. For each of the eight areas of shame covered, there are three related items addressing an experiential component (e.g., “Have you felt ashamed of your personal habits?”), a cognitive component (e.g., “Have you worried about what other people think of your personal habits?”), and a behavioral component (e.g., “Have you tried to cover up or conceal any of your personal habits?”). For bodily shame, there is an extra item asking about the participants avoidance of mirrors (in addition to concealing body parts from others). Participants respond according to how they have felt in the past year and each item is rated on a 4-point scale (1-not at all to 4-very much), resulting in total scores ranging from 25-100.
The Kyle Inventory of Sexual Shame

The Kyle Inventory of Sexual Shame (KISS; Kyle, 2013) is a 20 item self-report measure that assesses feelings among adults regarding current and past sexual thoughts and behaviors intended to measure sexual shame. Participants rate the items on a Likert scale (0- strongly disagree to 5- strongly agree). Some example items include, “I think people would look down on me if they knew about my sexual experiences,” and, “Overall, I feel satisfied with my current and past sexual choices and experiences.” While the measure shows strong internal consistency (α = .93, N = 102), the measure reports no reliability information. Furthermore, validity of the KISS was established by determining whether participants in treatment within the same study had reduced scores following treatment for sexual shame. The author states that “improvement upon receipt of treatment for sexual shame indicated they did in fact have this condition prior to starting therapy, thereby establishing the validity of the instrument,” (p. 25). However, given no definition for sexual shame had been empirically established, it is unlikely an empirically based treatment could exist. It is unknown whether the participants in the study did, in fact, exhibit sexual shame and whether the scale was measuring sexual shame, thereby it is difficult to determine the validity of this study. The scale has never been published or distributed.

The Male Sexual Shame Scale

The Male Sexual Shame Scale (MSSS; Gordon, 2018) is a 30 item self-report measure that assesses various aspects of sexual shame in men, such as sexual inexperience distress, masturbation/pornography remorse, libido disdain, body dissatisfaction, dystonic sexual-actualization, and sexual performance insecurity. Participants rate the items on a Likert scale (1- strongly disagree to 5- strongly agree). Some example items include, “I am ashamed of how few sexual experiences I’ve had at this point,” and, “If I could get rid of my interest in sex, I would.”
Although the measure shows good internal consistency ($\alpha = .88$, $N = 887$), the items were based on 10 hypothetical domains related to libido, sexual interests, masturbation, abundance of experience, lack of experience, homosexual interests and experiences, pornography use, body image, stereotype threat, and sexual disparity in relationships. The researchers stated that “Sexual shame may be defined as shame that is caused by negative evaluations of one’s sexual identity, behaviors, attractions, thoughts, or feelings” (2018, p. 107). As such, the items were not derived from an empirically based construct definition, rather through deliberations and observations of a panel, and a review of online discussions related to men’s issues and sexuality.

**Scale Evaluation**

While several different measures of shame exist, none of the measures examined in the previous section directly assesses the construct of sexual shame with established validity. The SI offers a unique perspective on shame, in that it assesses both global shame and specific events that could be considered shameful. Although these potential shame cues offer valuable data, it is difficult to encompass such a broad construct like shame in 50 potential cues of shame. Although, the SI includes cues related to sexuality, no psychometric data exists that parses out these cues from the others, nor have these cues been individually tested for validity in assessing sexual shame as a specific domain. Moreover, the TOSCA-3 focuses on global shame proneness rather than domain-specific shame. Further, the ESS specifically assesses shame in 8 different domains. Unlike other measures of shame, it looks specifically at characterological shame and how an individual experiences shame. The closest of these eight areas to potentially assess issues of shame around sexuality could be in the bodily shame subscale. However, with the research available on bodily shame, this should really be a construct on its own, rather than embedded in the ESS. Sexuality is not a focal point within this subscale or any of the others. Additionally, the
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KISS, while purportedly assessing domain-specific sexual shame, was created based on face validity and not an empirically founded construct of sexual shame. Lastly, the MSSS, like the KISS, seemingly assesses domain-specific sexual shame within men, but was also created based on face validity and a review of online discussions of men’s sexuality. As such, the items on both the KISS and MSSS may not reflect an empirically proposed construct of sexual shame. Therefore, this review of existing shame measures further supports the development of a domain-specific inventory for sexual shame that differentiates sexual shame from the overarching construct of shame.

Current Study

Researchers have speculated and conceptualized that domain-specific shame exists in regard to sexuality and have indicated that implications and treatment options should differ depending on whether someone is experiencing this form of shame. However, no measure existed that effectively measured the construct of sexual shame. In this study, I created and evaluated a new shame measure to specifically assess for sexual shame. A deductive approach was used to inform development of items. Items that reflected internal feelings of sexual shame were conceptualized as measuring internalized sexual shame, whereas items that included interactions with another person were conceptualized as measuring relational sexual shame. Therefore, I hypothesized that sexual shame spanned two domains, yielding 2 respective subscales encompassing internalized sexual shame and relational sexual shame.

To evaluate the reliability of the new sexual shame inventory, internal consistency of the subscales that form the instrument were estimated. To evaluate content validity of the instrument, the factor structure was analyzed to determine the dimensionality of the SSI. I hypothesized the SSI would evidence good convergent and concurrent validity by demonstrating
a significant, positive relationship with other measures of sexual shame (KISS) and shame (SI and Shame Proneness index on TOSCA-3). Additionally, I hypothesized that the SSI would show good discriminant validity by demonstrating a non-existent relationship with the Externalizing index on the TOSCA-3. Externalization encompasses tendencies toward impulse control problems of various types, including disinhibition across behavioral, personality, psychopathological, health, and neuroscientific outcomes (Nelson & Foell, 2018). Similarly, I hypothesized a non-existent relationship between the SSI and a measure of forgiveness of others. Given shame has been theorized and shown to be associated with submission and avoidance (Giner-Sorolla, 2012), it is unlikely to be related to externalization as well as forgiveness of others. Therefore, I hypothesized it would also unlikely be related to sexual shame.

Further, the aforementioned associations between shame and psychopathology warrant further investigation regarding the relationships between sexual shame and depression, anxiety, intimacy fear, and self-forgiveness. I hypothesized that sexual shame will demonstrate a positive relationship with a validated measure of depression (PHQ-9), anxiety (GAD-7), and intimacy fear (FIS), and a negative relationship with a validated measure of dispositional self-forgiveness (HFSS; Thompson et al., 2005), when controlling for shame, as measured by the SI, and shame proneness (TOSCA-3 Shame Proneness subscale). That is, one aim is to determine whether domain-specific sexual shame contributes uniquely to the relationship between sexual shame and depression, anxiety, intimacy fear, and self-forgiveness. Dispositional self-forgiveness is a tendency to respond to one’s transgressions with grace for the self (Thompson et al., 2005) and a propensity to reduce negative thoughts, feelings, and actions toward the self (Carpenter et al., 2019). Researchers have found that shame proneness predicts decreased self-forgiveness (Carpenter et al., 2016; Wright et al., 2017). Since shame has been evidenced as a strong
significant predictor of self-forgiveness, it is likely that domain-specific sexual shame will yield a negative relationship with self-forgiveness. As such, I expected a positive association to exist between sexual shame and depression, anxiety, and intimacy fear and a negative relationship between sexual shame and self-forgiveness; however, it would be interesting if associations continue to exist with sexual shame when controlling for the overarching domain of shame (controlling for shame and shame proneness).
Chapter III: Method

Measure Development

Findings from the previously outlined shame studies and the hypothesized relationship to sexuality, as well as the recent defining of the construct of sexual shame, were the primary suppositions used to develop the instrument for this study, the Sexual Shame Inventory (SSI). The SSI was designed on the principle that sexual shame is internalized as well as experienced relationally (Clark, 2017).

Item Development

In item generation, the primary concern is content validity and the first step in construct validation of a new measure. A necessary requirement in scale development is to establish a clear link between items and their theoretical domain. This can be established through a strong theoretical framework and matching items to construct definitions (Hinkin, 1995). In many cases, construct validity is addressed through using previously published measures. There are some caveats with this that are apparent after closer inspection. First, many published and commonly used measures have poorly written items, which threatens construct validity. As such, many measures may not measure the construct they are purported to measure, or they may be measuring similar but distinct constructs (Ford & Scandura, 2018). Second, measures may become outdated, requiring periodic revisions (Ford & Scandura, 2018). Lastly, if items are only generated from existing published measures, then we continue to “reshuffle” the same constructs and ideas (Ford & Scandura, 2018).

There are generally two ways in generating scale items: deductive and inductive. A deductive approach is built on an understanding of the literature, which is used to develop a theoretical definition of the construct. That definition is then used as a guide for the development
of items (Hinkin, 1995). A clear operational definition grounded in theory is imperative. Conversely, the inductive approach requires little theory as one attempts to identify constructs and generate measures from individual responses (Hinkin, 1995; Ford & Scandura, 2018). Content analysis is then used to classify responses to develop items. Hinkin (1995) found that most studies (83%) utilized deductive methods after a review of 75 psychometric studies published between 1989 and 1993. The inductive approach is used when there is little theory available to guide item writing. According to Ford and Scandura (2018), deductive approaches are by far the most common, and may be “due to the emphasis on strong theory in the major journals” (p. 134).

The deductive approach may be more appropriate when there is well-established theory to guide item creation (Ford & Scandura, 2018). As such, this scale was constructed utilizing a deductive approach to item generation. Using this approach, Clark (2017) provided a definition for the construct of sexual shame, which was used in the current study for item generation. The principal researcher reduced Clark’s (2017) definition to its fundamental components and generated five to ten items for each of these parts, resulting in a pool of 35 potential items. Items were worded as recommended by DeVellis (2016), that is, items should be unambiguous, brief, at an appropriate reading level, use adjective forms, and should not be double-barreled (i.e., two or more ideas) or have ambiguous pronoun references. Additionally, a mix of positively and negatively worded preliminary items were included to avoid acquiescence, affirmation, or agreement bias. As recommended, many items were considered “redundant” with respect to content, as to provide the greatest potential for internal-consistency reliability which is the foundation of validity (DeVellis, 2016, p. 110). The 35 preliminary items of the SSI are listed in Appendix A. As a result, two themes of sexual shame were hypothesized: (a) internalized sexual
shame; (b) *relational sexual shame*. Each of these themes were considered a potential factor on the SSI. The preliminary items were subjected to various forms of analyses which are described below. The hypothesized factor structure utilizing the deductive approach to item generation is shown in Table 1.
### Table 1

**Hypothesized Factor Structure**

<table>
<thead>
<tr>
<th>Hypothesized Factors</th>
<th>Fundamental Component</th>
<th>Preliminary Items</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internalized Sexual Shame</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Humiliation/Disgust | | I feel self-conscious about the way my body looks.  
I feel dirty when I think about my sexuality/sexual experiences.  
My naked body disgusts me.  
I feel like wanting to shower or wash off when thinking about my sexuality/sexual experiences.  
I like the way my body looks.*  
I am comfortable seeing my naked body.*  
I feel ashamed that I believed the lies told to me to get me to have sex.  
I replay sexual experiences I am ashamed of over and over in my mind. |
| Abnormal | | I feel bad about liking sex.  
I feel embarrassed by my sexual functioning or performance.  
It would be better if I had a greater sex drive.  
I feel bad about wanting to watch pornography.  
I feel bad about wanting to masturbate.  
I feel comfortable with the amount of sex I need/want.*  
When I think of my sexuality, I feel something is wrong with me.  
I am ashamed that I have used pornography.  
I am ashamed by how often I need/want sex.  
I worry people will find out about my sexual flaws. |
| Inferior | | When it comes to sex, I feel like I am never good enough.  
I worry about being able to sexually satisfy my partner(s).  
I feel bad about doing sexual acts with someone when I didn’t want to.  
I feel bad that I agreed to sexual acts when I truly didn’t want to.  
I feel bad that I have been tricked into sexual experiences in my past.  
I feel ashamed that I have been forced into uncomfortable sexual situations. |
| Trust/Communication | | I feel comfortable discussing sexual difficulties with my partner(s).*  
There are some things I just can’t talk about with my sexual partner(s).  
I am afraid of my sexual past being revealed to others.  
I’ve had sexual thoughts that I would be ashamed to tell anyone about.  
I feel ashamed to talk to others about my sexuality/sexual experiences.  
I am afraid of sharing my private sexual thoughts with my partner(s). |
| Relational Sexual Shame | | |
| Intimacy | | I feel bad about how many sexual experiences I’ve had.  
I feel bad about how few sexual experiences I’ve had.  
I feel uncomfortable sharing my past sexual experiences with others.  
I feel comfortable expressing my true sexual feelings.*  
I am content with my sexual choices and experiences.* |

*Note. *indicates reverse coded items.*
On the SSI, items are measured on a 6-point Likert-type scale ranging from strongly disagree to strongly agree. A 6-point Likert scale was chosen due to the amount of variance it would elicit across respondents. Allowing for 6-point responses would eliminate a midpoint (i.e., neutral) response, encouraging participants to choose responses in either direction. As a result, items would have a better chance of correlating well with other items since correlation is linked to the extent of variation, thereby potentially increasing scale reliability (DeVellis, 2016).

**Sexual Shame vs. Sexual Guilt.** As previously stated, it is hypothesized that sexual shame and sexual guilt are distinctly different concepts, with sexual shame focusing on the self and sexual guilt focusing on a particular behavior. Because sexual shame and sexual guilt are hypothesized to be distinctly different concepts, the scope of this study was limited to assessing for sexual shame. The assessment and evaluation of the concept of sexual guilt as well as the distinctness between these two concepts is outside the scope of this paper.

**Validity**

Factor analysis was used to evaluate the structural validity of the SSI, which is used for “defining the substantive content or meaning of the factors (i.e., latent variables) that account for the variation among a larger set of items” (DeVellis, 2016, p. 155). Although hypothesized factors are provided, exploratory factor analysis (EFA) will be used rather than confirmatory factor analysis (CFA) to improve structural validity. Researchers in some areas consider obtaining replicable results from traditional factoring methods (e.g., EFA) as stronger confirmatory evidence than demonstrating good model fit (e.g., CFA) according to a statistical criterion (DeVellis, 2016). For example, Saucier and Goldberg (1996) state that, “because exploratory factor analysis provides a more rigorous replication test than confirmatory analysis, the former technique may often be preferred to the latter” (p. 35). As such, if data from different
samples collected at different times can replicate factor analytic results using an exploratory approach, it is highly unlikely the results will be due to chance, thereby providing more confirmatory evidence for the structural model.

Additionally, correlational analysis was used to assess the construct validity of the SSI, which is the theoretical relationship between a variable to other variables (Cronbach & Meehl, 1955). I compared the SSI to an unpublished existing measure of sexual shame (KISS) to assess convergent validity. Furthermore, I compared the SSI to measures of shame (SI and the Shame Proneness index on the TOSCA-3) to evaluate concurrent validity. Moreover, I compared the SSI with two measures conceptualized to be theoretically distinct to assess discriminant validity (TOSCA-3 Externalizing index and HFSO). Discriminant validity means measures of different constructs should only relate modestly or not at all with one another (Kazdin, 2003). All analyses will be completed using SPSS 26.

**Exploratory Factor Analysis (EFA).** The dimensionality of the items from the SSI were analyzed using EFA. Data screening was conducted to determine suitability of the data for this analysis. First, inter-correlation variables were analyzed in order to exclude poorly related items from the factor analysis (Field, 2009). Second, the Kaiser-Meyer-Olkin measure of sampling adequacy (KMO; Kaiser, 1970) shows the ratio of the squared correlation between variables to the squared partial correlation between variables. The KMO value ranges from 0 to 1, with values closer to 1 indicating the patterns of the correlations are relatively compact, meaning the factor analysis should yield distinct and reliable factors suitable for analysis (Field, 2009). The KMO value should be a minimum of .5, and the suitability of the data for EFA increases as the KMO value approaches 1. Additionally, the Bartlett’s test of Sphericity was used to examine whether the population correlation matrix resembles an identity matrix (Field, 2005); if the value
is significant ($p < .05$), it is likely clusters of correlated variables exist. Further, multicollinearity was examined using the determinate of the $R$-matrix; if the value is greater than .00001, singularity of items is likely not present. However, assuming the sample is adequate (KMO greater than 0.5) and the data are appropriate (Bartlett’s test < .05), the correlation matrix was examined as variables have to be intercorrelated but should not correlate too highly as this would make it difficult to determine the unique contribution of the variables to a factor (Field, 2009). If the matrix shows variables with high intercorrelations, the clusters of variables could be “manifestations of the same underlying variable” (Rietveld & Hout, 1993, p. 255), implying redundancy that would unnecessarily lengthen the measure and falsely increase reliability. As such, the data presented in the matrix should then be reduced down into underlying variables or factors.

If data screening indicates sampling adequacy (i.e., KMO value > .5, Bartlett’s test < .05, and the determinant of the $R$-matrix >.00001), principle axis factoring (i.e., common factor extraction) was used to determine the number of factors to rotate to improve interpretability by loading factors to maximize discriminability. Principle axis factoring was used because it is likely there is a latent construct that defines the interrelationship among the items (e.g., sexual shame). Rotation of factors was based on four criteria: a priori theory, the scree plot test, the Eigenvalue-greater-than-one criterion (i.e., Kaiser’s criterion), and the interpretability of the factor solution.

For Eigenvalues, values greater than 1.0 indicate that the component explains a significant percentage of variance. The number of components with Eigenvalues greater than 1.0 is the number of factors that should be rotated. For the scree plot test, the number of factors that should be rotated is indicated by the number of points above the bend in the graph of the scree
plot. When there are multiple predictions of the number of factors to rotate, it is indicated by multiple bends in the graph. Lastly, interpretability of the factor solution was determined based on themes and content of items that loaded onto each factor. Because the distribution of items onto factors varied greatly from the constructs identified by a priori theory, rotation of the factors made the distribution of items more interpretable.

Because all of the items of the SSI are related and reflect sexual shame, I predicted that the factors were not orthogonal. Therefore, the predicted number of factors was rotated using the oblique Promax procedure. If items load onto multiple factors after being rotated, they will be removed from the SSI. As a result of EFA, I recommended changes to the factor structure of the SSI and items were removed.

Correlation Analysis. Correlation analysis was used to establish the linear relationship between the SSI, other shame related measures, and covariates. Zero-order correlation coefficients were calculated to assess the relationship between the SSI and another measure of sexual shame (i.e., KISS). Additionally, zero-order correlation coefficients were calculated between the SSI and a measure of shame (SI) and shame proneness (the Shame Proneness index of the TOSCA-3). Further, correlation analysis was used to investigate the linear relationship between the SSI and externalization (TOSCA-3 Externalizing index) and forgiveness of others (HFSO).

Moreover, associations between shame and depression, anxiety, intimacy fear, and self-forgiveness have been highlighted. Shame has been shown to be a significant predictor of self-forgiveness (Carpenter et al., 2016; Wright et al., 2017). As such, zero-order correlation coefficients were calculated to determine the relationship between sexual shame (SSI) and a screener for depression (PHQ-9), a screener for generalized anxiety (GAD-7), intimacy fear
(FIS), and self-forgiveness (HFSS). Further, partial correlation analysis was conducted to assess the relationship between sexual shame and depression, anxiety, intimacy fear and self-forgiveness while controlling for shame (SI) and shame proneness (TOSCA-3 Shame Proneness index) to investigate the associations that are above and beyond that of the overarching domain of shame.

**Reliability**

Reliability of the SSI was assessed to determine if the scores represent some true state of the construct being measured with consistency and predictability (DeVellis, 2016). Internal consistency was assessed for the SSI overall, which is measuring sexual shame, and the subscales of the SSI, which are hypothesized to measure *internalized sexual shame* and *relational sexual shame*.

**Internal Consistency Estimates.** Internal consistency of the SSI was estimated by calculating alpha coefficients of the sample for all items (i.e., the total SSI scale), as well as for the proposed individual factors that were identified using EFA. Alpha coefficients range from 0 to 1, with internal consistency increasing as alpha approaches 1. Alpha coefficients >.70 are considered acceptable (DeVellis, 2016). Regarding alpha estimates, DeVellis (2016) recommends shortening the scale if greater than 0.9. As per DeVellis (2016), a margin of safety was built into the alpha when optimizing the scale length. Additionally, DeVellis (2016) recommends those item-scale correlations whose omission has the least negative or most positive effect on alpha is usually the best one to drop first. This is an estimate of the item’s *communality*, the extent to which it shares variance with the other items. Further, items with the lowest squared multiple correlations are often prime candidates for exclusion as these indices of item quality converge. For instance, an item with poor item-scale correlation is typically accompanied by a
low squared multiple correlation and a small loss in alpha when the item is eliminated (DeVellis, 2016). Inter-item correlations, item-scale correlations, and lowest-squared multiple correlations were reviewed based on these recommendations.

**Cross-validation Study of the SSI.** The revised version of the SSI identified by this study will be normed on a sample of 400 participants. The cross-validation study will be completed following completion of this study; however, the subsequent cross-validation study of the SSI measure is not included as part of this dissertation.

**Participant Characteristics**

Adults at least 18 years of age were recruited from across the United States via online through social networking sites (e.g., facebook.com, twitter.com), advertising sites (e.g., craigslist.com), and by email invitation. While the sample of this study is not intended to be representative of any particular area, the demographic characteristics collected for this study regarded gender, culture/ethnic group, geographic region, relationship status, sexual orientation, and religious affiliation. Participant demographics are reported in Table 2. As part of the KISS, an additional question was asked regarding whether participants have experienced any of the following ($N = 260$): 81.9% viewing pornography, 39.9% were raised in an extremely religious household, 34.9% have experienced promiscuity, 34.2% have experienced sexual activity with someone of the same sex, 20.6% have experienced childhood sexual abuse, and 39.5% have experienced non-consensual sexual activity/sexual assault; additionally, 45.2% have experienced more than one of the above, and 27.8% have experienced more than three of the above.
### Table 2

**Participant Demographics**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category</th>
<th>M</th>
<th>SD</th>
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</thead>
<tbody>
<tr>
<td>Age (N = 63)</td>
<td></td>
<td>38.25</td>
<td>11.71</td>
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<tr>
<td>Gender (N = 281)</td>
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<td></td>
<td>Male</td>
<td>35</td>
<td>12.5</td>
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<td></td>
<td>Other</td>
<td>5</td>
<td>1.8</td>
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<tr>
<td>Race (N = 281)</td>
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<td>Multiracial</td>
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<td>Asian/Asian American</td>
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<tr>
<td></td>
<td>Hispanic or Latino</td>
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<td></td>
<td>Black or African/African American</td>
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<td>2.1</td>
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<td></td>
<td>American Indian or Alaska Native</td>
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<td>1.4</td>
</tr>
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<td></td>
<td>Hawaiian/Pacific Islander</td>
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<td>1.1</td>
</tr>
<tr>
<td>Sexual Orientation (N = 280)</td>
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<td></td>
<td>Bisexual</td>
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<td>Gay or Lesbian</td>
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<td></td>
<td>Other (e.g., asexual, demisexual, pansexual, queer)</td>
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<td>Relationship Status (N = 281)</td>
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<td>Single</td>
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<td></td>
<td>Cohabitating</td>
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<td></td>
<td>Divorced</td>
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<td>Remarried</td>
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<td>Geographic Region (N = 228)</td>
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<td>Other (e.g., Africa, Australia, Canada, Egypt, England, France, Guam, New Zealand, Puerto Rico, and South Africa)</td>
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<tr>
<td>Religious Affiliation (N = 281)</td>
<td>Protestant</td>
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<td>Atheist</td>
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<td></td>
<td>Catholic</td>
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<td></td>
<td>The Church of Jesus Christ of Latter-Day Saints</td>
<td>20</td>
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<td></td>
<td>Jewish</td>
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<td>Buddhist</td>
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<td>Other (e.g., Agnostic, Christian-nondenominational, Lutheran, Norse Pagan, Seventh Day Adventist, Wicca/Neopagan)</td>
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<td>13.5</td>
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<td>Past Experiences (N = 260)</td>
<td>Viewing pornography</td>
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<td>Raised in an extremely religious household</td>
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<td></td>
<td>Experienced promiscuity</td>
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<td>Sexual activity with someone of the same sex</td>
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<td>Childhood sexual abuse</td>
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<td></td>
<td>Non-consensual sexual activity/sexual assault</td>
<td>111</td>
<td>39.5</td>
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<tr>
<td></td>
<td>Experienced more than one of the above</td>
<td>127</td>
<td>45.2</td>
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<td></td>
<td>Experienced more than three of the above</td>
<td>78</td>
<td>27.8</td>
</tr>
</tbody>
</table>
Sampling Procedures

Individuals were recruited to participate in an online self-report survey. Participation was voluntary and occurred at the time of accessing the link to the online survey. Participants were compensated by being entered into a random drawing for one of five $20 Amazon gift certificates. As part of the self-report survey, age was screened immediately prior to filling out the online questionnaires. When participants access the site, they are required to verify they are at least 18 years of age before proceeding to the questionnaire phase.

Online research was conducted via online survey at Qualtrics.com. Participants first reviewed an invitation to participate and informed consent, and then indicated their consent to participate in the study. Participants then completed the online questionnaire, which took approximately 30 minutes. After completing the survey, each participant that chose to be entered into the drawing was redirected to a new survey to submit a contact email address for if they were chosen as the winner of the drawing. Participants received a debriefing form at the end of the survey that included contact information of the investigators, the National Alliance for Mental Illness (NAMI), and the American Association of Sexuality Educators, Counselors and Therapists (AASECT) following completion and submission of the survey.

Sample Size, Power, and Precision

It has been noted that a factor pattern that emerges from a large-sample factor analysis will be more stable than that emerging from a smaller sample, thereby increasing the likelihood of replicability (DeVellis, 2016). Therefore, the larger the number of items to be factored and the larger the number of anticipated factors, the larger the sample size should be. Tinsley and Tinsley (1987) suggest a ratio of 5 to 10 participants per item, up to 300 total participants. They suggest that when the sample reaches a certain threshold (they suggest 300), the ratio can be
relaxed. Comrey (1988) suggests a sample of 100 as poor, 200 as fair, 300 as good, 500 as very good, and 1,000 as excellent. They state that a sample size of 200 is often adequate in most cases of straightforward factor analysis that has no more than 40 items. Although the relationship of sample size in addressing validity when using factor analysis is more complex than these suggested guidelines, it provides safe estimates for this paper (DeVellis, 2016).

Measures and Covariates

I constructed a demographic questionnaire to collect demographic information on participants. Variables included sex, ethnicity, sexual orientation, relationship status, geographic region, and religious affiliation. Age was only collected on a subset of the sample. As part of assessing construct validity, I used the KISS to establish convergent validity of the SSI. I also used the SI and the Shame Proneness index of the TOSCA-3 to evaluate concurrent validity of the SSI. In order to evaluate discriminant validity, the relationship between the SSI and both the externalizing index of the TOSCA-3 and forgiveness of others scale on the HFS was examined. The relationship between the SSI and covariates was analyzed (PHQ-9, GAD-7, FIS, and HFSS).

Sexual Shame

The Kyle Inventory of Sexual Shame (KISS; Kyle, 2013) is an unpublished 20 item self-report measure that assesses feelings among adults regarding current and past sexual thoughts and behaviors intended to measure sexual shame. Participants rate the items on a Likert scale (0-\textit{strongly disagree} to 5-\textit{strongly agree}). Some example items include, “I think people would look down on me if they knew about my sexual experiences,” and, “Overall, I feel satisfied with my current and past sexual choices and experiences.” While the measure shows strong internal consistency ($\alpha = 0.93, N = 102$), the measure reports no reliability or validity information. In the current study, the internal consistency was sufficient ($\alpha = 0.93$).
Shame Inventory

The Shame Inventory (SI; Rizvi, 2010) is a self-report measure designed to assess an individual’s propensity to experience shame both globally and in response to specific life events. The measure includes a definition of shame and three general items about the experience of shame. These three questions use a 5-point Likert scale to assess the frequency, intensity, and negative effects of shame. After these three items, a list of 50 potential shame cues is presented to participants. Participants are asked to rate each cue on a 0-4 (0-no shame to 4-extreme shame) scale to indicate the intensity of their current levels of shame about that event or characteristic, or to indicate if they have never experienced the event/behavior/characteristic. The total score is the average rating on endorsed items and ranges from zero to four, with four indicating higher degrees of shame. Examples of items included, “Was laughed at in front of others,” “Was sexually harassed,” “Had sexual/kinky fantasies,” and “Being gay/lesbian/bisexual.”

Previous research indicates that the Shame Inventory is successfully able to measure an individual’s level of shame. Rizvi (2010b) suggests the Shame Inventory has sufficient internal consistency (α = 0.84), test-retest reliability (r = 0.85, p < .001), and predictive validity (F [2, 81] = 27.93, p < .001). Additionally, the inventory demonstrates a high degree of correlation between shame and guilt subscales of the Test of Self-Conscious Affect-3 (TOSCA; Covert, Tangney, Maddux, & Heleno, 2003; Tangney, Wagner, & Gramzow, 1992) and Personal Feelings Questionnaire-2 (PFQ; Harder, Cutler, & Rockart, 1992) indicating a high level of construct validity. Rizvi (2010b) reports the correlation between the TOSCA shame and guilt subscales was 0.48 (p < .001) and the correlation between the PFQ shame and guilt subscales was 0.62 (p < .001). Since the researcher’s intent was to measure shame as it differs from guilt, part correlations were used to factor out shame from guilt for all analyses of construct validity.
resulting in both convergent (i.e., how well the Shame Inventory correlates with other measures of shame) and discriminant validity (i.e., how distinct the Shame Inventory is from guilt, after controlling for the shared variance with shame). The Shame Inventory is unique in that it assesses global feelings of shame in addition to shame regarding certain individualized cues. The current study reflected sufficient internal consistency ($\alpha = 0.83$).

**The Test of Self-Conscious Affect**

The Test of Self-Conscious Affect Version 3 (TOSCA-3; Tangney & Dearing, 2002) is a self-report measure composed of 11 negative and five positive scenarios yielding indices of Shame Proneness, Guilt Proneness, Externalization, Detachment/Unconcern, Alpha Pride, and Beta Pride. For each of these scenarios, there are four 5-point Likert scale items (1-*not likely* to 5-*very likely*) that yield the indices aforementioned. A short version of the TOSCA-3 may be created by dropping the positive scenarios thereby eliminating the Pride scales. A shortened version of the TOSCA-3 shame and guilt scales correlated .94 and .93 respectively with their corresponding full-length versions, thus supporting the utility of the abbreviated version. An example of a scenario is “You attend your coworker’s housewarming party and you spill red wine on a new cream-colored carpet, but you think no one notices,” with examples of items being, “You think your coworker should have expected some accidents at such a big party,” and “You would wish you were anywhere but at the party.” Most of the research on the associations between shame and psychological symptoms are measuring shame proneness (Cândea & Szentagotai-Tătar, 2018). While the current study yielded sufficient internal consistency for the shame proneness ($\alpha = 0.80$) and guilt proneness ($\alpha = 0.75$) indices, the internal consistency for the externalizing ($\alpha = 0.69$) index was poor.
Forgiveness

The Heartland Forgiveness Scale (HFS; Thompson et al., 2005) is a widely used measure of dispositional forgiveness. It consists of eighteen items summed to create a total score. There are three subscales: self-forgiveness (HFSS), forgiveness of others (HFSO), and forgiveness of situations. Items are scored on a 7-point Likert scale (1-Almost Always False of Me to 7-Almost Always True of Me) where higher scores on the index indicate how forgiving one tends to be of themself. An example of an item is “I hold grudges against myself for negative things I’ve done.” Cronbach’s alpha was sufficient (α = 0.85), as well as the HFSS (α = 0.82) and HFSO (α = 0.80).

Depression

The Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001) is a 9-item self-report measure for major depression as described in the DSM-IV-TR. Items are scored on a 4-point Likert scale from 0-not at all to 3-nearly every day. A recommended cut-off score of 10 or above has a sensitivity and specificity of 0.88. It has demonstrated good internal consistency (α = 0.86-0.89) and test-retest reliability (0.84) within an outpatient setting. The current study yielded a sufficient Cronbach’s alpha (α = 0.91).

Anxiety

The Generalized Anxiety Disorder-7 (GAD-7; Spitzer et al., 2006) questionnaire is a widely used instrument that measures common symptoms of anxiety through seven items, scored from 0-not at all to 3-nearly every day. The measure provides a score of 0 to 21, with cutoffs of 5, 10, and 15 indicating mild, moderate, and severe anxiety, respectively. Sensitivity was 0.89 and specificity 0.82 for a cutoff above or equal to 10, with good internal consistency (α = 0.89). Internal consistency in the current study was sufficient (α = 0.92).
**Fear of Intimacy Scale**

The Fear of Intimacy Scale (FIS; Descutner & Thelen, 1991) is a 35-item measure of anxiety about close relationships. The FIS can be used independently of whether the individual is in an intimate relationship. Items are scored on a 5-point Likert scale where higher scores indicate more fear of intimacy and with reported normative sample means of 78.75 (men = 81.9, $SD = 20.58$; women = 76.10, $SD = 22.61$) and high internal consistency ($\alpha = 0.93$) and 1-month test-retest reliability ($r = 0.89$). Items included questions that assess difficulty in expressing feelings and thoughts, difficulty revealing personal flaws and failures, and anxiety experiences about close emotional ties (e.g., “I might be afraid to confide my innermost feelings to you.”). Cronbach’s alpha indicated sufficient internal consistency ($\alpha = 0.93$).

**Summary of Method**

To develop and test the SSI, items were generated, and data were collected to establish reliability and validity of the measure. Participants were recruited online to complete a self-report survey including informed consent, demographic information, the SSI, and seven additional measures (KISS, SI, TOSCA-3, PHQ-9, GAD-7, FIS, and the HFSS). Factor analysis was used to assess the factor structure of the SSI, and the additional measures were compared to the SSI to establish convergent, concurrent, and discriminant validity. A description of procedures, measures, recruitment material, online survey forms, and certificate of training completion can be found in the Institutional Review Board application. Items were removed and subscales were revised as a result of the above analyses (see Appendix B for the revised SSI). A cross-validation study of the revised measure will be completed following the completion of this dissertation.
Chapter IV: Results

Participant Flow

Participants were recruited online from August 29th, 2019 to June 10th, 2020. The survey consisted of informed consent, demographic information, the SSI, and several other measures that were used to assess reliability and validity. The total number of participants that attempted to complete the survey was 441. However, 67 of those participants only provided informed consent and did not complete any measure items. Additionally, 93 participants either did not complete the survey or failed to respond to enough items to be considered for the analysis (refer to Addressing Missing Data below). A total of 281 participants completed enough of the survey to be included in the analysis.

Statistics and Data Analysis

Next, data was screened, missing data was managed, exploratory factor analysis (EFA) was used to test the factor structure and to analyze the dimensionality of the SSI items, and reliability of the factor structure was analyzed by calculating internal consistency estimates.

Data Screening

Data were screened to assure participants met criteria to participate in the study. All participants were at least 18 years of age and provided informed consent to participate. Data of the participants that met criteria for the study were then screened for missing data.

Addressing Missing Data

Prior to estimating missing data, I examined missing data patterns. For the survey, there were several participants that completed the informed consent but did not begin the survey; additionally, several exhibited test fatigue and dropped out midway through the survey. Because there was less data available for some items compared to others, there was a need to estimate
item-level data. To address missing data, I used multiple imputation (MI; Enders, 2010). I chose to use MI because my sample had a high attrition rate. This method can estimate data in sets with up to 24% missing data (Olinsky et al., 2003), which allowed me to retain a higher number of cases for my analysis.

Only variables with missing data were used in the imputation model. Those variables with no missing data were set to be “only used as predictor.” The data were imputed at the item level. I constrained scale items to the minimum and maximum values determined for each scale. The fully conditional specification (MCMC) procedure was used for the imputation. Because the initial run failed to converge, maximum case draws were specified at 5,000 and maximum parameter draws at 250. I followed the suggestion of Olinsky et al. (2003) to retain only cases with 24% or less of missing item values. Of the 374 participants who attempted to complete my survey, 75.1% were included in the final analyses and made up the total sample (N = 281). Participants were disqualified because they had more than 24% of missing data (N = 93).

Exploratory Factor Analysis

Data screening were conducted to determine suitability of the data for the EFA. Sampling was adequate (KMO value = 0.85), indicating that EFA would yield distinct and reliable factors. Additionally, I was fairly certain that I had clusters of correlated values based on Bartlett’s test (p < .001). Finally, the determinant of the R-matrix was greater than .00001, indicating that singularity of items was not present. The correlation matrix was also examined in order to determine items that were highly intercorrelated. Consequently, fifteen items were identified as having multiple high intercorrelations and were subsequently removed as being redundant items (Field, 2009).
Given these positive indicators of sampling adequacy, I proceeded with the EFA. Because all items are related as sexual shame behaviors, I used the oblique (i.e. Promax) rotation procedure to predict the number of factors in the SSI. The Eigenvalue-greater-than-one test indicated seven factors and the scree plot indicated four factors. Considering themes and content of the items that loaded onto each factor, as well as the test results above, my solution resulted in three factors that accounted for 55.4% of the variance. Oblique rotations produce two types of information on factor loadings. The pattern matrix provides the regression coefficients for each variable on each factor; the structure matrix provides the correlation coefficient between each variable and each factor. In my data, both matrices were parallel to each other. To interpret the strength of the factor loading, I followed the guidelines presented in Stevens (1992) which recommends factor loadings less than .4 be suppressed. Consequently, five items did not load onto a factor. The three factors identified were: sexual inferiority (SINF), relational sexual shame (RSS), and internalized sexual shame (ISS). Table 3 shows the item loadings.
Table 3
Rotated Factor Matrix: EFA Item Loadings for the revised SSI

<table>
<thead>
<tr>
<th>Item</th>
<th>SINF</th>
<th>RSS</th>
<th>ISS</th>
</tr>
</thead>
<tbody>
<tr>
<td>30. I worry about being able to sexually satisfy my partner(s)</td>
<td>.876</td>
<td>-.172</td>
<td>-.028</td>
</tr>
<tr>
<td>17. When it comes to sex, I feel like I am never good enough</td>
<td>.816</td>
<td>.068</td>
<td>.002</td>
</tr>
<tr>
<td>16. I worry people will find out about my sexual flaws</td>
<td>.622</td>
<td>.179</td>
<td>.007</td>
</tr>
<tr>
<td>34. I am afraid of sharing my private sexual thoughts with my partner(s)</td>
<td>.017</td>
<td>.901</td>
<td>-.084</td>
</tr>
<tr>
<td>12. There are some things I just can’t talk about with my sexual partner(s)</td>
<td>-.079</td>
<td>.729</td>
<td>-.044</td>
</tr>
<tr>
<td>28. I feel ashamed to talk to others about my sexuality/sexual experiences</td>
<td>.182</td>
<td>.510</td>
<td>.146</td>
</tr>
<tr>
<td>5. I feel bad about how many sexual experiences I’ve had</td>
<td>-.083</td>
<td>.449</td>
<td>.200</td>
</tr>
<tr>
<td>25. I feel ashamed that I have been forced into uncomfortable sexual situations</td>
<td>-.183</td>
<td>.016</td>
<td>.877</td>
</tr>
<tr>
<td>35. I replay sexual experiences I am ashamed of over and over in my mind</td>
<td>.132</td>
<td>.000</td>
<td>.626</td>
</tr>
<tr>
<td>26. I feel like wanting to shower or wash off when thinking about my sexuality/sexual experiences</td>
<td>.178</td>
<td>-.031</td>
<td>.610</td>
</tr>
</tbody>
</table>

Note. An oblique rotation procedure was used to estimate item loadings. Pattern matrix values reported in table.

Correlation Analysis

Internal Consistency Estimates

After evaluating the structural validity of the SSI and identifying factor loadings, I analyzed the internal consistency reliability. After reviewing inter-item correlations, item-scale correlations, and the lowest squared multiple correlations for all items, five items were removed from the SSI, resulting in the final revision to the measure (see Appendix B). The final SSI measure resulted in 10 items (see Appendix B). I used the 10 items to calculate a Cronbach’s alpha coefficient of 0.86. Alpha coefficients for the three subscales can be found in table 4.
SEXUAL SHAME INVENTORY

Table 4
Subscales and Items of the revised SSI

<table>
<thead>
<tr>
<th>Subscale/Item</th>
<th>Alpha</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sexual Inferiority (SINF)</strong></td>
<td>.82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. I worry about being able to sexually satisfy my partner(s)</td>
<td></td>
<td>3.85</td>
<td>1.63</td>
</tr>
<tr>
<td>17. When it comes to sex, I feel like I am never good enough</td>
<td></td>
<td>3.12</td>
<td>1.58</td>
</tr>
<tr>
<td>16. I worry people will find out about my sexual flaws</td>
<td></td>
<td>3.03</td>
<td>1.58</td>
</tr>
<tr>
<td><strong>Relational Sexual Shame (RSS)</strong></td>
<td>.77</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. I am afraid of sharing my private sexual thoughts with my partner(s)</td>
<td></td>
<td>3.11</td>
<td>1.45</td>
</tr>
<tr>
<td>12. There are some things I just can’t talk about with my sexual partner(s)</td>
<td></td>
<td>3.38</td>
<td>1.49</td>
</tr>
<tr>
<td>28. I feel ashamed to talk to others about my sexuality/sexual experiences</td>
<td></td>
<td>2.98</td>
<td>1.37</td>
</tr>
<tr>
<td>5. I feel bad about how many sexual experiences I’ve had</td>
<td></td>
<td>2.59</td>
<td>1.47</td>
</tr>
<tr>
<td><strong>Internalized Sexual Shame (ISS)</strong></td>
<td>.76</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. I feel ashamed that I have been forced into uncomfortable sexual situations</td>
<td></td>
<td>3.23</td>
<td>1.74</td>
</tr>
<tr>
<td>35. I replay sexual experiences I am ashamed of over and over in my mind</td>
<td></td>
<td>2.93</td>
<td>1.57</td>
</tr>
<tr>
<td>26. I feel like wanting to shower or wash off when thinking about my sexuality/sexual experiences</td>
<td></td>
<td>2.14</td>
<td>1.31</td>
</tr>
</tbody>
</table>

Note. N = 281.

Validity

To assess for convergent validity, I calculated the correlation coefficient between the revised SSI and another measure of sexual shame. Additionally, I calculated the correlation coefficient between the revised SSI and measures of shame to assess for concurrent validity. Results of the correlation analysis indicate that scores between the revised SSI and another related measure (KISS) was significantly and positively correlated ($p < .01$). Similarly, the revised SSI was significantly and positively correlated to other measures of shame (SI and TOSCA-3 Shame Proneness index; $p < .01$). To assess for discriminant validity, I calculated the correlation coefficient between the revised SSI and a measure of externalization (TOSCA-3 Externalizing index) and forgiveness of others (HFSO). Results of the correlation analysis between a measure of externalization and the SSI indicate that no relationship exists ($p = .62$).
Additionally, results showed no relationship between the SSI and HFSO \((p = .54)\). Lastly, the correlation coefficient was calculated between the SSI and TOSCA-3 Guilt Proneness index, which indicated no relationship. Correlation coefficients can be found in table 5.

**Table 5**

*Correlations and Means of the SSI and Comparable Measures*

<table>
<thead>
<tr>
<th>Measure (M, SD)</th>
<th>SSI</th>
<th>KISS</th>
<th>SI</th>
<th>TOSCA-3 Shame</th>
<th>TOSCA-3 Guilt</th>
<th>TOSCA-3 Externalizing</th>
<th>HFSO</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI (30.33, 10.08)</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KISS (59.32, 20.44)</td>
<td>0.889**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SI (1.77, 0.67)</td>
<td>0.522**</td>
<td>0.586**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOSCA-3 Shame (36.49, 8.09)</td>
<td>0.403**</td>
<td>0.396**</td>
<td>0.495**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOSCA-3 Guilt (47.4, 5.34)</td>
<td>0.093</td>
<td>0.113</td>
<td>0.269**</td>
<td>0.323**</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOSCA-3 Externalizing (22.54, 6.19)</td>
<td>0.029</td>
<td>0.001</td>
<td>0.017</td>
<td>0.130*</td>
<td>-0.241**</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>HFSO (27.77, 6.70)</td>
<td>-0.037</td>
<td>-0.040</td>
<td>-0.012</td>
<td>-0.065</td>
<td>0.136*</td>
<td>-0.220**</td>
<td>1</td>
</tr>
</tbody>
</table>

*Note.* \(N = 281\)

Pearson’s correlation is significant *\(p < .05\); **\(p < .01\) (2-tailed).

**Partial Correlation Analyses**

Correlation coefficients were calculated to determine the relationship between the revised SSI and other measures of theorized related constructs. Results of the correlation analysis indicated that scores between the SSI and other measures were significantly and positively correlated \((p < .01; \text{see table 6})\). Additionally, the relationships between the overarching construct of shame and depression, anxiety, intimacy fear, and self-forgiveness were identified \((p < .01; \text{see table 7})\).
Next, partial correlation coefficients were calculated and results showed a significant and positive relationship between the SSI and the PHQ-9 ($p < .001$), the FIS ($p < .001$), and a significant and negative relationship between the SSI and the HFSS ($p = .001$), when controlling for the SI. Results also showed a significant and positive relationship between the SSI and the PHQ-9 ($p < .001$), GAD-7 ($p < .01$), and FIS ($p < .001$), and a significant and negative relationship between the SSI and the HFSS ($p < .001$) when controlling for the TOSCA-3 Shame Proneness index (see table 8).

Table 6
Correlations and Means of the SSI and Outcome Measures

<table>
<thead>
<tr>
<th>Measure (M, SD)</th>
<th>SSI</th>
<th>PHQ-9 (18.60, 6.58)</th>
<th>GAD-7 (15.39, 5.83)</th>
<th>FIS  (85.17, 22.76)</th>
<th>HFSS (25.64, 7.35)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI (30.33, 10.08)</td>
<td>1</td>
<td>0.378**</td>
<td>0.727**</td>
<td>0.258**</td>
<td>-0.422**</td>
</tr>
<tr>
<td>PHQ-9</td>
<td>0.378**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GAD-7</td>
<td>0.339**</td>
<td>0.727**</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FIS</td>
<td>0.475**</td>
<td>0.318**</td>
<td>0.258**</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>HFSS</td>
<td>-0.422**</td>
<td>-0.448**</td>
<td>-0.481**</td>
<td>-0.451**</td>
<td>1</td>
</tr>
</tbody>
</table>

*Note. N = 281
Pearson’s correlation is significant *$p < .05$; **$p < .01$ (2-tailed).
Table 7
**Correlations and Means of the SI, TOSCA-3 Shame Proneness and Outcome Measures**

<table>
<thead>
<tr>
<th>Measure (M, SD)</th>
<th>SI</th>
<th>TOSCA-3 Shame</th>
<th>PHQ-9</th>
<th>GAD-7</th>
<th>FIS</th>
<th>HFSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>SI (1.77, 0.67)</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOSCA-3 Shame (36.49, 8.09)</td>
<td>0.495**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHQ-9 (18.60, 6.58)</td>
<td>0.372**</td>
<td>0.451**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GAD-7 (15.39, 5.83)</td>
<td>0.515**</td>
<td>0.439**</td>
<td>0.727**</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FIS (85.17, 22.76)</td>
<td>0.351**</td>
<td>0.314**</td>
<td>0.318**</td>
<td>0.258**</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>HFSS (25.64, 7.35)</td>
<td>-0.525**</td>
<td>-0.608**</td>
<td>-0.448**</td>
<td>-0.481**</td>
<td>-0.451**</td>
<td>1</td>
</tr>
</tbody>
</table>

Note. N = 281
Pearson’s correlation is significant *p < .05; **p < .01 (2-tailed).

Table 8
**Partial Correlations of the SSI and Outcome Measures Controlling for Shame**

<table>
<thead>
<tr>
<th>Control Variable</th>
<th>Measure</th>
<th>SSI</th>
<th>PHQ-9</th>
<th>GAD-7</th>
<th>FIS</th>
<th>HFSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI</td>
<td>SSI</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHQ-9</td>
<td>0.232***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GAD-7</td>
<td>0.095</td>
<td>0.672***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FIS</td>
<td>0.365***</td>
<td>0.215***</td>
<td>0.096</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HFSS</td>
<td>-0.204**</td>
<td>-0.321***</td>
<td>-0.289***</td>
<td>-0.334***</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>TOSCA-3 Shame</td>
<td>SSI</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHQ-9</td>
<td>0.240***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GAD-7</td>
<td>0.197**</td>
<td>0.659***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FIS</td>
<td>0.401***</td>
<td>0.208***</td>
<td>0.140*</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HFSS</td>
<td>-0.244***</td>
<td>-0.246***</td>
<td>-0.300***</td>
<td>-0.345***</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Note. N = 281
Pearson’s correlation is significant *p < .05; **p < .01; ***p < .001 (2-tailed).
Chapter V: Discussion

Researchers have long speculated about the existence of sexual shame and its theorized impact clinically (Balsam, 2009; Elise, 2008; Jaffe, 2009; Mollon, 2005; Shadbolt, 2009). Various definitions of sexual shame presented have primarily been derived from modifications to the overarching construct of shame. Recently, Clark (2017) provided the only empirically derived definition for the construct of sexual shame that exists to date. Consequently, a measure assessing for the domain-specific construct of sexual shame had not been available that was derived from an empirically based construct. Therefore, the Sexual Shame Inventory (SSI) was developed to evaluate the presence of sexual shame. Items for the scale were created utilizing Clark (2017)’s empirically derived construct definition through a deductive approach. Online participants completed the SSI scale and several other related measures. This data was used to evaluate the reliability and validity of the SSI. As a result, modifications were made to the SSI. Data presented in the current study support further evaluation of the SSI as a clinical and research measure of sexual shame. The following discussion examines the implications of the results of this study and provides direction for further research and clinical intervention.

Scale Structural Validity

To establish structural validity of the SSI, exploratory factor analysis was used to assess the dimensionality and structure of the initial proposed scale. The revised version of the SSI is comprised of 10 items that make up three subscales (see table 2). Based on Clark (2017)’s definition of sexual shame, two factors were hypothesized: internalized sexual shame and relational sexual shame. While these two hypothesized factors were in fact supported, a third factor representing sexual inferiority was also identified. Items sufficiently loaded independently on each of these factors, and theoretical examination of each of the items within the factors
appeared to highlight distinct content within the construct of sexual shame. For example, *internalized sexual shame* appeared to emphasize one’s internalizing thoughts, feelings, and sense of control involving sexual experiences and sexuality, whereas *relational sexual shame* appeared to highlight feelings involving others. Of note, it is possible *internalized sexual shame* might also reflect trauma-related sexual shame. Coercive or forceful sexual experiences may impact the intensity or level of *internalized sexual shame* that individuals feel. Further research is needed to determine if the *internalized sexual shame* factor is reflective of trauma-related sexual shame. The third factor, *sexual inferiority*, uniquely focused on thoughts or feelings of being sexually flawed and inadequate. This appears to be consistent with Clark’s (2017) suggestion that sexual shame is not only shame related to sexual acts, but rather a more internalized judgement toward oneself, self-worth in relationships, and disgust at oneself as a sexual being. Overall, shame is felt when we assume others have judged us or rejected us, and shame is the internalization of that social judgment. As such, the mere presence of “slut shaming” experienced in our society may be sufficient to lead to sexual shame. Therefore, sexual shame appears to be more invasive than once theorized and can be differentiated as a domain-specific construct of shame. This three-factor model provides a foundation to further explore this unique and complex construct.

**Internal Consistency**

To assess for internal consistency, alpha coefficients were calculated for the SSI and the three subscales to determine if the scales consistently reflect the constructs they are measuring. The alpha coefficients ranged from 0.76 to 0.86, suggesting the scales consistently reflect sexual shame and the associated subscales.
Scale Construct Validity

To establish construct validity of the SSI as a measure of sexual shame, correlational analyses were used to compare the revised SSI to other measures of shame. The SSI was also compared to measures of constructs predicted to be similar and dissimilar to sexual shame.

Convergent Validity

The SSI was compared to an existing unpublished measure of sexual shame (i.e., KISS). Results indicated the SSI had a significant and positive relationship with the KISS. As expected, there was a high degree of correlation between the KISS and SSI. The KISS was developed by modifying items from other shame measures to reflect sexuality and sexual experiences, as was the existing definitions for sexual shame. However, Clark (2017) suggested there are specific characteristics unique to sexual shame that differ from the larger umbrella construct of shame. Prior to developing the SSI, the convergence between the two measures was unknown, making it difficult to determine a priori whether the KISS was accurately assessing sexual shame. Since the SSI was hypothesized as a domain-specific construct of shame, it was likely to also be significantly and positively correlated with measures of shame. Therefore, the SSI was also compared to measures of shame to assess for concurrent validity (i.e., SI and TOSCA-3 shame proneness). Results were consistent with these hypotheses and suggest the SSI is an acceptable measure of sexual shame.

Discriminant Validity

To assess for discriminant validity, the SSI was compared to a measure of externalization (i.e., TOSCA-3 Externalizing) and a measure of forgiveness of others (i.e., HFSO). Discriminant validity is established when constructs are not related. Based on the theory that shame is characterized by submission and avoidance (Giner-Sorolla, 2012), the relationship between
sexual shame and externalization, as well as sexual shame and forgiveness of others was hypothesized to not be related. Results indicated a nonsignificant, near zero correlation coefficient between the SSI and both the TOSCA-3 Externalizing index and the HFS Forgiveness of Others subscale, thereby suggesting discriminant validity. Lastly, while neither guilt nor sexual guilt were subjects of this paper, no relationship was found between the SSI and the TOSCA-3 Guilt Proneness index, indicating shame was indeed the umbrella construct being measured, rather than guilt.

**Partial Correlation Analyses**

Several correlation analyses were performed to better understand the relationship between the SSI and other measures. First, relationships were examined between the overarching construct of shame and measures of depression (PHQ-9), anxiety (GAD-7), intimacy fear (FIS), and self-forgiveness (HFSS). Results indicate a significant strong positive relationship between shame (SI) and anxiety (GAD-7), as well as significant moderate positive relationships between shame (SI) and depression (PHQ-9) and intimacy fear (FIS). Additionally, a significant strong negative relationship was identified between shame (SI) and self-forgiveness (HFSS). Further, significant positive moderate relationships were noted between shame proneness (TOSCA-3 Shame Proneness) and measures of depression (PHQ-9), anxiety (GAD-7), and intimacy fear (FIS). Lastly, as expected, the relationship between shame proneness (TOSCA-3 Shame Proneness) and self-forgiveness (HFSS) exhibited a significantly strong negative relationship.

Taken together, based on previous research and the current study, it is clear that relationships exist between shame and depression, anxiety, intimacy fear, and self-forgiveness, as well as between shame proneness and depression, anxiety, intimacy fear, and self-forgiveness. Additionally, significant moderate positive relationships were noted between domain-specific
sexual shame (SSI) and a measure of depression (PHQ-9), anxiety (GAD-7), and intimacy fear (FIS), as well as a significant moderate negative relationship between the SSI and a measure of self-forgiveness (HFSS). These results lend support for the a priori hypotheses mentioned previously.

With the relationship between shame, shame proneness, and depression, anxiety, intimacy fear, and self-forgiveness demonstrated, partial correlations were conducted to determine the unique variance contributed by sexual shame (SSI) when controlling for shame and shame proneness individually. After conducting initial bivariate correlations, partial correlational analyses were performed controlling for shame and shame proneness, independently, to determine the relationship between the SSI and measures of depression (PHQ-9), anxiety (GAD-7), intimacy fear (FIS), and self-forgiveness (HFSS). Research suggests relationships may exist between shame and depression, anxiety, intimacy fear, and self-forgiveness. Thus, it is important to know if sexual shame continues to contribute to the strength of the relationship between sexual shame and depression, anxiety, intimacy fear, and self-forgiveness when controlling for shame and shame proneness.

When controlling for shame (SI), the relationship between sexual shame (SSI) and depression (PHQ-9) maintained a significant and positive relationship that diminished from a moderate to a weak correlation. Sexual shame appeared to no longer be associated with anxiety when controlling for shame (SI). Regarding the relationship between intimacy fear and sexual shame when controlling for shame, a significant moderate positive relationship was maintained. Additionally, the relationship between sexual shame and self-forgiveness maintained a significant and negative association that decreased in strength from moderate to weak. When
controlling for shame, current research suggests that significant associations exist between sexual shame and depression, intimacy fear, and self-forgiveness.

When controlling for shame proneness (TOSCA-3 Shame Proneness), similar associations were noted. First, while the relationship between sexual shame and depression maintained a significant and positive relationship, the strength of the association decreased from moderate to weak. The relationship between sexual shame and anxiety was significantly positively weakly related. A significant and positive moderate relationship was maintained between sexual shame and intimacy fear when controlling for shame proneness. Lastly, the relationship between sexual shame and self-forgiveness indicated a significant negative association that decreased from moderate to weak. Overall, when controlling for shame proneness, significant associations exist between sexual shame and depression, anxiety, intimacy fear, and self-forgiveness.

**Future Research**

This study provides initial support for further research of the SSI as a measure of sexual shame. Because this measure has not been tested prior to the current study, research is needed to further validate the SSI to evaluate the occurrence and severity of sexual shame. To further assess the structural stability of the measure, cross-validation analyses of the revised factor structure should be conducted. Future research can also include utilizing the SSI across different groups and levels of treatment to determine clinical utility and ecological validity. For instance, population groups may be compared (e.g., gender, sexual orientation, age, etc.) to identify norms of specific groups. This can help identify within-group and between-group differences in sexual shame. Establishing norms of the SSI across groups may provide information on how to increase clinical utility for specific groups. Further, cross-validation and establishing norms may help
establish the SSI as a screening measure for sexual shame that can inform treatment intervention. Additionally, norms will help determine what one unit of change on the SSI means clinically. Utilizing it in outcome and intervention research would be beneficial to determining change scores and improvement in intervention protocols for sexual shame, therefore considerably increasing its clinical utility.

**Implications**

This study was designed to develop a measure to assess for sexual shame. As previously mentioned, sexual shame was recently empirically defined as a domain-specific construct of shame, although no measure existed to test theoretical models. The factor model produced the two hypothesized factors in addition to a third factor. This factor structure is consistent with the definition provided by Clark (2017) that sexual shame is partially one’s own belief as sexually inferior, and is not only internalized but also manifests in interpersonal relationships. Continued research of the SSI could indicate its use as a clinical measure of sexual shame. The construct validity of the SSI further supports its development. Currently, it is the only measure of sexual shame that is based on an empirically derived definition that highlights it as domain-specific. Overall, the SSI may be a useful self-report measure for identifying the presence and severity of sexual shame. The SSI’s parsimony (10 items) also supports its potential use as a self-report tool. With further validation and normative sampling, the SSI has the potential to aid clinicians as they determine treatment interventions. Lastly, the SSI has the potential to be a useful research measure of sexual shame. Several researchers have theorized relationships involving the construct of sexual shame, but no measure has existed to test these theories. Preliminary findings for the SSI support it as a prospective valuable measure for domain-specific sexual shame research.
Clinical Implications

In addition to the preliminary data suggesting the SSI has good psychometric properties, as well as its practical utility mentioned previously, the inventory may serve as a useful clinical tool. When an individual mentions sexual shame they do not purely mean shame related to sexuality or sexual acts but may also include meaning attributed to trust and openness in romantic relationships, shame related to the body and its functioning, locus of control related to sexual encounters, and internalized feelings toward one’s own sexual desire, worthiness, and sense of disgust towards the self as a sexual being. Additionally, as in the overarching construct of shame, domain-specific sexual shame may be trauma-related. Clinicians would likely benefit from a way to determine this level of specificity to parse out the nuanced and multifaceted experience of sexual shame. In doing so, clinicians will be able to provide more individualized treatment plans and interventions.

More specifically, treatment using the SSI can be further addressed through data obtained using the three subscales. By knowing the three subscale scores, clinicians can better understand the nature and variability that exists within an individual’s experience of sexual shame, thereby providing guidance for the focus of treatment. The first subscale, Sexual Inferiority, consists of items that highlight one’s feelings towards their body and their sexual flaws. The second subscale, Relational Sexual Shame, focuses on one’s trust and openness in romantic relationships. Lastly, the third subscale, Internalized Sexual Shame, emphasizes one’s sense of control related to sexual encounters and the internalized judgment toward the self as a sexual being. As such, the SSI may be a useful outcome measure throughout the therapeutic process to determine if interventions are helpful as part of an individual's treatment plan. While the SSI shows promise, further research is needed to establish its use as a clinical tool.
Limitations

Although this study suggests that the SSI has satisfactory reliability and structural validity as a measure for sexual shame, there are limitations to these findings. The first limitation pertains to the sample demographics. Due to the nature of online participant recruitment, self-selection bias was present. In other words, participants only consisted of individuals who viewed the advertisement on social media and chose to complete the voluntary survey. Consequently, the demographics of the sample were likely impacted. Majority of the participants identified as white, female, and living in the U.S. Also, several participants reported non-consensual sexual activity/sexual assault ($N = 111, 39.5\%$) which could have influenced outcomes, as this population tends to have higher rates of psychopathology (e.g., depression and anxiety). Additionally, several participants did not complete the survey. Many items in the survey, particularly early on, were sensitive in nature and pertained to an individual’s sexual experience. Although it is unknown why some did not complete the survey, it is possible the content of the survey deterred them from responding. As such, it is possible the sample may be more representative of individuals who are more comfortable reporting their sexual experience.

Another limitation with the sample concerns age. Age data was only able to be collected on 63 of the 281 participants due to survey error. Because of this, it is challenging to extrapolate age differences that might moderate the relationship between sexual shame and other outcomes. This also poses a significant challenge with normative sampling and determining whether these results can be replicated without knowing the extent of the ages sampled. Future cross validation studies utilizing the SSI will be helpful in discerning norms for specific age ranges.

Finally, the self-report nature of the questionnaire in an online format limits the amount of reliability analyses that are appropriate for this method of data collection. In order to increase
the likelihood of participant response, the questionnaires were administered anonymously online. Due to anonymity, temporal stability could not be estimated for a couple major reasons. One reason being that two time points could not be provided by the same participant if anonymity were to be maintained. Additionally, variations in the construct of interest are likely. In other words, sexual shame may not be stable over time, that is, experiences could contribute to alteration in levels of sexual shame at any point in time. It would be invalid to assume that the scale is unreliable when there could be potential variations in levels of sexual shame across the administration time. Potential confounding variables would need to be controlled, including live administration, clinical interviewing between administrations to determine potential influencing events, and fatigue.

Conclusion

This study was the first step in the development of the SSI, a measure of domain-specific sexual shame. Factor analysis was used to establish the structural validity of the SSI, which resulted in a revised 10-item, 3-factor model. Additional measures were compared to the SSI to establish convergent and discriminant validity. Reliability was assessed using internal consistency estimates of the revised factor structure. Results indicate further development of the SSI as a measure of sexual shame with clinical and research utility. With further research, the SSI has the potential to be a useful inventory and screener for the presence and severity of sexual shame.
References


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https://doi.org/10.1037/a0021466


## Sexual Shame Inventory (SSI)

The following are some statements 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.

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I feel self-conscious about the way my body looks.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>2.</td>
<td>I feel comfortable discussing sexual difficulties with my partner(s).*</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>3.</td>
<td>I feel bad about liking sex.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>4.</td>
<td>When I think of my sexuality, I feel something is wrong with me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>5.</td>
<td>I feel bad about how many sexual experiences I’ve had.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>6.</td>
<td>I feel embarrassed by my sexual functioning or performance.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7.</td>
<td>It would be better if I had a greater sex drive.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>8.</td>
<td>I feel bad about wanting to watch pornography.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>9.</td>
<td>I feel bad that I agreed to sexual acts when I truly didn’t want to.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>10.</td>
<td>I feel dirty when I think about my sexuality/sexual experiences.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>11.</td>
<td>My naked body disgusts me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>12.</td>
<td>There are some things I just can’t talk about with my sexual partner(s).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>13.</td>
<td>I feel bad about doing sexual acts with someone when I didn’t want to.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>14.</td>
<td>I feel bad about wanting to masturbate.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>15.</td>
<td>I feel comfortable with the amount of sex I need/want.*</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>16.</td>
<td>I worry people will find out about my sexual flaws.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>17.</td>
<td>When it comes to sex, I feel like I am never good enough.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>18.</td>
<td>I feel bad about how few sexual experiences I’ve had.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>19.</td>
<td>I feel uncomfortable sharing my past sexual experiences with others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>20.</td>
<td>I feel comfortable expressing my true sexual feelings.*</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>21.</td>
<td>I am afraid of my sexual past being revealed to others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>22.</td>
<td>I am ashamed by how often I need/want sex.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>23.</td>
<td>I’ve had sexual thoughts that I would be ashamed to tell anyone about.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>24.</td>
<td>I feel bad that I have been tricked into sexual experiences in my past.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>25.</td>
<td>I feel ashamed that I have been forced into uncomfortable sexual situations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>26.</td>
<td>I feel like wanting to shower or wash off when thinking about my sexuality/sexual experiences.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>27.</td>
<td>I like the way my body looks.*</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>28.</td>
<td>I feel ashamed to talk to others about my sexuality/sexual experiences.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>29.</td>
<td>I am ashamed that I have used pornography.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>30.</td>
<td>I worry about being able to sexually satisfy my partner(s).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>31.</td>
<td>I am content with my sexual choices and experiences.*</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>32.</td>
<td>I am comfortable seeing my naked body.*</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>33.</td>
<td>I feel ashamed that I believed the lies told to me to get me to have sex.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>34.</td>
<td>I am afraid of sharing my private sexual thoughts with my partner(s).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>35.</td>
<td>I replay sexual experiences I am ashamed of over and over in my mind.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

*Reverse coded items.
# Sexual Shame Inventory (SSI)

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<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
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<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I feel bad about how many sexual experiences I’ve had.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2.</td>
<td>There are some things I just can’t talk about with my sexual partner(s).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3.</td>
<td>I worry people will find out about my sexual flaws.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4.</td>
<td>When it comes to sex, I feel like I am never good enough.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5.</td>
<td>I feel ashamed that I have been forced into uncomfortable sexual situations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>6.</td>
<td>I feel like wanting to shower or wash off when thinking about my sexuality/sexual experiences.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7.</td>
<td>I feel ashamed to talk to others about my sexuality/sexual experiences.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8.</td>
<td>I worry about being able to sexually satisfy my partner(s).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9.</td>
<td>I am afraid of sharing my private sexual thoughts with my partner(s).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10.</td>
<td>I replay sexual experiences I am ashamed of over and over in my mind.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**Sexual Shame Inventory Scoring**

1. **Sexual Inferiority Subscale**: Add together your scores for items 3, 4, and 8. The result is your Sexual Inferiority score.
2. **Relational Sexual Shame Subscale**: Add together your scores for items 1, 2, 7, and 9. The result is your Relational Sexual Shame score.
3. **Internalized Sexual Shame Subscale**: Add together your scores for items 5, 6, and 10. The result is your Internalized Sexual Shame score.
4. **Total Sexual Shame Scale**: Add together your three scores for the Sexual Inferiority, Relational Sexual Shame, and Internalized Sexual Shame subscales (or add together your scores for items 1 to 10). The result is your Total Sexual Shame score. Higher scores indicate higher levels of sexual shame.