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Posttraumatic stress disorder symptoms and attitudes about social support: Does shame matter?

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ABSTRACT

Considerable research has examined the association between posttraumatic stress disorder (PTSD) symptoms and social support. One facet of this relationship that deserves greater attention concerns trauma survivors' negative expectations towards social support, termed negative network orientation. To expand our understanding of negative network orientation, the current study examined shame as a possible mediator in the relationship between PTSD symptoms and negative network orientation, in a sample of 202 female survivors of intimate partner violence (IPV). Additionally, a history of child abuse (CA) was evaluated as a moderator of the association between shame and negative network orientation in this model. Path analyses indicated a significant indirect effect between PTSD symptoms and negative network orientation through shame, indicative of mediation. A history of CA moderated this effect, such that women with a history of CA in addition to IPV showed a significantly stronger relationship between PTSD symptoms and negative network orientation through shame, relative to women who only had a history of IPV. These findings support the relevance of shame in understanding the association between PTSD symptoms and negative beliefs about social support and highlight the role of childhood abuse as a moderator in this process among IPV survivors.

1. Introduction

Past research has found a consistent relationship between PTSD symptoms and reduced levels of social support (Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2003). In considering this association, many scholars have focused on the direction of causality underlying this relationship, specifically whether social support is eroded by PTSD or buffers against its development (e.g., King, Taft, King, Hammond, & Stone, 2006). Studies have retuned an array of findings (see Kaniasty, 2005 for review), with some suggestion that the amount of time elapsed since trauma exposure may affect the directionality of influence (Kaniasty & Norris, 2008). As well, recent research has suggested that individuals with symptoms of PTSD may have negative attitudes and expectations about using social support, an orientation that could also help explain the robust association between PTSD symptoms and reduced support. Although negative expectations about social support have received some attention in the literature (e.g., Kallstrom-Fuqua, Weston, & Marshall, 2004; Clapp & Beck, 2009), greater effort is needed to examine variables that may be associated with this attribution process. One such variable is shame, defined as a self-conscious emotion, experienced when a core aspect of the self is judged as defective, inferior, or inadequate (Gilbert, 1997; Tangney, 1995). People who feel shame may describe themselves as "a bad person" and shrink away or withdraw from others to avoid possible negative social judgment (Gilbert, 1997). The current study examined the role of shame as a process that may underlie the association between greater PTSD symptoms and negative attitudes and expectations about the use of social support. A sample of women who had experienced intimate partner violence (IPV) was relied on for this study because several of the relationships assessed in this study have already been shown to be relevant for this population (e.g., Beck et al., 2011). Because past research has supported the relationship of childhood abuse (CA) with feelings of shame and negative expectations toward using social support, the current study assessed whether a history of CA moderated the relationship between shame and negative network orientation in this sample.

Tolsdorf (1976) defined a *negative network orientation* as "a set of expectations or beliefs that it is inadvisable, impossible, useless, or potentially dangerous to draw on network resources" (p. 413). Vaux and Wood (1987) reported that greater negative network orientation predicted lower social support resources and more negative appraisals of social support in a sample of college students,

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providing evidence for the validity of the negative network orientation construct. Within the trauma literature, Kallstrom-Fuqua et al. (2004) found that negative network orientation was associated with suspicion and mistrust of others in a sample of 178 women who had been exposed to childhood abuse. Clapp and Beck (2009) noted that negative network orientation mediated the relationship between PTSD symptoms and attenuated social support in cross-sectional data from 458 survivors of motor vehicle accidents. The findings from these two studies of trauma-exposed samples suggest that negative attitudes and expectations about accessing social support may be important in determining whether people will draw upon available social resources following a trauma and may help to better explain the well-documented relationship between PTSD symptoms and social support.

These findings also raise another question–why do people suffering from symptoms of PTSD have negative attitudes and expectancies about social support? Negative emotions such as shame may be relevant to this question because feelings of shame have been related to both PTSD symptoms (Leskela, Dieperink, & Thuras, 2002) and to turning away from possible social support (Buchbinder & Eisikovits, 2003), in trauma-exposed samples. The role of shame might be particularly relevant following interpersonal traumas such as IPV, as these events may be more likely to involve shaming reactions from others, relative to non-interpersonal traumas (Charuvastra & Cloitre, 2008). In line with this reasoning, past studies have found a consistent relationship between shame and PTSD symptom severity (Beck et al., 2011; Street & Arias, 2001) in survivors of IPV. Shame also has been associated with non-disclosure of abuse following IPV (Buchbinder & Eisikovits, 2003; Giles-Sims, 1998), which may result in loneliness, loss of social ties, and loss of trust in others (Buchbinder & Eisikovits, 2003). Post-trauma feelings of shame also were supported as a maintaining factor of PTSD symptoms longitudinally in a sample of 157 victims of violent crime (Andrews, Brewin, Rose, & Kirk, 2000). Past support for shame in both the maintenance of PTSD symptoms and turning away from social support provides evidence that shame may be a relevant factor in the relationship between PTSD symptoms and negative network orientation.

The current study examined shame as a mediator between PTSD symptoms and negative network orientation, using a sample of 202 women who had experienced IPV.[1] IPV involves physical, sexual, or psychological harm by a romantic partner or spouse (Centers for Disease Control and Preventions, 2010) and is a prevalent issue, with approximately 25% of American women experiencing some form of IPV in their lifetime (Breiding, Black, & Ryan, 2008). Longitudinal studies have indicated that mental health problems are long-standing following IPV (e.g., Sutherland, Bybee, & Sullivan, 1998), including PTSD symptoms (Golding, 1999; Kemp, Green, Hovanitz, & Rawlings, 1995). Based on the prevalence of IPV as well as its negative mental health consequences, the study hopes to identify relevant post-trauma processes for female IPV survivors. Additionally, a focus on other traumas that commonly co-occur with IPV, specifically childhood abuse (CA) may help to elucidate possible differential effects of cumulative traumas on mental health outcomes.

Many adult IPV survivors have also experienced abuse as children (CA; e.g., Bensley, Van Eenwyk, & Simmons, 2003; Whitfield, Anda, Dube, & Felitti, 2003) and several of the negative sequelae associated with IPV have also been related to CA. With respect to PTSD symptoms, Schumm, Briggs-Phillips, and Hobfoll (2006) examined a sample of 777 women who had experienced adult rape, CA, both adult rape and CA, or no abuse. These authors found that women who experienced CA in addition to adult rape had significantly more PTSD symptoms than women who had no history of CA prior to the rape. With respect to shame, Feiring and Taska (2005) supported the relationship between CA and persistent feelings of shame 6 years after first disclosure of the CA. As well, Gibson and Hartshorne (1996) found that childhood sexual abuse was related to a negative network orientation in both a treatment-seeking sample and a college sample. In considering the hypothesized associations between PTSD symptoms, shame, and negative network orientation, it is possible that a history of CA in addition to IPV may strengthen the relationship between PTSD symptoms and negative network orientation through shame, compared to the experience of IPV alone. In particular, it is possible that the experience of both IPV and CA may decrease a person's expectations about the utility of social support as they have already been victimized by several trusted others (e.g., romantic partners, family members). Repeated trauma during both childhood and adulthood may also reinforce feelings of shame. Thus, although speculative, it is possible that the relationship between shame and negative attitudes or expectations toward social support may be amplified among individuals who have experienced both IPV and CA.

Thus, in the current study, we examined the associations among PTSD symptoms, shame, and negative network orientation in a sample of female IPV survivors. We hypothesized that shame would mediate the relationship between PTSD symptoms and negative network orientation. Additionally, we examined whether a history of childhood abuse moderated the relationship between shame and negative network orientation, specifically predicting that a history of childhood abuse would contribute to a stronger relationship between feelings of shame and negative network orientation, relative to the association noted among individuals who experienced only IPV.

2. Method

2.1. Participants

The final sample included 202 women who sought assessment and possible treatment at a university-based research clinic for mental health problems following IPV. Announcements for the clinic were dispersed throughout the community via health fairs, presentations to the faith community, flyers, and public service announcements. Participants for the current study were recruited from January 2009 to September 2015. Women qualified for assessment if their IPV included actual or threatened death or serious injury and their emotional response included intense fear, helplessness, horror, or the perception that they would die (Criterion A; American Psychiatric Association (APA), 2000).[2] Not included in the sample were 24 additional women, who reported psychotic symptoms ($n = 10$), were inconsistent in their reporting ($n = 5$), and evidenced cognitive impairment ($n = 9$). An additional 24 women were excluded because they did not satisfy DSM-IV Criterion A for PTSD. The final sample (N = 202) ranged in age from 18 to 75 (mean age = 37.77, $SD = 12.51$). Approximately 21% of the participants ($n = 43$) reported still being involved with their most recent

[1] The mediation analysis conducted in the current study was based on cross-sectional data, and thus should not be considered true mediation, as true mediation requires longitudinal assessment of the variables (e.g., Kraemer et al., 2001).

[2] The *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. text-rev.; *DSM-IV-TR*; APA, 2000) definition of PTSD was used in this study as data collection began several years before the most recent *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; APA, 2013) was published and the majority of the participants were assessed using *DSM-IV-TR*.