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Bodily Shame as a Mediator Between Abusive Experiences and Depression

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The role of bodily shame as a mediator between sexual or physical abuse and depression was investigated in a community sample of 101 women who had been followed for 8 years. In general, childhood and adult abuse were related to the occurrence of depression in the study period but when both were considered together, only adult abuse showed an independent association. However, childhood and adult abuse were both independently related to chronic or recurrent depression. Bodily shame was related to childhood abuse, and this association could not be accounted for by bodily dissatisfaction or low self-esteem. Bodily shame, but not childhood abuse, was related to chronic or recurrent depression when both factors were considered together and current depressive symptoms were controlled.

Studies suggest that experiences of sexual and physical abuse may lead to later depressive disorder (e.g., Andrews & Brown, 1988a; Bagley & Ramsey, 1985; Burnam et al., 1988; Holmes & Robins, 1987). Chronic, recurrent, and more severe psychiatric disorders, including depression, have also been shown to be associated with a history of abuse in clinical samples (Bryer, Nelson, Baker Miller, & Kroll, 1987; Carmen, Reiker, & Mills, 1984). Little is known, however, about the psychological processes underlying this association or about the role of cognitive–affective factors in such a link. In this article, bodily shame is investigated as a possible mediating factor between abusive experiences and later depression in a community sample of adult women.

One of the few studies to investigate the relationship between childhood experiences of abuse and depressogenic cognitions did so in a sample of adult abuse survivors (Andrews & Brewin, 1990). It was found that women experiencing marital violence who made internal and stable attributions of blame for the abuse when in the violent relationship (what has been termed *characterological self-blame,* or CSB; see Janoff-Bulman, 1979) were more likely than other women to have been sexually or physically abused in childhood. Furthermore, women with CSB were more likely than the other women survivors to have suffered persistent depression after the violent relationship ended. These findings are in accord with those of Gold (1986), who found evidence for greater CSB for hypothetical bad events in women who had been sexually victimized in childhood. This attributional style was also related to depression and low self-esteem in the survivors in Gold's study.

The similarity of CSB to the experience of general shame, with its focus on stable negative characteristics of self, has been noted by a number of authors (e.g., Lewis, 1986; Tangney, Wagner, & Gramzow, 1992; Weiner, 1986), and two have demonstrated an association between shame as an affective style (shame proneness) and internal stable attributions for negative events in undergraduate students (Tangney et al., 1992; Weiner, 1986).

This evidence of an association between CSB and early abusive experiences, and between CSB and general shame proneness, prompted the current inquiry. Before attempting to explore the role of bodily shame in the abuse–depression link, however, a brief review of the literature is given concerning the definition of general shame and its relation to abuse and depression, along with consideration of the measurement of shame in existing research.

One of the most central aspects of shame pertains to how an individual appears in the eyes of others (e.g., Gilbert, 1989; Lewis, 1986; Sartre, 1956). Most definitions in the psychological literature reflect the findings of Wicker, Payne, and Morgan (1983), who asked students to recall and rate personal experiences of shame (as compared with guilt). Shame was experienced as a more incapacitating emotion, relating to feelings of inferiority and submissiveness, to behavior involving hiding and concealment, and to increased self-focus and self-consciousness.

Much of what has been written about the etiology of shame and its relation to depression has involved theory and speculation rather than empirical evidence (Lewis, 1986; Mollon, 1984). Gilbert's (1989) biosocial theory of depression is of interest, however, as it specifically addresses the relation of abuse and shame to depression. Gilbert cites evidence from ethological studies relating defeat and subordinate status to biochemical changes associated with depressive states. At a cognitive–affective level it is suggested that in humans, the dominant feeling related to defeat states is shame. Shame proneness is therefore a likely response to experiences of abuse, particularly where it is

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prolonged, as such experiences reduce the victim to subordinate status. The experience of abuse is thus associated with psychiatric disorder, particularly depression, through shame proneness. Gilbert and colleagues have recently reported an association between submissive behavior and both depression and shame proneness in a student sample (Gilbert, Pehl, & Allen, 1994).

In the literature on the effects of child sexual abuse, the relation of shame to abuse has also been noted by Finkelhor and Browne (1986). According to these authors, stigmatization is one of four trauma-causing factors following child sexual abuse. It is proposed that stigmatization occurs when the perpetrator and others blame the child. As a result, the child grows up with persistent feelings of shame, believing that he or she is damaged goods.

The relation of shame to depressive disorder is largely unstudied. There are, however, two published cross-sectional studies using student samples that show significant correlations between questionnaire measures of shame proneness and depression (Hoblitzelle, 1987; Tangney et al., 1992). Furthermore, the latter study showed a relation between shame proneness and depression when attributional style was controlled. However, the authors noted that the questionnaire measure of depression in their nonclinical sample might simply have been reflecting negative affectivity (see also Gotlib, 1984).

The two preferred methods of measuring shame proneness have used paper-and-pencil questionnaires. One uses hypothetical scenarios (sometimes defined as shame provoking) where individuals rate how much shame they would feel in a situation (e.g., Tangney et al., 1992), whereas the other specifies adjectives relating to shame and guilt, and asks individuals to rate how well each word describes them (e.g., Hoblitzelle, 1987). Neither of these questionnaire methods is without problems. The items typically used to measure shame may not be sufficiently specific (Hoblitzelle, 1987). It is also questionable whether these instruments reflect the extent to which shame is experienced in actual situations, although Tangney et al. (1992) did go to considerable lengths to overcome this objection, using situations generated by individuals in their questionnaire design.

In the present study, interview measures were used to investigate a different aspect of shame proneness than those previously considered. One aspect that has been consistently noted in the literature involves self-conscious feelings about the body (e.g., Gilbert, 1989; Mollon, 1984; Sartre, 1956). A substantial amount of literature confirms the centrality of physical self-concept to global self-concept, particularly in women (e.g., Lerner & Karabenick, 1974; Secord & Jourard, 1953). Furthermore, one study has shown that depressed individuals perceive themselves as less attractive than nondepressed individuals, even when observer-rated physical attractiveness is controlled (Noles, Cash, & Winstead, 1985). Because shame has been related to self-conscious feelings about the body, and depression to body image, this notion was used in the current measure. Feelings about the body provided a common and salient real-life focus for the women in the study. The goal was therefore to assess the role of bodily shame as a mediating factor in the abuse–depression link.

The women participants had been followed with four contacts over a period of 8 years, and longitudinal data from a standardized clinical interview were available. It was therefore possible to consider the relation of bodily shame to a past history of depressive disorder by asking women about shame felt at any time in their lives. This method allows for the occurrence of any such feelings to be related to the onset and course of depressive episodes documented in the 8-year study period, taking current symptoms into account. The longitudinal clinical data was particularly relevant because, as previously noted, chronic and recurrent course of depression has been associated with a history of abuse in clinical samples. In particular, it was hypothesized that (a) both abuse in childhood and abuse in adulthood would be related to depression in general and, more specifically, to a chronic or recurrent and more severe course in the 8-year study period, (b) childhood and adult abuse would be related to bodily shame experienced at any point in their lives, and (c) bodily shame would account for the relationship between abuse and depression in the 8-year period when current depressive symptoms were controlled.

Factors possibly related to bodily shame, such as low self-esteem and perceived physical attractiveness, have been shown to be associated with depression (Brown, Andrews, Bifulco, & Veiel, 1990; Noles et al., 1985) and with adversity in childhood and adulthood (Andrews & Brown, 1988b; Brown, Bifulco, Veiel, & Andrews, 1990). A second aim was to establish the discriminant validity of the shame measure relative to low self-esteem and dissatisfaction with body–appearance, and to demonstrate that bodily shame was not simply a proxy measure for these other two factors.

Method

Sample

One hundred one women (age range = 32 to 56 years) were selected from an original longitudinal study of 289 women carried out between 1980 and 1983 in Islington, an inner-city area of London, England (Brown, Andrews, Harris, Adler, & Bridge, 1986). The original 3-year inquiry was designed to investigate onset and course of depressive disorder and required a group of women who were at high risk of developing clinical depression. The study therefore concentrated on working-class women with at least one child at home. The women had been interviewed on three occasions between 1980 and 1983, and they had participated in a fourth interview in 1987 or 1988. The main purpose of the fourth contact was to investigate social and cognitive vulnerability factors for depression in two generations of women, and the women in the subsample were selected because they had at least one daughter between the ages of 15 and 25 (although the present report considers data only from the mothers). This subsample did not differ in rate of psychiatric disorder in the 3-year study period of the original survey from women from the original sample (27% vs. 29%). (For further details, see Andrews, Brown, & Creasey, 1990, and Andrews & Brown, 1993.)

Measures

The tape-recorded, semistructured interview allowed women to talk freely, and all measures were in the form of numerical ratings by the investigator that were based on the woman's verbal descriptions in response to questioning. Information was transcribed and interviewers made ratings on the basis of predetermined indicators and with reference to a series of examples.

Depression

The shortened version of the ninth edition of the Present State Examination (PSE: Cooper, Copeland, Brown, Harris, & Gourley, 1977; Wing, Cooper, & Sartorius, 1974) was used to assess depression and other psychiatric disorders for the 12 months or so before each interview carried out in the original 3-year study period, starting in 1980. Ratings of *caseness* are based on the frequency and severity of key symptoms and have good interrater reliability (Finlay-Jones et al., 1980). The threshold for caseness has been compared favorably with those of other well-known diagnostic systems (Dean, Surtees, & Sashidharan, 1983). Onset and offset of case depression episodes were documented throughout the study period. In addition, a four-level index of current depressive symptoms was created to denote level of depression at interview (see Andrews & Brown, 1993); 7 women were currently depressed at a *case* level, 1 at *high borderline case* level, and 1 at *medium borderline case* level. Although interrater reliability was not formally examined in the present study, interviewers were extensively trained, and throughout the study further checks were made on their standards. Difficult decisions on individual symptoms and all caseness ratings were brought before a weekly team meeting for consensus rating. At the last contact in 1987–1988, the PSE covered the preceding 4 years since the woman had last been seen. The PSE has been used retrospectively by other investigators to cover longer time periods with good interrater reliability and validity (McGuffin, Katz, & Aldrich, 1986).

Psychiatric History

At the third stage of the original study a brief history of psychiatric disorder since early adulthood had been taken. This measure was used in the current study to assess whether episodes of depression earlier in a woman's life preceded or followed other factors under consideration. Age at any first episode and treatment received were established. The four categories of psychiatric history were "episode vaguely reported," "contact with doctor for definite psychiatric disorder," "psychiatric outpatient" and "inpatient." Women who had had inpatient or outpatient treatment for depression were defined as having had a case depression. Those who reported contact only with their doctor were included if antidepressant drugs had been prescribed for them.

Physical and Sexual Abuse in Childhood

Women were questioned in detail at the end of the interview about abusive experiences throughout their lives; abuse in childhood was defined as that occurring before the age of 17.

Sexual abuse. All reports of sexual abuse before the age of 17 were considered for inclusion. Sexual abuse was defined as that involving direct physical contact of the sexual parts but excluded willing contact in teenage years with nonrelated peers. These criteria are similar to those used in other studies examining the relationship of sexual abuse to depression (e.g., Burnam et al., 1988; Gold, 1986).

Physical abuse. Reports of physical violence experienced at the hands of a family member, most usually a parent, were considered only when they were not a one-time occurrence. Criteria for inclusion for such abuse followed Straus's Severe Violence Index (Straus, Gelles, & Steinmetz, 1980), which excludes milder acts of physical chastisement such as being slapped, pushed, or shoved, but includes being punched, kicked, and hit with an instrument such as a stick or a belt (see Andrews & Brown, 1988a; Andrews et al., 1990).

Physical and Sexual Abuse in Adulthood

Physical abuse. Women who were currently or had ever been in a relationship where their partner had been physically violent toward them were defined as having been physically abused in adulthood. The definition involved having been physically struck by a spouse (see Andrews & Brown, 1988a). All the women so defined had been struck more than once, and more than 90% of them had experienced severe violence according to recognized criteria (Straus et al., 1980).

Sexual abuse. Women were defined as having been sexually abused in adulthood if they had been involved in sexual contact against their will, accompanied by threats, coercion, or force, since age 17. As with the definition of sexual abuse in childhood, abuse involving no physical contact, such as exhibitionism and obscene telephone calls, was not included.

The transcribed affirmative responses by women for any form of physical and sexual abuse during their lives were brought by raters to weekly consensus meetings for confirmation that they reached criteria for inclusion on simple yes–no indexes.

Feelings of Bodily Shame

At the last contact in 1987–88, in the context of more general questions about self-esteem and body-image, women were asked: "Have you ever felt ashamed of your body or any part of it?" If there was any hint of affirmation, they were asked to describe their feelings in more detail and were also asked, "When was the first time you felt like that?", "Do you still feel like that?", and "How long did you go on feeling like that?" to ascertain onset and duration of such feelings. Elements taken into account, although not necessarily present in every case, included aspects of shame previously referred to in the literature, such as self-consciousness and embarrassment about appearance in general and about exposing specific body parts, actual concealment of different parts of the body, and feelings of mortification concerning others' comments about appearance and body parts. As with the other cognitive–affective variables described below, both frequency and intensity of comments were taken into account in the ratings. Ratings of (a) bodily shame experienced at any time and (b) current bodily shame were made on 4-point scales (4 = *marked*; 3 = *moderate*; 2 = *some*; and 1 = *little–none*). The mean score for the two scales was 1.88 (SD = 1.02) for bodily shame at any time and 1.61 (SD = .82) for current bodily shame. The mean duration of bodily shame among the 41 women who reported experiencing "some," "moderate," or "marked" shame was 17.39 years (SD = 12.33). Construct validity was assessed by correlating the shame measures with the PSE symptom representing self-consciousness. Reports of experiences of self-consciousness at any time in the 8-year period were significantly correlated with experiences of bodily shame at any time (r = .41, $p < .001$) and current bodily shame (r = .38, $p < .001$). Interrater reliability for the scale was calculated using a second independent judge who was unaware of any information about the respondent, including abuse and clinical status. Agreement between the two raters for the two shame scales was high (weighted kappa 0.87 and 0.90, respectively). Disagreements between raters were resolved by discussion.

Other Cognitive–Affective Variables

The following two measures were used to establish the discriminant validity of the shame measure:

Dissatisfaction with body–appearance. Current general dissatisfaction was rated on a 4-point scale (as above) from responses to questions concerning evaluation and dissatisfaction with body and physical appearance. Women were asked how they would describe and evaluate their appearance and also whether they were dissatisfied with their body or any part of it. The mean dissatisfaction score was 2.4 (SD = .94). Interrater reliability for the scale was 0.93 (weighted kappa).

Data for feelings of shame and dissatisfaction with the body were missing for 17 of the women. (Only after the study had started was it decided to collect this information.) Analyses concerning these measures are therefore based on a subset of 84 respondents.

Low self-esteem. The score on the current negative evaluation of self (NES) has been shown to predict depression in a longitudinal study (Brown, Andrews, Bifulco, & Veiel, 1990). It is the sum of three measures, each rated on a 4-point scale as above, with scores ranging from 3 to 12: (a) negative evaluation of personal attributes such as intelligence, temperament, and so on; (b) negative evaluation of role performance in roles such as wife, mother, and worker; and (c) self-acceptance, reflecting more generalized feelings about self. The mean NES score was 5.92 (SD = 1.64). Interrater reliability for the three NES scales has been shown to be high (see Andrews & Brown, 1993).

Results

Prevalence of Abuse Across the Life Course

Overall, 52% of the women reported having been physically or sexually abused at some time in their lives. Twenty-seven percent reported physical abuse and 12% sexual abuse in childhood, with an overall rate of 31% for any childhood abuse. For adult abuse, 33% reported marital violence and 11% reported sexual abuse, with an overall rate of 38% for any adult abuse.

Abuse Across the Life Course and Adult Depression

Abuse and Occurrence of Depression

At some time in the 8-year study period, 39% of the women had been depressed at a case level.[1] For the sake of clarity and brevity, physical and sexual abuse were combined to form two categories of abuse–no abuse in childhood and adulthood. There was a significant association between childhood abuse and depression—55% (17 out of 31) with childhood abuse had been depressed compared with 31% (22 out of 70) of the other women, $\chi^2(1, N = 101) = 4.02$, $p < .05$. Abuse in adulthood was also associated with depression. Sixty-one percent (23 out of 38) of those who had experienced such abuse had been depressed, compared with 25% (16 out of 63) who had not been abused, $\chi^2(1, N = 101) = 10.90$, $p < .001$. The relationship between childhood abuse and depression was not as strong as the relationship between adult abuse and depression, and when both childhood and adult abuse were considered together in their relation to depression, a logistic regression confirmed that only adult abuse had an independent relationship with depression. The odds ratios for childhood abuse and adult abuse were 2.2 (Wald = 2.75, $p < .1$) and 4.1 (Wald = 7.13, $p < .01$), respectively.

Abuse and Course of Depression

Women with chronic or recurrent depression were distinguished from those reporting one single episode of less than 12 months' duration to investigate depression course. Sixteen women had a single episode (none of which lasted longer than 6 months), 15 had chronic unremitting episodes ranging from 1 to 13 years, 5 had recurrent depressions with at least one chronic episode, and 3 had recurrent but nonchronic episodes. However, 2 of these 3 had subclinical depressive symptoms between episodes. Table 1 shows little difference between women with and without childhood abuse in terms of single short episodes of depression. There was, however, a strong relationship between childhood abuse and chronic or recurrent depression. When the total chi-square in Table 1 was partitioned into additive components (Bresnahan & Shapiro, 1966), 99%, $\chi^2(1, N = 101) = 12.75$, $p < .001$, was due to chronic or recurrent depression (vs. single episodes or no depression).[2] Both childhood physical and sexual abuse were independently related to such depressions when a logistic regression analysis was carried out. The odds ratios were 3.1 (Wald = 4.22, $p < .05$) and 6.6 (Wald = 7.07, $p < .01$), respectively.

Adult abuse was also related to chronic or recurrent depression (see Table 1). When the total chi-square in Table 1 was partitioned into additive components, 73%, $\chi^2(1, N = 101) = 9.66$, $p < .01$, was due to such depressions (vs. single episodes or no depression). The remaining 27% was due to single episodes (vs. no depression); this proportion was only marginally significant, $\chi^2(1, N = 101) = 3.61$, $p < .1$. Both adult sexual abuse and marital violence were independently related to chronic or recurrent depression when they were considered together. The odds ratios were 3.9 (Wald = 3.89, $p < .05$) and 3.9 (Wald = 7.34, $p < .01$), respectively.

When both childhood and adult abuse were considered together, both were needed to predict chronic or recurrent depression (Table 2). Childhood abuse increased the odds of being depressed nearly fivefold; adult abuse increased the odds nearly fourfold. Table 2 shows that women who had experienced both childhood and adult abuse in their lives had a particularly high risk of developing chronic or recurrent depressions. They accounted for nearly half of all such depressions. (Those with abuse at any time in the life course accounted for 83% [19 out of 23] of chronic or recurrent depressions.) To determine whether the effects of early and adult abuse were additive or interactive in predicting depression, the interaction of the two categories was entered into the logistic regression on a second step. It did not, however, significantly improve the overall model fit, $\chi^2(1, N = 101) = .07$.

Abuse and Severity of Depression

Severity was investigated by comparing the number of core depressive PSE symptoms (Finlay-Jones et al., 1980) in the different abuse categories for the 39 women who had been depressed in the study period. The episode with the highest number of symptoms was used in the analysis where more than one episode had been recorded. Childhood abuse was associated with the highest mean number of symptoms. A two-way analysis of variance showed a significant main effect for childhood abuse, $F(1, 35) = 5.02$, $p < .03$, but not for adult abuse, $F(1, 35)$

[1] The analyses in this and the following two sections were carried out on the whole sample, regardless of whether they had a shame rating. Removing the 17 women who did not have a shame rating did not change the results.

[2] Sixty percent of women with at least one chronic episode and 67% with recurrent nonchronic episodes reported childhood abuse. When the 3 women with recurrent nonchronic episodes were excluded from the analysis, the results remained essentially the same.

Table 1
Abuse in Childhood and Adulthood by Type of Depression in the 8-Year Study Period

	Type of depression							
	Chronic–recurrent		Single episode		No depression		Total	
Abuse	*N*	%	*N*	%	*N*	%	*N*	%
In childhood								
Yes	14	45	3	10	14	45	31	100
No	9	13	13	19	48	69	70	100
In adulthood								
Yes	15	39	8	21	15	39	38	100
No	8	13	8	13	47	75	63	100

Note. For the childhood data, $\chi^2(2, N = 101) = 12.84, p < .001$; for the adulthood data, $\chi^2(2, N = 101) = 13.27, p < .001$.

= .01, *ns*. The interaction between the two abuse categories was not significant, $F(1, 35) = 3.06, p > .05$.

Abuse and Bodily Shame

The next stage of the analysis considered whether abuse was associated with bodily shame.[3] Table 3 shows the correlations between all the variables under consideration: childhood abuse, adult abuse, occurrence of depression, chronic or recurrent depression, current level of depression, current bodily shame, experience of bodily shame at any time, current dissatisfaction with body, and current NES.

Childhood Abuse and Bodily Shame—Discriminant Validity of the Shame Measure

All four cognitive–affective variables—experience of bodily shame at any time, current bodily shame, NES, and dissatisfaction with body—were significantly positively correlated with childhood abuse, which was the first variable in the hypothesized temporal chain (Table 3).[4] None of the four variables showed significant correlations with adult abuse, and body dissatisfaction was not significantly correlated with depression. Childhood abuse was therefore chosen as the most appropriate variable on which to establish the discriminant validity of bodily shame.

A paired *t* test revealed a significant difference between reports of experiencing bodily shame at any time and current bodily shame, women being more likely to report feeling shame ever than currently, $t(84) = 4.14, p < .001$. As NES and dissatisfaction with the body were measured currently and not retrospectively, the current shame measure was used in the logistic regression analysis to determine the relative contributions of the current cognitive–affective variables to predicting the likelihood of childhood abuse. When all the variables were entered simultaneously, bodily shame had an additional independent effect above the other variables, thus supporting its discriminant validity (Table 4).

Table 2
Percentage of Women With Chronic or Recurrent Depression in 8-Year Study Period by Abuse in Childhood and Abuse in Adulthood

	Abuse in childhood		
Abuse	Yes	No	Total
	% chronic or recurrent depression		
In adulthood			
Yes	63 (10/16)	23 (5/22)	39 (15/38)
No	27 (4/15)	8 (4/48)	13 (8/63)
Total	45 (14/31)	13 (9/70)	23 (23/101)

	Logistic regression analysis				
	B	*SE*	Wald	*p*	Odds ratio
In childhood	1.58	.5288	8.88	.003	4.83
In adulthood	1.34	.5309	6.36	.01	3.81

Note. All degrees of freedom equal 1.

Bodily Shame as a Mediating Factor Between Childhood Abuse and Chronic or Recurrent Depression

Childhood abuse was more strongly related to chronic or recurrent depression than to depression in general (as it was not related to single short episodes). It therefore remained to determine the role of experiences of bodily shame at any time in the link between early abuse and such depressions. To control for the possibility that current depressed mood might influence the reporting of bodily shame, current level of depressive symptoms was entered on the first step of two logistic

[3] The 84 women in these analyses did not significantly differ from the 17 who did not have shame ratings in terms of the variables in the foregoing analyses. The respective proportions were childhood abuse, 36% versus 6%, $\chi^2(1, N = 101) = 2.66$; adult abuse, 37% versus 41%, $\chi^2(1, N = 101) = 0.00$; any depression, 37% versus 47%, $\chi^2(1, N = 101) = 0.26$; and chronic–recurrent depression, 20% versus 35%, $\chi^2 = 101) = 1.06$.

[4] Both physical and sexual components of childhood abuse were separately and similarly positively correlated with the bodily shame measures, bodily dissatisfaction, NES score, and chronic–recurrent depression. The sizes of the correlations did not significantly differ.

Table 3
Correlations Between Abuse Measures, Cognitive Measures, and Depression

Measure	1	2	3	4	5	6	7	8
1. Current bodily shame[a]								
2. Bodily shame ever[a]	.78**							
3. Current dissatisfaction with body[a]	.48**	.43**						
4. NES	.19	.33*	.21					
5. Abused in childhood[b]	.41**	.49**	.29*	.33*				
6. Abused in adulthood[b]	.15	.19	.03	.07	.22			
7. Dep. level[a]	.30*	.36**	.07	.46**	.30*	.12		
8. Dep. occurrence[b]	.28	.37**	.05	.34*	.27	.33*	.40**	
9. Chronic–recurrent depression[b]	.41**	.54**	.24	.43**	.44**	.29*	.47**	.67**

Note. NES = (current) Negative Evaluation of Self (10-point scale); dep. level = level of depressive symptoms at interview; dep. occurrence = any depressive episode in 8-year study period.
[a] 4-point scale. [b] Dichotomous variable.
* $p < .01$, two-tailed. ** $p < .001$, two-tailed.

regression equations. The first confirmed childhood abuse as a significant predictor of chronic or recurrent depression when entered on its own (Wald = 8.3, $p < .01$, odds ratio = 7.1). In the second, experiences of bodily shame at any time and childhood abuse were entered simultaneously. In this equation bodily shame was the only predictor of chronic or recurrent depression, childhood abuse no longer being significant, thus demonstrating the mediating role of bodily shame (Table 5). The possibility that bodily shame moderates abuse consequences for depression was examined by entering the interaction between childhood abuse and bodily shame at any time on a third step, but no significant effect was found. These results were unchanged when current depression was left out of the equation.

Direction of Causality

As abuse, bodily shame, and chronic or recurrent depression were all significantly intercorrelated, it was possible that bodily shame was a concomitant or consequence of depression, rather than a mediating factor between abuse and depression. It is also possible that bodily shame preceded abuse, as shame-prone children and adolescents may be more likely to attract abuse. The data were therefore examined to explore the direction of causality between bodily shame reported at high level (the top 2 points on the 4-point scale) and childhood abuse and depression. This analysis was exploratory and any conclusions tentative because of the retrospective nature of the measure of bodily shame at any time. Considering that the clinical data were collected over an 8-year period, it seemed unlikely that depression would have biased reports of bodily shame. It was possible, however, that questions about early abusive experiences might have influenced recollections of when such shame began. To control as far as possible for such bias, questions about bodily shame were asked at the beginning of the interview, whereas the abuse questions were asked at the end, after much interim material had been covered. In this regard, it is of interest that abuse was not spontaneously mentioned as a likely cause of bodily shame in any of the women's accounts.

Eleven of the 18 women reporting childhood abuse (i.e., before age 17) and high bodily shame had not felt such shame before the age of 17. Of the remaining 7 women, the earliest reported age for feeling such shame was 10, and in all 7 instances examination of the accounts of childhood abuse showed that it had occurred before bodily shame was first experienced.

The 16 women who were depressed in the study period and who experienced high bodily shame all reported having first felt shame before the onset of any depressive episode. Using the measure of adult lifetime disorder (see the Method section), only one of the 16 women with depression in this longer period and high bodily shame had developed it following her

Table 4
Logistic Regression Showing the Relationship of Current Negative Evaluation of Self (NES), Current Dissatisfaction With Body, and Current Bodily Shame, to Abuse in Childhood

Measure	B	*SE*	Wald	*p*	Odds ratio
NES	.44	.19	5.37	.02	1.55
Dissatisfaction	.22	.32	0.44	.50	1.24
Current shame	.94	.37	6.44	.01	2.57

Note. All degrees of freedom equal 1.

Table 5
Childhood Abuse, Bodily Shame Ever, and Their Interaction as Predictors of Chronic or Recurrent Depression, Controlling for Current Level of Depression

Variable	B	*SE*	Wald	*p*	Odds ratio
Step 1					
Dep. level	0.80	.30	9.28	.01	2.46
Step 2					
Shame ever	1.04	.40	6.82	.01	2.83
Childhood abuse	1.09	.76	2.05	.15	2.98
Step 3					
Shame Ever × Childhood Abuse	0.44	.84	0.27	.60	1.55

Note. Dep. = depressive. All degrees of freedom equal 1. Variables were entered on the step numbers indicated in the logistic regression.

first onset of depression (she had four additional episodes); for the rest of the women, high bodily shame preceded the first episode.

Discussion

The present study set out to explore the relation of abuse to bodily shame and bodily shame to depression. As hypothesized, bodily shame appeared to account for the relationship between early abuse and depression in adulthood. However, whereas adult abuse was related to depression, it was not related to bodily shame.

To my knowledge, no other study to date has tested empirically the relation between shame and abuse. Replication of a link between shame (in its bodily form) and depression in a community sample using a standardized measure of clinical depression and different methodology to that used in previous studies adds weight to existing evidence (Hoblitzelle, 1987; Tangney et al., 1992). The association between bodily shame, measured in the current study period, and the longitudinal measure of depression could not be explained by current level of depressive symptoms, suggesting that shame proneness, at least in relation to the body, may be a vulnerability factor for depression, or an influence on its course, rather than simply a concomitant of negative affectivity.

Overall, a particularly high lifetime rate of abuse was reported in this group of high-risk women. Around half reported physical or sexual abuse at some time in their lives, and just under a third reported abuse in childhood. It is possible that adult accounts of such early experiences are affected by memory bias. However, a recent review concluded that retrospective reports are likely to be reasonably valid provided they are restricted to factual accounts of significant episodes occurring after the period of infant amnesia. Furthermore, no convincing evidence was found that such reports were compromised by current psychiatric status (Brewin, Andrews, & Gotlib, 1993). The results are therefore presented with some confidence that they are reflecting effects worthy of consideration.

Depression was also a fairly common experience in this high-risk sample. Nearly 40% reported at least one episode of depression reaching case criteria over an 8-year period. Both childhood and adult abuse were related to the occurrence of depression, but the relation between childhood abuse and depression was strengthened when chronic or recurrent depression was distinguished from single short episodes, as such abuse was associated with the former but not the latter. There was a strong independent relationship between early abuse and these persistent depressions, although the highest rate was among those who had also been abused in adulthood. Adult abuse therefore appeared to increase the risk of chronic and recurrent depression among those with early experiences of abuse.

The prediction that bodily shame would be associated with childhood abuse was confirmed. This association could not be explained by two other related variables: low self-esteem or dissatisfaction with the body. Indeed, current bodily dissatisfaction was not independently related to early abuse, suggesting it was the specific element of shame in the measure that was critical, rather than any related general negative evaluations of the body. However, adult abuse was not significantly correlated with any of the cognitive factors measured in the study. Therefore, bodily shame appears to be rooted in childhood experiences and not usually the result of later abusive experiences alone. The majority of those experiencing adult abuse in the form of marital violence reported that it had occurred in the past, rather than currently. This raises the possibility that some other cognitive factor evoked at the time by the experience, such as helplessness, CSB (Andrews & Brewin, 1990), or shame in some other form not measured in this study, is involved in the relation of adult abuse to depression.

The results provide some support for Finkelhor and Browne's (1986) hypothesis relating early sexual abuse to shame through stigmatization, although their theory would not predict a relation between early physical abuse and bodily shame. The findings may be better understood in the context of Gilbert's (1989) proposal that shame is the consequence of subordinate or defeat states that are implicit in any form of abusive victimization, particularly as this theory emphasizes the centrality of bodily concerns in the experience of shame. However, the theory does not specify a critical period in human development when shame proneness is more likely to take root.

Even in the absence of early abuse, those with prior bodily shame had a higher risk of chronic or recurrent depression than those who did not report shame. The major feature of such depressions was their enduring quality—only 3 of the 23 cases had nonchronic but recurrent episodes, and 2 of these had chronic subclinical symptoms between episodes. It seems likely, therefore, that early abuse and bodily shame may be particularly relevant to issues concerning recovery, although this does not necessarily rule out their relevance to onset or exacerbation of depression. Those reporting early abuse also suffered more depressive symptoms than other women when they became depressed. The relation of abuse to chronicity and severity of depression is consistent with evidence from clinical studies (Bryer et al., 1987; Carmen et al., 1984). The present findings suggest a complex relationship between abuse, bodily shame, and severity of depression in their relation to the course of depression. Further understanding of the influence of the factors on each other merits more attention in a clinical sample.

However, other biographical, situational, and possibly related

cognitive factors are probably involved in the link between early abuse and adult depression. For example, childhood abuse is likely to be embedded in other adverse childhood factors (Briere, 1988), and experiences such as emotional and material deprivation may also play a role in the associations reported in this article. Further investigation of these factors is needed. The interaction of proximal situational factors with the experience of shame also merits further attention. It is possible that particular life events, or chronic problems involving hostile reactions and rejection in intimate sexual relationships, may be more likely than other stressors to provoke or exacerbate bodily shame in those already prone to such feelings, whether prior to onset or during the course of depression.

The women's accounts reflected aspects of shame already outlined in the literature (e.g., Gilbert, 1989; Lewis, 1986; Wicker et al., 1983). The two main themes in the content of the accounts involved individual concerns about bodily appearance in the eyes of others, and behavior involving concealment of the body. The majority focussed feelings of shame on specific parts of the body, in particular, breasts, buttocks, stomach, and legs. One woman recalled she would not get into the communal shower when she was at school unless she was wearing her underwear. Another reported how she would not go anywhere without a jacket to cover her arms, even in hot weather. Several women spontaneously reported feeling so ashamed of their bodies they would not let their husbands see them undressed. The accounts illustrate how bodily shame may differ from bodily dissatisfaction and low self-esteem. Both these factors involve not living up to one's own standards (which may reflect societal and cultural values), but they do not necessarily involve concealment of supposed deficiencies and inordinate concern about how one appears to others.

The measure of shame in the current study was simple, asked about shame at any time, and asked only one direct question to elicit a general response. It is noteworthy, therefore, that it proved so sensitive in terms of supporting the hypotheses, despite the possibility that the retrospective aspect of the measure may have been open to memory bias. However, the women appeared able to recall feelings of shame about their bodies with no apparent difficulty, recalling shame when it was no longer felt and making the distinction between what was felt at the time and what they were feeling currently. The simplicity of the measure suggests that the results are of potential value for clinicians working with abuse survivors, as responses to questions about bodily shame appear to be readily elicited, given the right conditions. However, it is possible that the effects observed also pertain to shame about nonphysical personal attributes, and this possibility requires further investigation.

Further evidence of the validity of the measure of experiences of bodily shame at any time was provided by its correlation with the symptom of self-consciousness, reported as part of the longitudinal clinical data. This symptom was related to questions about actual social situations in which people may suffer from such feelings, whereas the question pertaining to shame related to a common focus—physical aspects of the self. The development of further questions, taking situational, bodily, and nonphysical personal attributes into account, either for use in an interview or in questionnaire form, may help to shed light on some of the dynamics relating abuse to shame and shame to depression.

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