"I Still Feel Like I Am Not Normal": A Review of the Role of Stigma and Stigmatization Among Female Survivors of Child Sexual Abuse, Sexual Assault, and Intimate Partner Violence

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Abstract

Child sexual abuse (CSA), sexual assault (SA), and intimate partner violence (IPV) occur within social contexts that shape how survivors judge themselves and are evaluated by others. Because these are gendered sexual and intimate crimes that violate social norms about what is appropriate and acceptable, survivors may experience stigma that includes victim-blaming messages from the broader society as well as specific stigmatizing reactions from others in response to disclosure; this stigmatization can be internalized among survivors as self-blame, shame, and anticipatory stigma. Stigma and stigmatization play an important role in shaping survivors' thoughts, feelings, and behaviors as they recover; their risk of revictimization; and their help-seeking and attainment process. In this review, we synthesize recent CSA, SA, and IPV research ($N = 123$) that examines female survivors' self-blame, shame, internalized stigma, and anticipatory stigma as well as negative social reactions in response to survivors' disclosure. We highlight critical findings as well as implications for research, practice, and policy, and we note gaps in our current knowledge.

Child sexual abuse (CSA), sexual assault (SA), and intimate partner violence (IPV) occur within social contexts that shape how survivors judge themselves and are evaluated by others. Because these are gendered sexual and intimate crimes that violate social norms about what is appropriate and acceptable, survivors may experience stigma that includes victim blaming from the broader society as well as stigmatizing reactions from others in response to disclosure. Goffman, in his 1963 hallmark work on stigma theory, conceptualized stigma as a dynamic social process that discounts certain groups or individuals based on their perceived inferior moral status and rationalizes animosity toward them; his work explored how those who are stigmatized internalize this discounting as self-blame, shame, and the anticipation of negative judgments by others should their secret be revealed. Building on Goffman's work, contemporary scholars have explored aspects of stigma such as labeling and discrimination, and elements of stigmatization such as status loss and isolation, and detailed how they function in tandem to enforce norms and trigger behavioral adaptations such as passing (disclosure avoidance) among those who are stigmatized (Bos, Pryor, Reeder, & Stutterheim, 2013; Link & Phelan, 2001).

Stigma theorists have explored the intricacies of both stigma and stigmatization, and early conceptual work by Finkelhor and Browne (1985) vividly captures the role of stigma by external others, and how it may become internalized as stigmatization by CSA survivors:

[Stigma and stigmatization refer] to the negative connotations— *e.g.,* badness, shame, and guilt—that are communicated to the child around the experiences and that then become incorporated into the child's self-image. These negative meanings are communicated in many ways. They can come directly from the abuser, who may blame the victim for the activity, demean the victim, or furtively convey a sense of shame about the behavior. Pressure for secrecy can also convey powerful messages of shame and guilt. But stigmatization is also reinforced by attitudes that the victim

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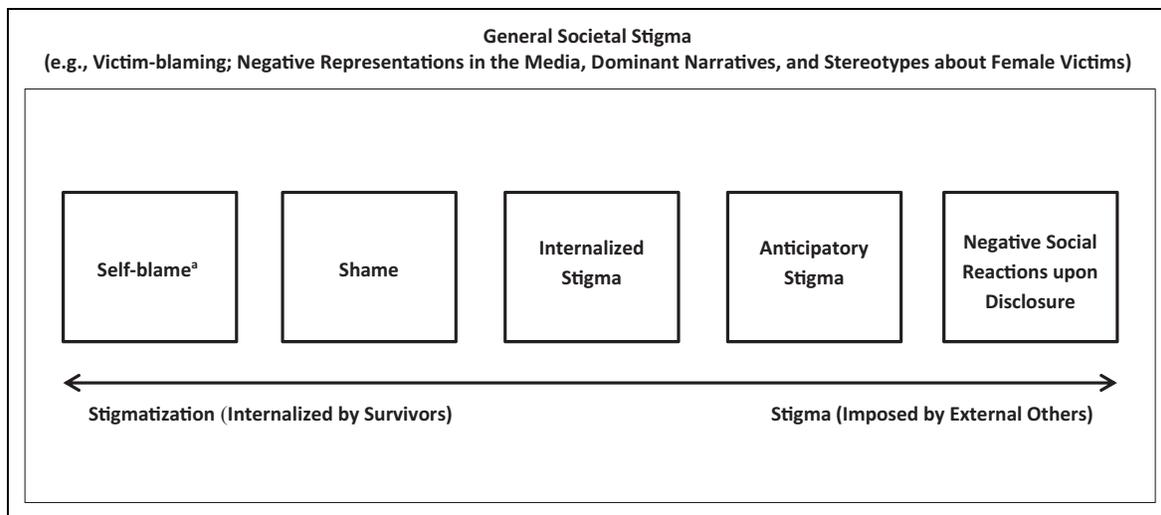
Figure 1. Forms of stigma and stigmatization. Although general societal stigma toward female survivors is not examined in the empirical child sexual abuse, sexual assault, and intimate partner violence literature and thus not covered in the review, we have included it here to emphasize its overarching role in influencing all forms of stigma and stigmatization experienced by survivors. [a]Within the sexual assault literature, self-blame is sometimes further delineated into behavioral and characterological self-blame.

infers or hears from other persons in the family or community. Stigmatization may thus grow out of the child's prior knowledge or sense that the activity is considered deviant and taboo, and it is certainly reinforced if, after disclosure, people react with shock or hysteria, or blame the child for what has transpired. (pp. 532–533, italics in original)

Thus, from this perspective, a survivor of abuse or assault may learn through the broader societal context, via media representations, dominant narratives, stereotypes, and so on, that certain behaviors are considered to be morally and socially unacceptable, and certain statuses—incest victim, rape victim, and abused woman—are stigmatized and blameworthy. This broader, more general stigma conveyed to the survivor may be compounded by specific victim-blaming responses from family members, friends, partners, and/or service providers upon disclosure.

Despite this early, influential conceptualization of both stigma and stigmatization, within the fields of CSA, SA, and IPV the focus has almost exclusively been on survivors' internal stigmatization such as self-blame, shame, internalized stigma, and anticipatory stigma. By and large, researchers have failed to explore broader societal stigma processes and effects, instead focusing on stigmatization at the intraindividual level as experienced by survivors. A notable exception to this general focus has been a concerted effort by SA researchers to examine survivors' reports of victim-blaming social reactions by informal and formal support providers. Thus, this review will follow the available empirical literature and focus on female survivors' self-blame, shame, internalized stigma, and anticipatory stigma (all types of internalized stigmatization at the individual survivor level) as well as stigmatizing social reactions in response to survivors' disclosure (a form of stigma imposed by external others).

Before proceeding, we draw on the CSA, SA, and IPV literature for definitions of the different types of stigma and stigmatization we will review. While CSA, SA, and IPV researchers have not examined the role of general societal stigma (e.g., victim blaming; negative media representations, dominant narratives, and stereotypes about victims) in shaping stigmatization, it is understood that this internalizing of stigma by individuals could not occur without prior exposure to victim-blaming messages from the broader society (Finkelhor & Browne, 1985; see Figure 1). Stigmatization includes cognitive, affective, and behavioral dimensions at the individual level (Dovidio, Major, & Crocker, 2000). *Self-blame* is conceptualized as a cognitive attribution by a survivor, in which she places blame for the abuse/assault on herself; it is understood as internal, stable, and global (Feiring, Taska, & Lewis, 1996). Building on the work of Janoff-Bulman (1979), in which she conceptualized two distinct types of self-blame, some SA researchers further delineate self-blame into *behavioral self-blame*, defined as a cognitive attribution of blame that rests on one's own controllable behavior, and *characterological self-blame*, understood as a cognitive attribution that emphasizes one's nonmodifiable character as at fault (Hassija & Gray, 2013; Koss, Figueredo, & Prince, 2002).

Shame is the key affective component of stigmatization following abuse or assault; it is defined as a moral emotional response, in which the survivor feels deeply unworthy, defective, and debased in comparison to others (Bonanno et al., 2002; Negrao, Bonanno, Noll, Putnam, & Trickett, 2005). *Internalized stigma* is a composite concept that includes aspects of self-blame, shame, and anticipatory stigma (Gibson & Leitenberg, 2001). *Anticipatory stigma* is a belief by the survivor that, should she reveal the abuse or assault to others, she will be stigmatized as blameworthy and lesser (Goffman, 1963; Overstreet & Quinn, 2013). Each of these forms of

stigmatization is associated with adaptive behaviors such as avoidance, lack of disclosure, and isolation; for example, IPV researchers have found that anticipatory stigma is a barrier to help seeking and attainment among survivors. Finally, *negative social reactions* in response to disclosure are a type of stigma frequently explored by researchers, particularly in the SA field; these negative reactions (e.g., by family, friends, partners, and service providers) include responses such as attempts to take control or distract; we focus here on those specific social reactions that are perceived as stigmatizing or victim blaming by survivors (Ullman & Filipas, 2001).

Stigma and stigmatization play a critical role in shaping survivors' thoughts, feelings, and behaviors as they recover; their risk of revictimization; and their help-seeking and attainment process (Kennedy et al., 2012). The vast majority of CSA survivors do not disclose during childhood in part because of anticipatory stigma (Ullman, 2003); women who have been raped may be blamed for their own assaults when they seek help, thus exacerbating their trauma (Campbell, 2008); and survivors of IPV may feel shunned by their own families and communities, furthering the isolation enforced by their partners (Sylaska & Edwards, 2014). These experiences are fundamentally about stigma and stigmatization, which cut across each form of victimization and unite survivors with their powerful effects.

While stigma and stigmatization have been conceptualized as key elements in theoretical models of post-CSA sequelae and help seeking among IPV survivors (Finkelhor & Browne, 1985; Overstreet & Quinn, 2013) and have been examined within the fields of CSA, SA, and IPV, our review represents the first time that the stigma and stigmatization research literature across each area has been synthesized. Including research from all three fields is merited because forms of victimization are likely to co-occur, the boundaries between each research area are not clearly demarcated (e.g., sexual violence by a partner may be categorized as CSA, SA, or IPV, depending on the survivor's age and the researcher's perspective), and we can gain a deeper understanding through a comparative review across each field (Hamby & Grych, 2013). We have organized the literature into broad sections (CSA, SA, IPV, then co-occurring CSA, SA, and/ or IPV); we chose to do this because of the large number of studies we reviewed and because researchers within particular subfields tend to develop their own particular foci (e.g., the delineation in some SA research into the two types of self-blame). Within each section, we present the literature in accordance with the order shown in Figure 1, moving from the internalized stigmatization types of self-blame, shame, internalized stigma, and anticipatory stigma to negative social reactions, a form of stigma imposed on survivors by external others.

Typically, researchers have used cross-sectional designs to both qualitatively and quantitatively examine the different types of stigma and stigmatization as immediate sequelae of the abuse or assault, which are then linked to poor outcomes such as posttraumatic stress disorder (PTSD), psychological distress, failure to seek help, and so on; occasionally, researchers have assessed the different forms as moderators or mediators and used longitudinal designs. We have organized the review in this order, from simpler designs with fewer variables to more complex. Further, we present literature that focuses on one type of stigma or stigmatization before presenting literature that examines more than one type at once, given that the former provides a logical foundation for the latter (e.g., a subsection on SA and negative social reactions is followed by a subsection of literature that explores SA, self-blame, internalized stigma, and/or negative social reactions in combination). Because we know that stigma and stigmatization are social processes grounded in societal, community, neighborhood, and family contexts and that survivors from a disadvantaged social location oftentimes experience greater stigma and barriers to help seeking compared to their more advantaged peers (Kennedy et al., 2012), we include information on race/ethnicity, class, age, sexual orientation, immigration status, and setting (e.g., community vs. college) whenever possible. At the conclusion of our review, we highlight key themes and findings as well as implications for research, practice, and policy; and we note gaps in our current knowledge.

Method

We identified relevant studies using multiple search approaches: In addition to conducting searches via Medline, PsycINFO, Scopus, and Social Sciences Citation Index, we reviewed the reference lists of previously identified stigma-related studies as well as each issue of 10 leading violence journals. Articles were eligible for inclusion in the review if they reported on studies that included CSA, SA, and/or IPV plus any aspect of stigma or stigmatization related to victimization (self-blame, shame, internalized stigma, anticipatory stigma, and/or negative social reactions involving victim blaming or stigmatizing), focused on the point of view of female survivors (e.g., we did not include studies of police officers' perceptions of SA victims), were published in a peer-reviewed journal between January 2000 and September 2015, and were conducted in the United States. See Figure 2 for further details about the search strategy, which yielded 14 CSA articles (1 qualitative, 13 quantitative, with 3 longitudinal); 58 SA articles (6 qualitative, 5 mixed methods, 47 quantitative, with 11 longitudinal); 38 IPV articles (20 qualitative, 3 mixed methods, 15 quantitative, with 1 longitudinal); and 13 co-occurring CSA, SA, or IPV articles (all 13 quantitative, with 1 longitudinal) for a total of 123.

CSA, Stigma, and Stigmatization

Influential conceptual models within this area include Finkelhor and Browne's (1985) traumagenic model, which emphasizes stigmatization as a critical sequela of CSA, and Feiring, Taska, and Lewis' (1996) process model, which conceptualizes poor adjustment following CSA as mediated by increased negative cognitive attribution (e.g., self-blame) and shame, the latter understood as the primary affective component of stigmatization.
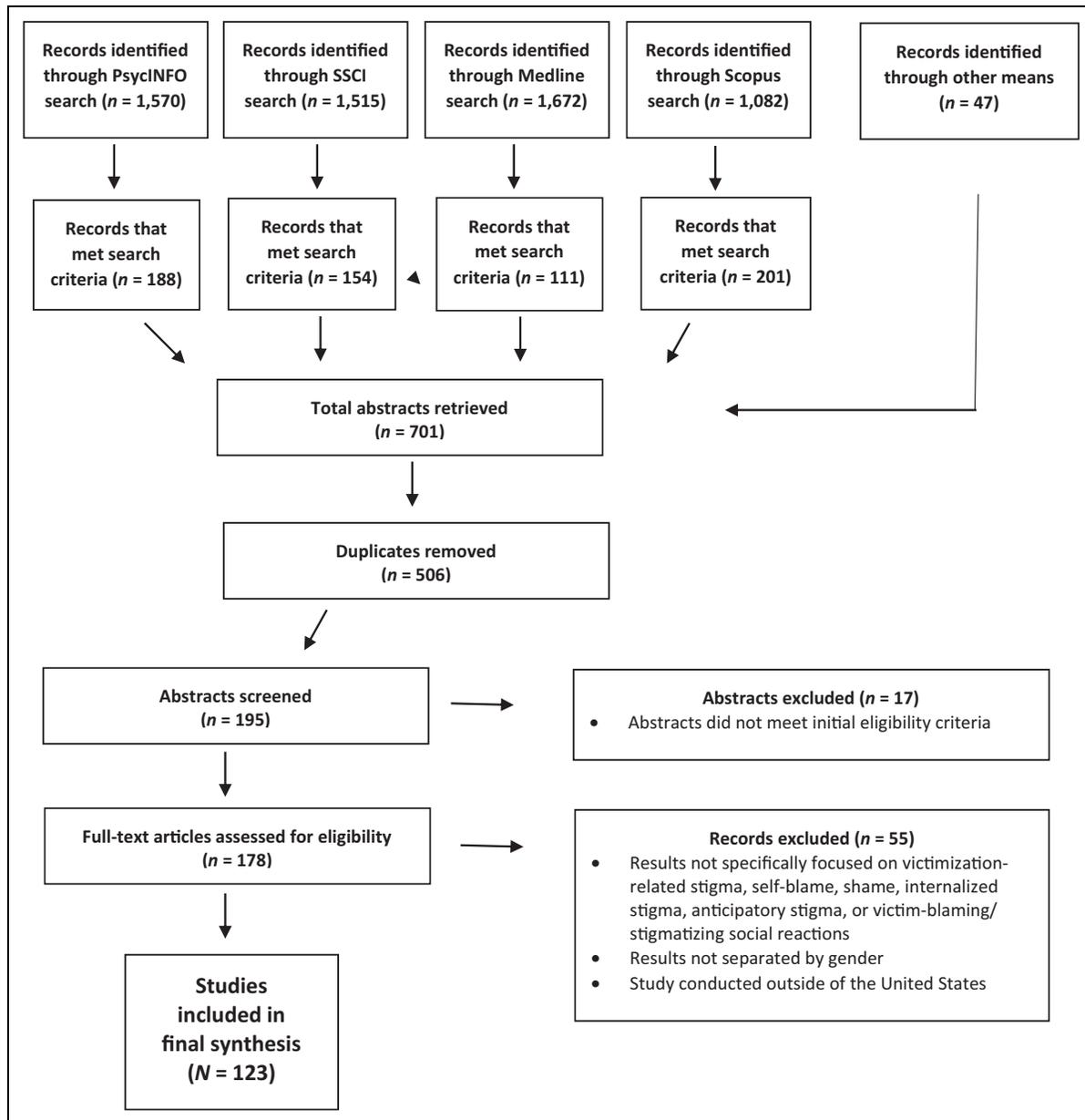
Figure 2. Figure based on preferred reporting items for systematic reviews and meta-analyses group model. *Source.* Adapted from Moher, Liberati, Tetzlaff, Altman, and The Preferred Reporting Items for Systematic Reviews and Meta-Analyses Group (2009). *Key words*: (stigma* OR shame* OR prejudice OR discrimination OR stereotype* OR labeling OR "status loss" OR blame OR "victim blame" OR "social reaction" OR "social reaction questionnaire" OR SRQ) AND (women OR girls OR survivor OR victim OR "female survivor" OR "female victim" OR children OR adults) AND ("sexual abuse" OR "sexual assault" OR rape OR incest OR "sexual victimization" OR "dating violence" OR "intimate partner violence" OR battering OR "domestic violence").

CSA, Self-Blame, and Shame

Self-blame has been associated with abuse severity as well as a variety of poor outcomes, including PTSD, affect dysregulation, and maladaptive coping. Among low-income Mexican American and White CSA survivors, Latina participants reported more self-blame, with self-blame linked to higher rates of abuse by a family member (Katerndahl, Burge, Kellogg, & Parra, 2005). In a predominantly White community sample, survivors' self-blame was associated with PTSD

(Owens & Chard, 2001), while Johnson and Lynch (2013) found that self-blame mediated the effects of CSA (defined as forced sexual contact prior to age 14) on PTSD and affective dysregulation, which in turn predicted maladaptive coping, among incarcerated women (82% White). Utilizing a college sample (73% White, upper-middle class), CSA age of onset, duration, and severity, along with peer perpetration, predicted self-blame, while self-blame was a predictor of PTSD, after controlling for a variety of abuse- and family-related variables (Zinzow, Seth, Jackson, Niehaus, & Fitzgerald, 2010).

Building on and testing their process model involving CSA, self-blame, and shame as predictors of poor adjustment (Feiring et al., 1996), Feiring and colleagues have conducted extensive research with a diverse, low-income longitudinal sample who were verified CSA victims. We focus here on studies that report gender-specific results; we include gender comparisons insofar as they provide the necessary foundation to interpret the female participants' results. In the first study, Feiring, Rosenthal, and Taska (2000) found that both self-blame and shame declined between Time 1 and Time 2 (1 year later). Girls reported higher satisfaction with same-sex peers, with self-blame and shame at Time 1 related to less satisfaction with same-sex support and lower peer acceptance, respectively, at Time 2. In the second study, girls had higher abuse severity and shame at Time 1, with steeper declines in shame over time, versus boys. Reduction in self-blame over time was associated with a decrease in PTSD at Time 2, while reduction in shame over time was linked to declines in PTSD and depression and increased self-esteem (Feiring, Taska, & Lewis, 2002). In the third study, Feiring, Miller-Johnson, and Cleland (2007) explored internalized stigma, anger, peer deviance, and delinquency over 3 time points. Female youths reported more internalized stigma at Time 2, which predicted increased anger at Time 3, although they had lower rates of delinquency; internalized stigma at Time 2 mediated the effects of Time 1 internalized stigma on Time 3 anger, peer deviance, and delinquency.

CSA, Self-Blame, Shame, and Anticipatory Stigma: Effects on Disclosure

A recent qualitative study of adult Pacific Islander CSA survivors revealed that, as members of a collectivist culture, many accepted blame for the abuse and sought to protect family members from the associated shame by either delaying or avoiding disclosure (Xiao & Smith-Prince, 2015). In two lab studies of verbal and nonverbal shame and disclosure among young adult survivors with verified CSA histories, the researchers found that nonverbal shame was higher among survivors whose CSA was accidentally discovered, in comparison to those who disclosed during childhood (Bonanno et al., 2002; Negrao, Bonanno, Noll, Putnam, & Trickett, 2005). Further, nonverbal shame was higher among those who did not disclose during the study when asked to describe their most distressing life event, versus those who did disclose, with the study nondisclosers who displayed nonverbal shame coupled with abuse-related humiliation demonstrating higher levels of PTSD.

CSA, Self-Blame, and Negative Social Reactions

Using a diverse sample of female college students including CSA survivors and those reporting nonvictimization negative life events prior to age 18, Palo and Gilbert (2015) found that CSA survivors had higher rates of depression, PTSD, and somatic complaints; CSA survivors who reported negative reactions in response to disclosure had higher anxiety, PTSD, and somatic symptoms compared to participants who disclosed negative life events. In a community-based study with African American and Latina CSA survivors, although a link between victim-blaming reactions and depression was not supported, self-blame in interaction with disclosure resulted in higher levels of depression among African American participants (Sciolla et al., 2011). In two studies with a diverse college sample that included CSA survivors (defined as a range of sexually abusive acts before age 14, by a perpetrator at least 5 years older), female survivors reported more self-blame and PTSD symptoms, in comparison to male survivors, but similar levels of negative reactions; self-blame at the time of the abuse was associated with negative reactions upon disclosure, with the latter predictive of increased PTSD, after controlling for abuse severity, coping, and current self-blame (Ullman & Filipa, 2005a). Among the female CSA survivors, self-blame decreased from the time of the abuse (56%) to the present (42%) with no racial/ethnic differences in levels of self-blame; upon disclosure, Asian American survivors reported more negative reactions than Latinas (Ullman & Filipa, 2005b).

SA, Stigma, and Stigmatization

Influential conceptual models in this area include Janoff-Bulman's (1979) model of two forms of self-blame, post-SA: She conceptualized behavioral self-blame as adaptive because behavior is perceived to be within one's control, while characterological self-blame was understood as maladaptive because character is not modifiable—thus, the person feels as though she deserves it when bad things happen to her. Ecological theory, with its focus on how individual development is influenced by multiple systems levels such as family, institutions, community, and culture, has been critical in understanding how negative social reactions and secondary victimization experienced by SA survivors upon disclosure have exacerbated their trauma across a variety of outcomes (Campbell, Dworkin, & Cabral, 2009; Ullman, 2010).

SA and Self-Blame (Behavioral, Characterological, and General)

There is little current empirical support for Janoff-Bulman's (1979) conceptualization of behavioral self-blame, post-SA as promotive for survivors' recovery. Instead, behavioral self-blame has typically been linked with poor outcomes, although the relationship between characterological self-blame and negative sequelae is stronger. In studies involving community and college samples of predominantly White female survivors who reported a range of forced sexual contact, behavioral self-blame has been associated with depression, social withdrawal, psychological distress, and labeling sexual coercion as serious miscommunication (Frazier, Mortensen, & Steward, 2005; Orchowski, Untied, & Gidycz, 2013a; Walsh & Bruce,

2011), while characterological self-blame—but not behavioral—has been linked to psychological distress, after controlling for assault severity and other factors (Breitenbecher, 2006; Koss et al., 2002). Two studies have offered more equivocal findings: In one, behavioral self-blame in interaction with perceptions of future SA avoidability predicted reduced depression and PTSD, while the second found that behavioral self-blame was associated with reduced global distress (Hassija & Gray, 2013; Koss et al., 2002). Finally, two studies that assessed for general self-blame within college students who reported rape or attempted rape found that survivors were more likely to blame themselves in comparison to third parties (e.g., friends), with self-blame associated with negative self-cognitions and higher rate of ''shoulds'' and ''what ifs'' in reaction to the assault (Miller, Handley, Markamn, & Miller, 2010; Perilloux, Duntley, & Buss, 2014).

Recent longitudinal research has refuted Janoff-Bulman's (1979) theory that behavioral self-blame positively improves survivors' recovery. Koss and Figeuredo (2004), in a follow-up to their cross-sectional study detailed above, found that decreasing behavioral self-blame over time predicted decreased maladaptive beliefs, which in turn predicted reduced psychosocial distress, within a mostly White community sample who had been raped. Two studies by Frazier using a sample of women recruited at emergency rooms (77% White) indicated that declining behavioral self-blame over time was associated with reduced psychological distress, while increased behavioral self-blame was positively linked to social withdrawal, which predicted psychological distress (Frazier, 2003; Frazier et al., 2005). Among predominantly White college students who had experienced forced sexual contact, behavioral self-blame at Time 1 predicted later sexual revictimization, while Time 1 behavioral and characterological self-blame were associated with decreased sexual assertiveness, which in turn predicted revictimization (Katz, May, Sörensen, & DelTosta, 2010; Miller, Markman, & Handley, 2007).

SA, Self-Blame, Shame, and Anticipatory Stigma: Effects on Disclosure and Help Seeking

Research in this area has focused on how these forms of internalized stigmatization act as a barrier to disclosure, either to people in general, or to formal systems such as medical staff and law enforcement (LE). In a qualitative study involving incarcerated women who had been raped prior to prison (66% White), survivors discussed self-blame and shame and described how these feelings, along with anticipatory stigma, kept them from disclosing: "It's not something we wanted brought up and I didn't want to be ashamed and embarrassed and raked through the coals" (Heath, Lynch, Fritch, McArthur, & Smith, 2011, p. 602). In a second qualitative (case) study of a rural lesbian woman who was raped by a woman, she similarly expressed shame and the need to hide the assault from both the lesbian, gay, bisexual, and transgender and broader community in order to avoid humiliation and scandal (Wang, 2011). In a related vein, an online survey of women (mostly White, educated) who had

been raped found that those disclosing for the first time during the survey had higher self-blame than previous disclosers (64% vs. 39%), with first-time disclosers much more likely to have never sought therapy (Carretta, Burgess, & DeMarco, 2015). Indeed, Patterson, Greeson, and Campbell's (2009) qualitative study with a diverse sample of rape survivors who had never disclosed, echoed these findings of self-blame and shame as key barriers: " . . . . why would I talk to somebody? I was at fault. I blamed myself so heavily and felt so guilty" (p. 130).

Anticipatory stigma may prevent survivors from sharing the assault with a variety of different formal providers, including health-care personnel (Sturza & Campbell, 2005) and LE (Jones, Alexander, Wynn, Rossman, & Dunnuck, 2009). If you anticipate that you are going to be characterized as a liar or blamed for your own assault, why seek help? Weiss' (2010) qualitative analysis of survivors' narratives from the National Crime Victimization Survey lends support to this view: Self-blame, shame, and anticipatory stigma emerged as key barriers to disclosure to LE, with rape survivors (vs. attempted rape), younger and adolescent victims, and sexual IPV survivors (vs. those assaulted by a nonpartner) endorsing more stigmatization and reluctance to disclose. SA survivors who are especially wary of interacting with LE, such as Native American women, may be more likely to perceive that they will be blamed or not believed (Hamby, 2008). Two quantitative studies with female college students (the vast majority White) who reported forced sexual contact, echo these findings: Zinzow and Thompson (2011) found that self-blame was a predictor of shame and nondisclosure, after controlling for a variety of variables, while Miller, Canales, Amacker, Backstrom, and Gidycz's (2011) longitudinal study showed that anticipatory stigma–motivated nondisclosure to LE at Time 1 increased the odds of revictimization by Time 2 (4 months later).

SA and Negative Social Reactions

When SA survivors *do* tell people about what happened to them, they frequently face negative reactions such as victim blaming and disbelief, especially from formal providers such as LE; these experiences, termed the second rape or secondary victimization, exacerbate survivors' PTSD and can impede the receipt of effective formal help that meets their needs and facilitates recovery (Campbell, 2008; Kennedy et al., 2012). Utilizing diverse community-based samples of women who had been sexually assaulted and disclosed to at least one person, researchers have explored the relationships between negative reactions, type of disclosure recipient (informal vs. formal), relationship quality, and self-esteem using mixed methods. Results from these studies indicate that most social reactions are mixed and involve at least one blaming reaction perceived as hurtful by the survivor; negative reactions from intimates are associated with relationship deterioration, with partners' stigmatizing reactions perceived as most hurtful (Ahrens & Aldana, 2012; Ahrens, Cabral, & Abeling, 2009). Women who disclosed to both informal and formal supports reported more negative than positive reactions, with blaming reactions associated with reduced self-esteem (Ahrens,

Campbell, Ternier-Thames, Wasco, & Sefl, 2007; Filipas & Ullman, 2001). Finally, negative reactions were associated with increased rates of PTSD, depression, and health problems (Ahrens, Stansell, & Jennings, 2010).

The quantitative results mirror these mixed methods findings. Beginning with general social reactions (vs. those from informal and/or formal supports), Ullman and colleagues have examined relationships between negative reactions, assault and survivor characteristics, and survivors' outcomes within a diverse urban sample of women who reported forced sexual contact since the age of 14 (with most reporting rape). Negative reactions have been linked to PTSD and reduced perceived helpfulness of mental health providers with sexual minority survivors, Latinas (vs. White survivors), and gang rape victims most likely to report negative reactions (Sigurvinsdottir & Ullman, 2015a; Starzynski & Ullman, 2014; Ullman, 2007; Ullman & Filipas, 2001; Ullman & Peter-Hagene, 2014); longitudinal analysis indicated that negative reactions predicted revictimization over the course of a year (Mason, Ullman, Long, Long, & Starzynski, 2009). In two studies—one cross sectional, the second longitudinal—with the same sample of female college students (94% White, upper income) who reported forced sexual contact, victim-blaming reactions were linked to survivors' reduced self-esteem and problem-solving coping as well as later hostility and paranoia (Orchowski & Gidycz, 2015; Orchowski, Untied, & Gidycz, 2013b).

With a diverse sample of rape survivors recruited from a large urban setting, Campbell and colleagues have examined how negative social reactions perceived as hurtful from both informal and formal supports further victimize survivors. Hurtful, victim-blaming reactions from friends and family have been associated with PTSD, depression, and health problems (Campbell, Ahrens, Sefl, Wasco, & Barnes, 2001); a majority of negative reactions from LE have been perceived as hurtful (52%), followed by medical personnel (29%) with hurtful LE and medical personnel reactions linked to physical and psychological distress (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001) as well as self-blame, feelings of shame, and reluctance to seek further help (Campbell, 2005). The presence of rape victim advocates at the hospital where survivors sought services was associated with decreased victim blaming from both LE and medical staff (Campbell, 2006). Similarly, findings from a diverse community sample of survivors and a survey of female veterans who had been sexually assaulted (77% African American) indicated that victim-blaming reactions from formal systems were associated with PTSD, with African American survivors particularly affected (Campbell & Raja, 2005; Jacques-Tiura, Tkatch, Abbey, & Wegner, 2010). In a study with college students (80% White, middle class), negative reactions from informal supports predicted PTSD (Borja, Callahan, & Long, 2006).

SA, Self-Blame, Internalized Stigma, and Negative Social Reactions

In the sole qualitative study in this area, using a diverse community sample, Ahrens (2006) explored how blaming reactions

upon disclosure reinforced survivors' feelings of self-blame, and internalized stigma led to their being silenced: "I felt really, really, really bad . . . I couldn't talk, look at your face. I would, I would look down 'cause I'd think you'd look and I'd be [a] filthy, dirty whore . . . " (p. 267). In a second study with a diverse community sample of SA survivors, those who acknowledged the assault as rape (vs. unacknowledged victims) reported higher levels of internalized stigma, with no differences in negative reactions (Littleton, Breitkopf, & Berenson, 2008). The results from four studies with predominantly White college samples indicate a link between being impaired or incapacitated at the time of the assault, self-blame, and avoidant coping, with internalized stigma associated with trauma symptoms; longitudinal analyses revealed that negative reactions at Time 1 predicted PTSD, though not depression, at Time 2 (Deitz, Williams, Rife, & Cantrell, 2015; Littleton, 2010; Littleton & Breitkopf, 2006; Littleton, Grills-Taquechel, & Axsom, 2009).

Ullman and colleagues have examined relationships between both forms of self-blame, negative reactions, and survivor outcomes within a diverse urban sample of women who reported a range of forced sexual contact since the age of 14 (with most reporting rape). In studies examining characterological self-blame and social reactions, self-blame has been linked to PTSD among survivors raped by nonrelative perpetrators, as well as negative reactions, although not to rate of disclosure among survivors with either normal or problem drinking (Ullman, Filipas, Townsend, & Starzynski, 2006a; Ullman, Starzynski, Long, Mason, & Long, 2008); negative, blaming reactions have been associated with self-blame, PTSD, depression, maladaptive coping, and reduced sexual assertiveness among survivors in general, with negative reactions associated only with self-blame among those with alcohol-related assaults (Relyea & Ullman, 2014, 2015; Ullman et al., 2006a). In two studies that included both forms of self-blame, examined separately, results indicated that behavioral self-blame was more common than characterological, with the former associated with age, the latter inversely related to education level; characterological self-blame, but not behavioral, mediated the effect of negative reactions on problem drinking (L. M. Long, Ullman, Starzynski, Long, & Mason, 2007; Sigurvinsdottir & Ullman, 2015b). Combined self-blame was linked to assault severity and negative reactions, with bisexual women reporting lower positive reactions compared to heterosexuals and lesbians (S. M. Long, Ullman, Long, Mason, & Starzynski, 2007; Ullman, Townsend, Filipas, & Starzynski, 2007). Longitudinal analyses support these findings, with characterological self-blame and blaming reactions as mediators of the effects of assault cluster characteristics on PTSD at Time 2, and characterological self-blame and social reactions bidirectionally or reciprocally related over time (Peter-Hagene & Ullman, 2015; Ullman & Najdowski, 2011).

IPV, Stigma, and Stigmatization

Overstreet and Quinn's (2013) IPV stigmatization model, which details the ways in which IPV-related stigmatization acts

as a barrier to help seeking, and Sylaska and Edwards' (2014) review of IPV disclosure and social reactions by informal supports provide conceptual foundations for research in this area.

IPV, Self-Blame, and Shame

Within a diverse sample of IPV survivors seeking shelter, self-blame was associated with dysphoria, after controlling for self-esteem and abuse characteristics; in a second study involving a diverse sample of poor housed and homeless IPV survivors, the latter were more likely to report self-blame for their partner abuse (Clements, Sabourin, & Spiby, 2004; Tucker, Wenzel, Straus, Ryan, & Golinelli, 2005). Self-blame was linked to decreased self-esteem, while self-blame in interaction with physical abuse predicted PTSD, such that when physical IPV was high, self-blame was associated with almost double the level of PTSD, within a diverse community sample of survivors (Reich et al., 2015); survivors with police-involved IPV who were characterized by both intermediate PTSD and low-symptom-with-high-hypervigilance PTSD profiles were more likely to report self-blame compared to those with low PTSD symptoms (Hebenstreit, Maguen, Koo, & DePrince, 2015).

Utilizing a diverse sample of survivors with police-involved IPV, Messing, Wilson, and colleagues have examined the relationships between IPV and shame: Shame was found to be a predictor of PTSD, with sexual IPV survivors reporting greater levels of shame than survivors who experienced physical IPV (Messing, Thaller, & Bagwell, 2014; Wilson et al., 2011). Among IPV survivors (60% White) seeking help at a mental health clinic, shame was linked to self-blame, with shame a moderator of the effects of emotional IPV on PTSD, such that those with both high shame and emotional abuse demonstrated significantly higher PTSD (Beck et al., 2011, 2015).

IPV, Self-Blame, Shame, and Anticipatory Stigma: Effects on Disclosure and Help Seeking

Work in this area has been almost exclusively qualitative and exploratory, as researchers have sought to understand how different types of stigmatization hinder disclosure and help seeking among IPV survivors in community settings, particularly members of marginalized groups such as immigrants, women of color, and older women. Diverse samples of survivors have described their abuse as a shameful secret that isolates them from others and provokes fear of role and status loss (e.g., losing their job or custody of their children) should their secret be revealed (Dziegielewski, Campbell, & Turnage, 2005; Fugate, Landis, Riordan, Naureckas, & Engel, 2005; Swanberg & Logan, 2005). Survivors with visible injuries as a result of the abuse poignantly talk of feeling "distanced from others, not part of the group" and "not normal," with self-blame a recurrent theme: "The way I feel is like a stupid bitch. I should have seen it coming" (Weaver, Turner, Schwarze, Thayer, & Carter-Sand, 2007, pp. 93, 96). In the sole study with a college sample (66% African American), survivors similarly voiced self-blame: "You

feel guilty, like you're not a good person if something like that could happen to you" (Amar & Alexy, 2005, p. 167).

Women who are immigrants have shared feelings of self-blame about the failure of their marriage as well as fear about how revealing the abuse would shame their families and communities and lead to ostracism and status loss; these fears are key barriers to seeking help and leaving their partner (Abu-Ras, 2003; Bauer, Rodriguez, Quiroga, & Flores-Ortiz, 2000; Crandall, Senturia, Sullivan, & Shiu-Thornton, 2005; Reina, Lohman, & Maldonado, 2014; Ting & Panchanadeswaran, 2009). Focus groups with older women echo these findings of self-blame, shame, and anticipated stigma as critical barriers (Beaulaurier, Seff, & Newman, 2008; Beaulaurier, Seff, Newman, & Dunlop, 2005; Lichtenstein & Johnson, 2009). Finally, members of religious communities as well as the lesbian community have similarly described their self-blame and shame when they are unable to live up to the idealized standard of devoted wife or good lesbian, and the shunning and status loss they face if they disclose (Hardesty, Oswald, Khaw, & Fonseca, 2011; Kanuha, 2013; Knickmeyer, Levitt, & Horne, 2010; McLeod, Hays, & Chang, 2010; Petersen, Moracco, Goldstein, & Clark, 2004).

IPV and Negative Social Reactions

Results from qualitative and mixed methods studies with diverse community samples as well as an online survey (majority White) indicate that survivors have experienced victim blaming, discrimination, and invalidation from court personnel, medical staff, and mental health providers: "The stigma within the court system was the worst. It seemed to me that the judge was yelling at me and blaming me. She often asked me why I hadn't done anything earlier and if I was telling the truth . . ." (Battaglia, Finley, & Liebschutz, 2003; Crowe & Murray, 2015, p. 170; Lutenbacher, Cohen, & Mitzel, 2003). Quantitative findings with both a diverse community sample and a predominantly White college sample have demonstrated a link between negative reactions from informal supports and psychological distress, PTSD, and reduced quality of life (Edwards, Dardis, Sylaska, & Gidycz, 2014; Goodkind, Gillum, Bybee, & Sullivan, 2003).

Two studies of the relationship between general social reactions (vs. from formal service providers or informal supports) and IPV type indicate that high rates of co-occurring IPV (physical, emotional, verbal, and/or sexual) are associated with shame and social isolation, with sexual IPV in particular linked to negative reactions (Murray, Crowe, & Brinkley, 2015; Sullivan, Schroeder, Dudley, & Dixon, 2010). Within a diverse community sample of survivors, a majority reported a mix of positive and negative reactions from social network members, with some women experiencing victim blaming, minimization, and rejection upon disclosure (Trotter & Allen, 2009); African American women recruited from shelters described being labeled "stupid" and as a source of amusement: " . . . he would talk to other people in the street . . . they would look at me and laugh" (Morrison, Luchok, Ricther, & Parra-Medina, 2006, p. 1503).

IPV, Self-Blame, Anticipatory Stigma, and Negative Social Reactions

In a diverse community sample of IPV survivors seeking an order of protection, self-blame and victim-blaming reactions were associated with PTSD and depression (Flicker, Cerulli, Swogger, & Talbot, 2012). Two studies have examined predictors of negative social reactions to disclosure by IPV survivors. In the first, a cross-sectional survey of a mostly White sample of IPV survivors, anticipatory stigma predicted survivors' indirect support seeking (e.g., seeking support without sharing the reason why), which was then linked to negative, unsupportive reactions (Williams & Mickelson, 2008). In the second, longitudinal analyses revealed that PTSD at Time 1 predicted victim-blaming reactions at Time 2; the authors hypothesized that survivors' trauma might be overwhelming to supports, which results in negative reactions in order to mitigate trauma threat (DePrince, Welton-Mitchell, & Srivinas, 2014).

Co-Occurring CSA, SA, and/or IPV, Stigma, and Stigmatization

The work in this area focuses on co-occurring CSA and SA; only one study has examined CSA in combination with IPV. Most of the research on CSA, SA, self-blame, and negative social reactions has been conducted by Ullman and colleagues using a diverse urban sample of women who had been sexually assaulted. After controlling for CSA, self-blame was associated with suicidal ideation, though not suicide attempts (Ullman & Najdowski, 2009); path analysis results indicated that self-blame was linked to PTSD and trauma (including CSA), with maladaptive coping as a mediator of the effects of self-blame on PTSD (Najdowski & Ullman, 2009). After controlling for CSA, behavioral self-blame was associated with decreased disclosure to both informal and formal supports—although it did not predict disclosure to mental health providers—and characterological self-blame was linked to decreased posttrauma growth (Starzynski, Ullman, Filipas, & Townsend, 2005; Starzynski, Ullman, Townsend, Long, & Long, 2007; Ullman, 2014). Characterological self-blame was related to CSA but did not predict PTSD in one path analysis study, while CSA, characterological self-blame, and negative reactions all predicted PTSD in a second regression analysis; finally, characterological self-blame and negative reactions, but not CSA severity, increased the odds of comorbid PTSD and drinking problems (Ullman, Filipas, Townsend, & Starzynski, 2006b; Ullman et al., 2007; Ullman, Peter-Hagene, & Relyea, 2014). In a related longitudinal analysis using the same sample, Time 1 negative reactions, but not CSA, predicted problem drinking at Time 2, especially among those participants who had been revictimized by Time 2 (Ullman & Najdowski, 2008).

Among female college students who reported forced sexual contact since the age of 14, in one study with a diverse sample, current self-blame related to the CSA was associated with PTSD, with both current and immediate post-CSA self-blame higher among participants who reported sexual revictimization

(Filipas & Ullman, 2006); in a second with a diverse sample, CSA was linked to self-blame, which predicted reduced self-esteem (Neville, Heppner, Oh, Sapierman, & Clark, 2004); and in a third, mostly White college sample of women reporting SA within the year, those with a CSA history reported higher levels of internalized stigma related to the SA compared to those with no CSA history (Gibson & Leitenberg, 2001). The sole study of CSA, IPV, and self-blame, utilizing a diverse community sample of women with police-involved IPV, found that both childhood trauma involving betrayal (including CSA) and IPV severity were associated with self-blame related to the IPV (Babcock & DePrince, 2012).

The State of Current Knowledge, Gaps in the Literature, and Implications

Across each of the research areas, there are some commonalities in terms of what we know. The qualitative and mixed methods findings tell us that self-blame, shame, and anticipatory stigma are powerful barriers to CSA, SA, and IPV survivors' disclosure and help seeking. Based on the results from the quantitative studies, abuse severity is related to self-blame and shame, with certain abuse types (peer-perpetrated CSA and sexual IPV) particularly associated with these aspects of stigmatization. Self-blame (general, behavioral, and characterological), shame, and negative social reactions are linked to a host of poor outcomes, including PTSD, depression, psychological and physical distress, affect dysregulation, social withdrawal, maladaptive coping and beliefs, and reduced self-esteem; longitudinal analyses indicate that self-blame, anticipatory stigma–related nondisclosure, and negative reactions predict sexual revictimization. These different aspects of stigma and stigmatization are interrelated: Across each subfield, self-blame, shame, anticipatory stigma, and negative reactions are associated with one another, with one longitudinal SA study demonstrating a bidirectional relationship over time between characterological self-blame and social reactions (Ullman & Najdowski, 2011). Turning to the few studies that have examined co-occurring victimization and stigmatization, prior CSA seems to exacerbate self-blame and stigmatization among both SA and IPV survivors.

When researchers have explored differences by social location factors such as race/ethnicity, class, age, sexual orientation, and immigration status, they have generally found social disadvantage to be associated with greater stigma and stigmatization. Within the CSA subfield, Latinas and Pacific Islanders report higher self-blame (Katerndahl et al., 2005; Xiao & Smith-Prince, 2015), while African American women experience higher depression symptoms as a result of the interaction of self-blame and CSA disclosure, in comparison to White women (Sciolla et al., 2011); Asian American women report more negative social reactions upon CSA disclosure, compared to Latinas (Ullman & Filipa, 2005b). Research on SA reveals that lower education levels among African American women are associated with higher characterological self-blame (L. M. Long, Ullman, Starzynski, Long, & Mason, 2007), while

Native American women experience more anticipatory stigma resulting in a reluctance to disclose to LE (Hamby, 2008). Additionally, Latinas, African American women, and sexual minority women report higher levels of negative, victim-blaming social reactions upon disclosure, in comparison to their White, heterosexual peers (Jacques-Tiura et al., 2010; Sigurvinsdottir & Ullman, 2015a; Ullman & Filipas, 2001). Within the subfield of IPV research, women who are homeless feel more self-blame in comparison to housed peers (Tucker et al., 2005), while women who are immigrants, lesbians, members of religious communities, and/or older report high levels of self-blame, shame, and anticipatory stigma which together impede disclosure and attainment of help (Abu-Ras, 2003; Bauer et al., 2000; Beaulaurier et al., 2008; Crandall et al., 2005; Hardesty et al., 2011; Kanuha, 2013; Knickmeyer et al., 2010; McLeod et al., 2010; Petersen et al., 2004; Reina et al., 2014). Women from disadvantaged groups typically experience greater societal stigma such as discrimination and prejudice and may also face stigma when they seek help from formal service providers (Kennedy et al., 2012); additionally, membership in ethnic communities that are collectivist and shame-based such as Asian and Latino/a cultures may be associated with greater internalization of stigmatization such as self-blame and shame in response to abuse or assault (Fontes, 2007; Wong, Kim, Nguyen, Cheng, & Saw, 2014).

While these areas of research have produced notable findings, important gaps remain. Across all three areas of study, researchers have neglected to examine how general societal stigma (e.g., victim blaming; negative representations in the media, dominant narratives, and stereotypes about victims) influences survivors' internalization of stigma and experiences with seeking and attaining effective help. Within the CSA subfield, there are few qualitative studies, limited research involving college samples or adolescent survivors (vs. adults retrospectively reporting), and no studies that have examined the role of stigma or stigmatization as a barrier to help seeking and attainment; additionally, few studies have taken a developmental perspective or examined how the type of perpetrator (family member vs. acquaintance vs. peer or partner) might influence self-blame, shame, anticipatory stigma, or social reactions. SA research is relatively well developed and comprehensive; key gaps include limited qualitative studies, a lack of diverse college samples and adolescent samples, and limited focus on the role of perpetrator type (partner vs. acquaintance vs. stranger) in influencing different types of stigmatization among survivors. Within the subfield of IPV, there are only two studies involving college samples and none with adolescents; another gap is our limited understanding of how forms of IPV (physical, sexual, emotional, and economic) relate to the different types of stigmatization.

Overall, given that different forms of victimization tend to co-occur (Hamby & Grych, 2013) and prior CSA seems to exacerbate stigmatization among SA and IPV survivors (Babcock & DePrince, 2012; Gibson & Leitenberg, 2001), there has been very limited attention to the relationships between multiple forms of victimization, stigmatization, disclosure, and help

seeking. For example, do survivors who report multiple forms of victimization tend to disclose and seek help less often in part because of their higher levels of self-blame, shame, and anticipatory stigma? Our empirical understanding would be enhanced by research that both comprehensively assesses victimization (vs. assessing one type and having participants describe their worst or most recent experience) and social location factors and how these relate to stigmatization, and utilizes both person-centered methods (e.g., cluster and latent class analysis) and longitudinal approaches designed to capture patterns of change in victimization and sequelae over time. Additionally, we need to begin examining the role of broader societal stigma in influencing stigmatization and stigma from specific external others such as service providers and LE; interventions must be designed that address both stigmatization within individual survivors and stigma imposed by the broader society, community, institutions, and family. While future research should incorporate these emphases, trauma-informed practice and policy would likewise be strengthened by an understanding of the role stigma and stigmatization play in shaping survivors' recovery process, risk of revictimization, and help seeking—particularly among women from a disadvantaged social location—so that we might best meet survivors' needs and prevent future victimization.

Critical Findings Across CSA, SA, and IPV

- Abuse severity is related to self-blame and shame, with certain types of abuse such as peer-perpetrated CSA and sexual IPV particularly associated with these forms of stigmatization.
- Self-blame, shame, and negative social reactions are linked to poor outcomes such as PTSD, depression, psychological and physical distress, affect dysregulation, and maladaptive coping.
- Self-blame, shame, and anticipatory stigma are key barriers to disclosure and help seeking.
- Self-blame, anticipatory stigma–related nondisclosure, and negative reactions predict sexual revictimization over time.
- Prior CSA seems to exacerbate self-blame and stigma among both SA and IPV survivors.
- Survivors from a disadvantaged social location appear to report higher levels of stigmatization and stigma in comparison to their more advantaged peers.

Implications for Research, Practice, and Policy

- Researchers should explore the relationships between different types of victimization, social location factors, and stigmatization/stigma, within a variety of diverse community and college samples.
- The role of broader societal stigma (e.g., victim-blaming, negative representations of victims in the media) on stigmatization—particularly among disadvantaged groups—should be examined.

- Trauma-informed practice and policy must incorporate an understanding of the role of stigma and stigmatization in shaping survivors' recovery, risk of revictimization, and help seeking and attainment.
- Interventions designed to ameliorate the negative sequelae associated with CSA, SA, and IPV should address both internalized stigmatization and external stigma (victim blaming in the broader society, negative reactions by informal and formal support providers).
- Formal service providers such as law enforcement and medical personnel must be trained on the role of victim-blaming reactions in worsening survivors' self-blame, shame, and psychological outcomes such as PTSD, so they do not revictimize survivors.

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Quote in title is from Weaver, Turner, Schwarze, Thayer, and Carter-Sand (2007, p. 93).

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