DEVELOPING THE REFINED SEXUAL SHAME INVENTORY:

VALIDATION STUDY OF THE KYLE INVENTORY OF SEXUAL SHAME

by

Jang Soon Lim

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Philosophy

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May, 2019

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ABSTRACT

There has been an increase in a need to provide appropriate assessments and treatments for sexual shame associated with pornography use, a dysfunctional result of the development of the Internet and social network services. There is no clinically validated inventory of sexual shame in the literature, while many active studies of shame have recently produced meaningful results. This study aimed to develop a brief measure of sexual shame based on the Kyle Inventory of Sexual Shame (KISS) that has not truly been validated with multiple samples. The KISS is comprised of some items confound cause and effect rather than assess the conceptually distinct feelings of sexual shame irrespective of cause. For developing the refined sexual shame inventory, this study removed questions regarding cause and effect from the original KISS in expectation that counselors and researchers on sexual shame will understand the factors that may moderate the relationship between a specific potential cause of shame and feelings of sexual shame. The first study used exploratory factor analysis to refine the initial battery of 20 items of the KISS. By using Maximum Likelihood Extraction with Oblique Rotation, the KISS-9 was developed. Results show that there is a significant correlation between anxiety, pornography use, and sexual shame, while a relationship between avoidance, pornography use, and sexual shame is not significant.

Keywords: sexual shame, shame, sexuality, pornography, pornography use, avoidant relationship with parent, anxious relationship with parent, religiosity

Acknowledgments

First and foremost, I thank my Heavenly Father who saved and strengthened me to finish this long journey.

It is a pleasure to thank those who have made this dissertation journey possible. I would like to express my gratitude to the dissertation committee. Dr. Fred Volk, my committee Chair, is worthy of the first mention. He always allocated priority to my success in the doctoral program, offering endless encouragement. He was also remarkably supportive in multiple ways and was praying for my family and me. I believe that his encouragement, supervision, and support from the preliminary to the concluding level enabled me to finish this long journey. I am also thankful for Dr. Steve Warren and Dr. Nicole DiLella who have been readers in the committee. They guided me to have broader views and an unbiased mind by suggesting various options about certain issues.

I would like to thank my family and church members for the endless support and love they added to this research project. I would like to thank my father, Hee Jae Lim, mother, Jin Sook Choi, father-in-law, Ho Gang Cho, and mother-in-law, Gyu Ho Jeon, for their invaluable support, not only financially, but in numerous other ways.

Finally, I would like to thank So Young, my wife, for her constant patience, commitment, and encouragement as I completed this journey. Words cannot adequately describe how thankful I am for her. I would like to express deep love to Hannah (Yae Ji) and James (Yu Bin), my precious heritage from God, for their love and endurance all these years.

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Kyle Inventory of Sexual Shame (KISS)

Mechanical Turk (MTurk)

Root Mean Square Error of Approximation (RMSEA)

Standardized Root Mean Residual (SRMR)

CHAPTER ONE: INTRODUCTION

Shame negatively affects an individual's self-esteem and relationships with others because the negative emotions associated with shame can cause one to feel defective or unacceptable (Tangney & Dearing, 2003). People with a high level of shame may have great difficulty in becoming socialized. Sexual shame is the feeling of these negative emotions associated with a person's current or past sexual thoughts, behaviors, or experiences (Clark, 2017; Iwen, 2015). Researchers have found that a variety of conditions can affect a person's shame in a complex way (Bradshaw, 2005; Dearing & Tangney, 2011; Gilbert & Irons, 2009; Mollon, 2005; Talbot, Talbot, & Tu, 2004). Counselors should have an understanding of these conditions in order to provide proper treatments to clients suffering from shame. Although many studies of shame have been performed over the last few decades, research on sexual shame has received little attention.

Many problems related to sexuality have occurred as a result of the development of the Internet and social network services, but many people hesitate to disclose issues related to sexuality. This passive culture of sexuality has led people to become more inclined to experience the problem of sexual shame. Particularly, the religiously committed and conservative more suffer from sexual shame than the nonreligious do (Murray, Ciarrocchi, & Murray-Swank, 2007; Sellers, 2017). In this manner, counselors should consider clients' relationship styles to others, religious activities, and religious beliefs in order to provide appropriate treatments. This study emphasizes the various factors relating to sexuality that influence people's psychological health, such as avoidant relationship style, anxious relationship style, pornography use, and sexual shame. Given religious pornography user's propensity to induce one's sexual shame (Volk, Thomas, Sosin, Jacob, & Moen, 2016), it is acceptable to assume that the use of pornography at

least partially affects a user's identity and mental problems. Therefore, for investigating the relationship between them, appropriate assessments should be provided. The Kyle Inventory of Sexual Shame (KISS; Kyle, 2013) was developed to assess the degree to a person's events and thoughts influencing one's sexual shame. However, the validity of the KISS has not been obtained because of the lack of research. Furthermore, the KISS contains several items relating to cause and effect that could induce a feeling of shame. This present research aims to contribute to develop the refined KISS and test the validity and reliability of the refined KISS for future use.

Background and Theoretical Considerations

Researchers of recent decades have found a significant correlation between an individual's identity and his or her life events (Carvalho, Dinis, Pinto-Gouveia, & Estanqueiro, 2015; Erikson, 1993; Pinto-Gouveia & Matos, 2011; Thomason, 2015). An individual's experience of shame affects his identity negatively. Sexual shame is a shame associated with sexual identity formed by various relational and cultural experiences in an individual's life (Kyle, 2013). If an individual is exposed to pornography in the process of forming his or her identity, he or she may experience difficulty with sexual shame (Picone, 2016). Therefore, it can be inferred that the use of pornography by religious people with strongly conservative beliefs has a negative impact on identity and self-esteem (Gordon, 2017; Isom, 2018). Traumatic events experienced in childhood can significantly influence a person's faith and identity (Pinto-Gouveia & Matos, 2011; Talbot et al., 2004). The use of pornography can be considered a traumatic life event that affects a person's view of the world and identity. However, the extent to which individuals are impacted varies depending upon their resilience, their age, and the type and severity of the event (Pinto-Gouveia & Matos, 2011). Various life events can influence a

person's mental health, self-awareness related to identity, and personality traits. In this respect, as life events, religious activities and pornography use are factors with a strong impact on one's moral standards, moral inclination, and identity.

The frequency of a person's life difficulties influences his or her mental health as well. Life events linked to religious activities with one's parents and difficult experiences are very important factors in determining quality of life (Perry & Snawder, 2017; Picone, 2016). In particular, a person's religious activities and beliefs, which are inevitably influenced by parents, should be considered essential factors to a person's identity and mental health (Power & McKinney, 2013). The problem is a lack of research on the use of pornography and sexual shame that influence the formation of an individual's identity, religiosity, and sexual identity. In order to bridge this gap, this study focuses on a person's sexual shame relating to pornography use and attachment style.

There are many studies about how shame affects an individual's life and self-awareness (Gilbert & Irons, 2009; Morrison, 1983). Specifically, the relationship between shame and mental health issues has been heavily studied over the last two decades (Fergus, Valentiner, McGrath, & Jencius, 2010; Gilbert, 2000; Pivetti, Camodeca, & Rapino, 2016). Over recent years, as information technology has developed, people can gain a lot of information by accessing various Websites through a personal laptop and mobile devices. The prevalence of Internet use has rapidly increased (Short, Kasper, & Wetterneck, 2015). The Internet seems to provide guaranteed anonymity for an individual's activities. A person is now able to use pornography much more easily than before the anonymized Internet became so accessible (Short, et al., 2015; Stack, Wasserman, & Kern, 2004). Although the use of pornography on the Internet does not directly affect a person's shame because its anonymity, research has recently been

conducted that indicate that a person may experience sexual shame under several conditions, such as religious beliefs and activities and cultural expectations (Mollon, 2005; Volk et al., 2016). Recently, researchers have begun to investigate whether an individual's religious activities and beliefs influence sexual shame caused by using pornography (Exline, Wilt, Stauner, Harriott, & Saritoprak, 2017, Kvalem, Traen, Lewin, & Štulhofer, 2014). However, more research is required on the relationship between pornography use, religious beliefs, relational attachment, and sexual shame.

With the availability of information technology, it is difficult to separate people's lives from Internet use. As people use the Internet, they are often exposed to pornography. In fact, Internet pornography business continues to grow through network services (Short et al., 2015). The more the use of pornography increases, the more religiously conservative people are exposed to pornography anonymously (Short et al., 2015; Thomas, 2013). The problem is that the psychological suffering of religious people surrounding pornography use is more serious than for the nonreligious (Grubbs, Exline, Pargament, Hook, & Carlisle, 2015; Stack et al., 2004; Volk et al., 2016). In this regard, counselors, pastoral counselors, and pastors should be attentive to the sexual shame of religious individuals. This research focuses on evaluating tools for studying sexual shame, with interest in the relationship between sexual shame, pornography use, religious activities, and relationship styles. The influence of pornography use on sexual shame varies according to the conditions and factors relating to an individual's mental problems. It is reasonable to assume that under certain conditions, one person's use of pornography can cause serious sexual shame. Unfortunately, there are currently no validated measures of sexual shame. The KISS was developed to identify those experiencing sexual shame as part of a treatment

study. Some researchers (Volk et al., 2016) have used the KISS in their research, but the current form has not been thoroughly validated.

Purpose of the Study

The goal of the present study is to develop a brief measure of sexual shame based on the KISS. The original KISS was designed to evaluate clients' sexual shame (Kyle, 2013). However, there is a need to provide evidence for its validity and reliability with sufficient empirical research. While the KISS has shown some promise in recent research, it has been applied sparingly; at the same time, research on dysfunctional sexual behavior and shame have increased. One potential issue is that the KISS is comprised of some items confound cause and effect (e.g., feel shame related to same-sex attraction) rather than the conceptually distinct feelings of sexual shame irrespective of cause. The separation of cause and effect is key to understanding the factors that may moderate the relationship between a specific potential cause of shame (e.g., childhood sexual abuse) and feelings of sexual shame. The focus of this research is refining the KISS into a more conceptually coherent measure of sexual shame rather than a set of items that may be associated with negative affect related to specific sexual behavior. The second focus of this study is to identify the set of items that most efficiently address sexual shame that researchers can easily employ across a wider range of studies that focus on the impact of sex-related feelings of shame.

This study takes a three-step analytical approach, which the research questions reflect. The first research question focuses on the development of a measurement that assesses the latent constructs and will be answered by using exploratory factor analytic techniques using an initial sample ($n = 640$); the second set of research questions focuses on the model-data fit of the factor

structure that emerged from the first phase of the analysis ($n = 432$); and finally, the third research question assesses the validity of the new measure as it relates to other constructs.

Research Questions

The five research questions for this current study are as follows:

RQ1: What are the latent constructs that emerge from a refined set of items derived from the KISS?

RQ2a: Does a one-factor model have a close model fit?

RQ2b: Does a two-factor model have a close model fit?

RQ2c: Does a bifactor model have a close model fit?

RQ3: Are the refined KISS subscales related to other measures in a way that is theoretically consistent with shame?

Assumptions and Limitations

This study was based on multiple assumptions. The first assumption is that the original KISS measurement tool measures a client's sexual shame. It is assumed that the participants of this study have a cognitive ability to reflect on their experiences and to recognize that sexual shame can influence their psychological well-being and identities. Although enough research data have not been accumulated, literature shows that the original KISS has meaningfully measured sexual shame. However, the KISS's ability to meaningfully measure sexual shame remains an assumption. The second assumption is that the Experiences in Close Relationships-Revised Structure (ECR-R) and the Experiences in Close Relationships–Relationship Structure (ECR-RS) significantly measure the participants' relationship styles to others. The ECR-R and ECR-RS measure participants' attachment-based avoidance and attachment-based anxiety. The third assumption is that the Cyber-Pornography Use Inventory-9 (CPUI-9) meaningfully

measures the participants' online pornography compulsivity. The fourth assumption is that

participants in this study will provide meaningful answers to the questions of those

measurements because they have the ability to self-reflect on their experiences. The fifth

assumption is that the use of Mechanical Turk (MTurk) will provide a highly various sample of

participants and will include those who are representative of sexual shame bearers and online

pornography users. MTurk is an online survey tool developed and provided by Amazon.

Participants are asked to answer the questionnaire online and are paid when they complete all

questions. (Kittur, Chi, & Suh, 2008; Paolacci & Chandler, 2014; Peer, Vosgerau, & Acquisti,

2014). Even though MTurk is considered as a useful tool that has the advantage of being able to

obtain a variety of information and data easily and simply at a low cost (Buhrmester, Kwang, &

Gosling, 2011), this researcher admits that the nature of the information and data obtained

through MTurk represents those of some representative population.

There are some acknowledged limitations to this study. First, the use of MTurk has the

limitation that it cannot clearly identify the degree of participants' sexual shame and the

frequency of online pornography use because the data is collected by participants' self-report. It

can be reported incorrectly due to participants' various uncontrolled excuses. In addition, the

collected samples may not properly identify morbid users for sexual shame or pornography use

because participants may not represent pathological patients who experience sexual shame or

pornography use. MTurk has a clear limitation in its ability to gain accurate information about

people who are in the early stages of sexual shame or who are not aware of serious problems

relating to sexuality. The second limitation to consider is that the definition of sexual shame and

pornography use may vary due to participants' cultures and experiences. For example, some

people from conservative families consider pictures of people in swimsuits or rated-R movies to

be pornography and feel sexual shame by viewing them, but others do not. Because of participants' relative and subjective concepts about pornography use and sexual shame, there is a limitation that the participants' self-reports may not be accurate. If this researcher had tried to provide a unified definition of pornography use or sexual shame, it could have led to errors by controlling participants' responses. The last limitation that should be considered in this study is the need to test the validity of the refined KISS. Because the refined KISS has not yet been studied, further studies are needed to ensure its validity in order to overcome this limitation.

Definitions of the Terms

Attachment – Attachment is defined in psychology as a person's emotional bond to caregivers or significant figure for obtaining or maintaining proximity (Bowlby, 1997). A child tries to communicate with his/her primary caregiver by using signaling behaviors such as smiling, crying and calling in order to gain proximity (Ainsworth, Blehar, Waters, & Wall, 1978). In childhood one's relationship with his or her authoritative figures plays an important role in forming various attachment styles such as avoidant attachment anxious attachment, and secure attachment. During infancy and early childhood, a child acquires the ability to predict and respond to the primary caregivers' behaviors and emotions in order to build and maintain relationships with them.

A person's attachment figure (mother/father) indicates whom the person is bonding to. A child's appropriate attachment to the parent plays a significant role in developing a healthy identity and self-awareness. If a child is properly attached to one's attachment figures, the figures play the role of a safe haven and a secure base. When a person is confronted with a challenge or danger, he or she retreats to find a safe haven in order to protect himself or herself (Bowlby, 1997, 2008).

Attachment-related anxiety – Those who have an anxious relationship style are not easily soothed. They struggle with the feelings of ambivalence and anger toward attachment figures. People with anxious attachment to caregivers have difficulty in expressing their emotions in a healthy way to others and accepting others' emotions properly (Bowlby, 2008; Clinton & Sibcy, 2002; Fraley, Waller, & Brennan, 2000).

Attachment-related avoidance – is a form of insecure relationship that is characterized by one's tendency to have an inordinately positive view of self and an improbably negative view of others. Avoidant people have a propensity not to trust others, and they struggle to openly express their feelings. They are not able to develop close relationships with others (Ainsworth et al., 1978; Fraley et al., 2000).

Pornography – The origin of pornography is the Greek word *pornographos*. *Pornographos* is a compound word of πόρνη for prostitutes and γράφω for writing (Vine & Unger, 1996). In this study, pornography is a photograph or video providing sexual content.

Pornography Use – is defined in this study as a person's active participation in viewing photos or videos containing sexual content. Individual perceptions of pornography use can vary depending on a person's culture and environment.

Religiosity – is defined in this study as an individual's religious position on his or her belief in a supernatural being, and one's religious activities. Theology and dogma play a pivotal role in forming a religious person's morality, which significantly influences his or her feelings of shame (Hilton, 2013; Perry & Snawder, 2017).

Sexuality – Sexuality is a very important factor in forming a person's identity. A person's sexual identity is formed through various experiences with parents. In this study, a person's sexuality is considered as a factor that is influenced by his or her attachment styles with

parents. When a person struggles with shame associated with sexuality, he or she experiences feelings of sexual shame.

Sexual Shame – The standard definition of sexual shame does not currently exist (Kyle, 2013). In this study, sexual shame is considered as a feeling of shame associated with sexuality (Mollon, 2005; Shadbolt, 2009). It relates closely to a person's negative experiences, including humiliation and disgust for one's body and uncertainty in one's identity as a sexual being (Clark, 2017).

Shame – Shame is characterized by a sense of failure, excessive sensitivity, and inner wounds from the critical gaze of others. Shame developed between six and eight months of age is a negative emotion that triggers self-consciousness, inferiority, powerlessness, and the desire to disappear.

Significance of the Study

This study emphasizes on the relationship between sexual shame, pornography use, and attachment-based relationship style. Attachment style to one's caregiver or partner can play a pivotal role in moderating between sexual shame and pornography use. An appropriate assessment inventory is required to provide better treatment and research relating to sexual shame (Kyle, 2013). There is hope that the refined KISS can become the new method of measuring one's feeling of shame relating to sexuality.

Summary

Chapter One provided a brief overview of the theoretical and conceptual components of this study. Over the last two decades, research on shame has progressed in certain areas, but more research on sexual shame is needed. Shame negatively influences a person's identity and

cause great difficulty in establishing healthy relationships with others. This study is designed to discover what factors affect an individual's sexual shame.

More studies about sexual shame are required because online pornography use is becoming more prevalent overall. This study not only explores the relationship between Internet pornography use, sexual shame, and attachment, but more fundamentally, it focuses on developing a simpler, more effective, and refined KISS using the original KISS inventory. In addition to sexual shame related to the use of Internet pornography, further research is needed to explore other factors that affect sexual shame. Some studies address the significant relationship between childhood sexual abuse and sexual shame. In this regard, this study will examine various factors related to sexual shame through the literature review. This researcher considers a person's religiosity and the background and culture of the family to be a very important factor in the presence of sexual shame. It is important to develop a proper definition of sexual shame and an accurate diagnostic tool because of the various factors that cause sexual shame. In this respect, it is meaningful to develop a refined KISS and to measure its validity and reliability.

CHAPTER TWO: REVIEW OF THE LITERATURE

This study will explore the relationship between sexual shame (KISS), cyber-pornography addiction (CPUI-9), family relationship (ECR-RS), and religiosity (Demographic). To understand the impact of sexual shame, it is necessary to evaluate the validity and reliability of the original KISS and developing the refined KISS. This study sought to identify: (1) The latent constructs that emerge from a refined set of items derived from the KISS, (2) a one-factor model that has a close model fit, (3) a two-factor model that has a close model fit, (4) a bifactor model that has a close model fit, and (5) the refined KISS subscales that are meaningfully related to other measures in a way that is theoretically consistent with shame. This chapter provides an investigation into the literature about shame, mental problems relating to shame, the causation of sexual shame, the influence of relationship styles (avoidance or anxiety) on sexual shame, and the relationship between sexual shame and pornography use.

Shame

Definition of Shame

Shame, along with guilt, is an important factor in the emotional development of morality. Specifically, shame affects the development of early morality, which has a great influence on a person's moral behaviors (Erikson, 1993; Freud, 1899/1973; Shahar, Doron, & Szepsenwol, 2015; Thompson, 2015). Some scholars address the difficulty of distinguishing shame and guilt because shame and guilt develop at the same time in the early life (Cândea & Szentágotai-Tătar, 2018; Kim, Thibodeau, & Jorgensen, 2011). Shame is characterized by a sense of failure and excessive sensitivity and inner wound from the critical evaluation of others, while guilt is characterized by a tendency to recover after violating the norm (Clark, 2017; Pivetti et al., 2016).

Shame and guilt are distinguished in this manner: Guilt is the feeling of "what I did"; shame is the feeling of "who I am" (Kim et al., 2011; Pinto-Gouveia & Matos, 2011; Pivetti et al., 2016).

Childhood abuse and neglect can cause children to become immersed in and immobilized by shame, which affects their cognitive schema and personality (Shahar et al., 2015). Shame is a negative emotion associated with self-consciousness and feelings of inferiority (Gilbert & Irons, 2009), powerlessness (Gilbert, Allen, & Goss, 1996), and the desire to disappear (Cândea & Szentágotai-Tătar, 2018). In this respect, shame can be considered a significant influence on a person's personality. It is necessary to pay attention to shame in the fields of moral education and counseling (Rüsch et al., 2007). The essential factor causing shame is a tension between the true-self and the ideal-self (Thompson, 2015).

Development of Shame

There are basic emotions such as anger, sadness, disgust, and joy that develop early in life (i.e., between six and eight months of age) and are common across regions and cultures (Erikson, 1993; Kim et al., 2011). Based on these basic emotions, an infant develops and expresses various emotions and mental abilities, such as symbolic representation, self-awareness, and metacognition (Clark, 2017; Erikson, 1993; Pinto-Gouveia & Matos, 2011). Another of these basic emotions is shame, which is formed between two to three years of age (Erikson, 1993; Freud, 1899/1973; Lagattuta & Thompson, 2007; Kim et al., 2011; Pinto-Gouveia & Matos, 2011). Self-consciousness about shame arises from the initial interactions with important caregivers (Pinto-Gouveia & Matos, 2011). Shame consists of the self-conscious evaluative emotions that emerge after a child is equipped with the ability to perceive himself or herself in a mirror or photograph and include embarrassment, guilt, envy, and self-esteem (Lewis, 1971; 1993). Wei, Shaffer, Young, and Zakalik (2005) emphasized that shame is the emotion that

begins to be experienced through attachment and interaction with the mother in her early life and attachment.

Shame and Attachment

The child' s appropriate attachment to the parent plays a significant role in developing a healthy identity and self-awareness (Bowlby, 1997, 2008). Attachment can be considered as a person's emotional tie to caregivers or significant figure for obtaining or maintaining proximity. A child uses signaling behaviors such as smiling, crying and calling in order to communicate with one's parents (Ainsworth et al., 1978). An infant's relationship with parents plays a significant role in forming various attachment styles such as avoidant attachment anxious attachment, and secure and intimate attachment.

The child's appropriate attachment to the parent plays a significant role in developing a healthy identity and self-awareness (Bowlby, 1997, 2008). However, early experience with shame hinders a significant attachment to parents by the child. Shame occurs when a caregiver refuses to properly reply to a child who is trying to experience gradual autonomy with free choice (Lewis, 1971; Wei et al., 2005). In other words, the main cause of early experiences of shame is the withdrawal of a caregiver's love. A baby experiences a reaction of shame when the mother exhibits strange and unfamiliar behaviors instead of loving kindness.

A primitive model of shame would show that a child avoids the mother's gaze and suddenly falls down when the mother who generally smiles reacts differently with rigidity. If a child experiences the withdrawal of a caregiver's love, attachment to parents is easily undermined. Between 18 and 36 months of age, a child develops essential emotions and self-awareness (Erikson, 1993; Lewis, Sullivan, Stanger, & Weiss, 1989). However, when emotional rejection and damage to a child's attachment to parents occurs, one experiences the

internalization of shame. The lower the level of parental care and attention, the higher the level of internalized shame. From this perspective, shame should be considered interpersonal from its origin.

Shame and Childhood

Shame is the emotion generated by negative evaluation of one's value, primarily the parents' evaluation. Shame is an emotion of inferiority (Clark, 2017; Tangney, Wagner, & Gramzow, 1992). Shame is deeply related to the presence of the caregiver, especially parents. Children begin to feel shame when they are negatively evaluated by their caregivers (Kim et al., 2011). Furthermore, shame is generated and aggravated when one's natural tendency to love oneself is hurt in a child's relationship with parents. During childhood, a person becomes vulnerable to shame if he or she feels criticized by parents or perceives himself or herself to be less loved than his or her siblings by the parents.

When the children's identity is not accepted by the parent, their self-awareness is fragmented into a grandiose-self and a small-self (Johnson, Nguyen, Anderson, Liu, & Vennum, 2015). Shame causes various symptoms relating to the emotional struggle that negatively influence a person's dignity and self-esteem (Gilbert & Irons, 2009). A rupture in the interpersonal bridge between a mother or a significant caregiver and child is a crucial event that activates shame. The shame developed during the early years affects the identity of the individual and is internalized into the personality, which sustains the damage of the interpersonal relationship.

Shame and Interpersonal Relationships

The person with shame is evasive, submissive, and sometimes aggressive in interpersonal relationships (Galhardo, Pinto-Gouveia, Cunha, & Matos, 2011). Shame induces unhealthy

thoughts and feelings, including (a) the thought of lagging behind others, (b) the self-perception that something is lacking in oneself, (c) sexual flaws, and (d) the impulse to run away before being exposed to others (Fergus et al., 2010). Shame is a person's emotional reaction to others who evaluate them negatively, and studies show that there is a connection between an individual's assessment of oneself and perception of what other people think of him or her (Carvalho et al., 2015). The internalization of shame implies that a person fears others' evaluation when he or she is revealed to the world. Shame motivates a person to withdraw or avoid interactions with others because a person with shame believes that he or she is not acceptable to others (Lewis, 1993). Shame is the emotional experience surrounding how individuals believe others perceive them.

A person with internalized shame has a propensity to hide oneself or to escape the view of others. The internalized shame creates an obstruction to establishing a significant and intimate relationship with family, friends, and lovers (Perry & Snawder, 2017). Individuals with a high level of shame will constantly and frequently struggle to interact with others and will maintain distance from important relationships or relational problems. Shame is related to various personality constructs and psychopathological symptoms, including anxiety, anger, hostility, vengeance, irritability, a tendency to blame others, and a fear of negative appraisal that adversely influences interpersonal relationships.

Shame and Psychopathology

Shame can be positively conceptualized as a social emotion that helps people to keep their social promises (Bradshaw, 2005). However, in many cases, shame negatively influences individuals to hide misdeeds and even minor mistakes from others (Picone, 2016). A person who struggles with shame has difficulty building close relationships with others, even family

members, because it motivates the person not to reveal oneself to others (Clark, 2017; Kim et al., 2011; Picone, 2016). Furthermore, those struggling with shame often do not take responsibility for their own faults or transgression (Clark, 2017; Dearing & Tangney, 2011; Johnson et al., 2015). In this respect, it is not easy to help the client with shame to experience recovery from psychological problems through counseling sessions because of the client's defense mechanism. The tendency to avoid self-disclosure and defend against self-expression hinder the efficiency of the counseling process (Lewis, 1971; Tangney & Fischer, 1995). In order to help a client with the internalized shame, a counselor should be aware of the fact that the client is more likely to hide and defend oneself.

People with low self-esteem caused by shame often experience mental health problems like anger, contempt, jealousy, and depression because they are not able to properly respond to external stimuli and are weak in resilience. Clients with shame primarily try to defend themselves through oppression, but they, in the end, use a range of negative emotions to avoid feelings of shame: (a) anger that attacks those who make a client feel shame, (b) contempt to make one's opponents feel shame by projecting one's subjective experience of shame on others, (c) jealousy that tries to destroy one's opponents for revenge, and (d) depression by self-deprecation that takes the place of shame (Gilbert et al., 1996). Thus, an individual does not limit his or her responses to simply avoiding and withdrawing from shame, but rather acts against himself or chooses behaviors that inflict pain on others. The more a person feels shame, the less he or she uses mature and healthy defenses in appropriate ways. Such clients need to learn effective and mature skills like self-disclosure and self-awareness of one's emotions. They need to be encouraged to overcome symptoms of shame by disclosing the shame because self-

disclosure is one of the important factors that effectively and efficiently facilitate the counseling process. Clients should not ignore but instead, focus on and understand their emotions.

Depression. Depression closely relates to shame because depression is a common symptom of shame (Gilbert, 2000). Shame is generally known as a kind of emotion caused by a shameful thought (Kim et al., 2011; Pivetti et al., 2016). A person merely feels ashamed and depressed not because of appropriate emotional reactions but because of inappropriate thoughts. By nature, people generally experience shame when they do wrong. However, a depressed patient experiences shame even without having done any wrong (Hedman, Strom, Stunkel, & Mortberg, 2013). A patient with depression is often overwhelmed even by small mistakes (Kim et al., 2011). There is a significant relationship between early shame experiences with parents and depression (Gilbert, 2000; Gilbert et al., 1996). Based on their early shame experiences, some patients set their moral standards too high and defeat themselves due to their dissatisfaction with their moral performances. Such depressed patients need to diminish their feelings of shame by gradually lowering their idealistic expectations. The distinction between guilt and shame is helpful for counselors and patients in understanding why such patients need to lower their expectations: Guilt is related to the behavioral violation of moral standards, but shame arises merely from a thought that one is inferior to others (Fergus et al., 2010; Kim et al., 2011; Lewis, 1971). In this manner, counselors need to help their patients to overcome the thoughts and feelings of shame by helping them to deal with their early shame experiences and their relationship with authority figures through the process of self-disclosure.

Anxiety. Anxiety is one of the basic human emotions. There is no person who does not experience anxiety. Even an infant who cannot speak is able to read the signs of anxiety (Feldman, 2011; Freud, 1899/1973). Furthermore, anxiety is an essential component of human

survival and reproduction, as it can protect a person from external attack. It would not have been possible for humans to survive and reproduce without anxiety. Therefore, anxiety can be considered a necessary phenomenon that has been a part of human survival history. However, excessive anxiety is considered the cause of mental illnesses, generating a variety of mental problems (Fergus et al., 2010). Many people suffering from anxiety have a tendency to cause an interruption to daily life and to destroy a healthy life. Scholars have investigated the internal and cognitive causes of anxiety: (a) recognizing the self as a worthless and incompetent person, (b) recognizing the world and others as extremely dangerous and intimidating, (c) being very easily concerned, and (d) being equipped with very low self-esteem (Hedman et al., 2013; Wei et al., 2005). In this manner, an anxious person can be easily distracted by shame because of his or her low self-esteem and unhealthy belief that he or she is worthless and not acceptable.

Depression and anxiety were assumed to be generally caused by patients' shameful or guilty feelings (Gilbert, 2000; Lewis, 1971; Tangney et al., 1992). However, recent studies have found that shame-related emotion is significantly more related to psychopathological problems such as depression than guilt-related emotion (Kim et al., 2011; Tangney et al., 1992). Additionally, shame is closely linked to mental illnesses such as anxiety (Shahar et al., 2015) and eating disorders (Fergus et al., 2010; Harder, Cutler, & Rockart, 1992; Pinto-Gouveia & Matos, 2011; Rizvi, 2010; Tangney & Dearing, 2003). There are many documented studies about shame that provide clinical and academic support for counselors and patients to assist them in understanding causations and symptoms of various mental problems related to shame. However, given shame surrounding sexuality has recently become a prevalent problem, there is a lack of literature on the shame associated with sexuality.

Shame, Sexuality, and Sexual Abuse

Even in their adulthood, those who have experienced sexual abuse during their childhood need to receive care specifically because of the higher risk for sexual or physical victimization (Feiring & Taska, 2005; Gordon, 2017). People with a history of sexual abuse experience substantial and varied interpersonal conflicts due to their lack of communication skills and interpersonal functions (Gordon, 2017). In comparison to clients without experiences of childhood sexual abuse, victims of childhood sexual abuse find it more difficult to build healthy communication skills (DiLillo, Giuffre, Tremblay, & Peterson, 2001), and their lack of communication skills leads to less intimacy, less satisfaction with others, separation, and divorce (Gordon, 2017; Stoops, 2015; Walker-Williams, van Eeden, & van der Merwe, 2012). While there isn't an empirically established relationship between shame and family conflict among female clients with childhood sexual abuse, various studies purport that the feeling of shame among clients with the experience of sexual abuse plays a pivotal role in communication and relationship development (Feiring & Taska, 2005; Gordon, 2017; Stoops, 2015; Talbot et al., 2004). While a number of scholars in previous studies have concluded that patients who experienced sexual abuse are highly affected by shame and struggle with interpersonal conflict, many recent studies argue that there is no pivotal evidence for a direct relationship between sexual abuse, shame, and interpersonal conflict (Campbell, 1994; Carvalho et al., 2015; Cooper, Delmonico, & Burg, 2000; Feiring, Taska, & Lewis, 1996; Talbot et al., 2004).

Relationship style to caregivers (avoidance or anxiety), more than abuse severity, should be considered as an essential factor that influences a patient's shame from sexual abuse (Feiring, Taska, & Lewis, 2002; Gorden, 2017). When a person experiences sexual abuse during childhood, shame produces various cognitive-emotional scars (Feiring et al., 1996). When these

scars are affected by moral and religious condemnations, a child becomes vulnerable to sexual shame. This means that attribution style, which is significantly affected by religious education and conservative family background, can be considered as a factor that develops sexual shame.

Sexual Shame

Sexual shame generally refers to the shame associated with sexuality (Lewis, 1993). The subject of sexuality is fundamentally related to the existence of humankind. Even the Bible introduces the sexual shame of Adam and Eve, the first ancestors of humanity in chapter three of Genesis (Vine & Unger, 1996). Adam and Eve were naked in the Garden of Eden, but they were not ashamed at all. However, after eating the fruit of the knowledge of good and evil, they began to distinguish between good and evil and between the boundaries of self and the world. They became ashamed of their naked bodies. In the distorted perception between good and evil, a person begins to experience sexual shame by fearing others' gaze on their naked body.

In comparison to the many studies of shame that have produced many meaningful results for the last two or three decades, the progress of studies on sexual shame has been minimal (Campbell, 1994; Carboneau, 2018; Clark, 2017; Kyle, 2013; Thompson, 2015). Insufficient psychological and clinical research has been done on sexual shame, even though many concerns for clients suffering from sexual shame are discussed in psychological fields and on various media, such as News, films, and social network services (Clark, 2017; Shadbolt, 2009). Shame is an emotion that forms during infancy and affects the person throughout his or her whole life. It has considerable influence and a ripple effect on both the identity of a person and the function of identity in one's life.

The term sexual shame is mentioned in research in various areas, including religious counseling and clinical counseling (Mollon, 2005; Shadbolt, 2009; Volk et al., 2016), but only a

few studies try to provide an accurate definition of sexual shame and a clear explanation of its differences from shame. The standard definition of sexual shame does not currently exist, but it generally indicates one's unhealthy tendency to consider oneself as seen in the perspectives of others, particularly in relation to sexuality (Brown, 2006; Kyle, 2013). Clark (2017) pays attention to the client's negative experiences relating to sexual shame, including humiliation and disgust for one's body and uncertainty in one's identity as a sexual being. Furthermore, a person with sexual shame builds up unhealthy beliefs about oneself, which causes the person to consider oneself as being inferior and unworthy.

Once these dysfunctional experiences and feelings internalize, they negatively influence a person's ability to trust, communicate, and form physical and emotional closeness (Clark, 2017). Children become aware of sexual shame between ages three and five (Shadbolt, 2009). After that age, they are able to recognize the differences between men and women, and they begin to recognize the different roles undertaken by males and females. If, however, children are not provided with the proper education about sexuality as they become older, they will have a distorted perception about the nature and the roles of sexuality, which then become the basis for experiencing sexual shame.

Sexual shame significantly influences self-consciousness (Clark, 2017; Lewis, 1993). If a person, without one's awareness or conscience, struggles with the fear of exposing one's sexual problems or deficiencies, he or she is not able to identify his or her true self. People who were exposed to inappropriate sexual behaviors or abuse during one's childhood tend to believe that they are unworthy of acceptance and belonging (Clark, 2017). Shame generally develops into a chronic issue that causes an individual to lose his or her identity and to feel like an outsider (Volk et al., 2016). Because of this tendency, the feeling of sexual shame leads a person to

sorrow, fear, inner rage, feelings of worthlessness, and self-judgment. A patient with sexual shame feels alone, rejected, and despised by others.

Development of Sexuality

Sexuality is an essential factor in a person's identity, and it should be formed through various experiences with parents (Feldman, 2011; Freud, 1905/2000; Lichtenberg, 2011; Shadbolt, 2009). The emotional and psychological issues of adults are not solely determined by one's childhood experiences. However, studies show that the psychological and physical events related to sexuality during adolescence should not be underestimated or exaggerated, and that an individual's experience with siblings during one's adolescence undoubtedly has an ineradicable effect upon the formation of one's mental health and sexual identity (Shadbolt, 2009). Similarly, a person's sexuality can be considered as an outcome of his or her relationship with parents and peers. Shadbolt (2009) emphasized that the development of sexuality is inextricably tied to one's attachment and relationship with caregivers.

Human sexual function begins at an instinctual level even before a baby is born (Sellers, 2017). A child usually learns about sexuality before adolescence and establishes a sexual identity at adolescence (Cook, 2012; Lichtenberg, 2011). Parents should understand their child's sexual development and level of development to provide appropriate information relating to sexuality and sexual identity (Braeken & Cardinal, 2008). The relationship between parents and children is a very important factor in the dynamics of sexuality as well as the potential for sexual shame (Shadbolt, 2009). In this manner, parents' values around sexuality should be considered as a pivotal factor in the determination of the character of a child's sexuality. The child generally asks one's parents questions related to sexuality (Malcom, 2014; McClintock, 2001).

At this point, if the parents are embarrassed or uncomfortable, the children feel that they are unacceptable to their parents, which causes shame.

This unpleasant experience allows children to hide their thoughts and behaviors and to manipulate behaviors to be accepted culturally and socially. This makes the children lose their self, and they live with the fear of disapproval (Braeken & Cardinal, 2008; Clark, 2017; Cook, 2012). Through the unfortunate perception that their thoughts and desires are not culturally and socially accepted, children begin to build up a shame-ridden emotional structure.

The difference between parents' expectations and adolescents' expectations produce many relational problems. In adolescence, the adolescent's minor conflict in communication with parents can be easily exaggerated and causes great pain to the youth (Clark, 2017; Malcom, 2014; Shadbolt, 2009). The shame experienced during this period can cause adolescents to overturn their interpretation of their diverse experiences and produce emotional wounds that cause the emotional scar influencing and lasting in adulthood. Therefore, caregivers and counselors should not ignore the adolescent's psychological, physical, and sexual desires and their potential for shame. The unpleasant experiences of childhood can be linked to negative results, including sexual abuse, exposure to pornography, and excessive humiliation. Adults who have experienced sexual abuse, sexual secrecy, and promiscuity often end up struggling with interpersonal and romantic relationships (Clark, 2017).

Internet and Pornography Use

It is not easy to accurately measure the number of users who access sexual content through websites and the number of websites providing sexual contents because of the anonymity of users and the rapid growth of the pornography industry. Nevertheless, there is no question that there is a tremendous amount of pornographic content and millions of users who

access that content every day (Short et al., 2015; Stack et al., 2004; Volk et al., 2016). In particular, the Internet pornography industry is evolving because of three features: anonymity, accessibility, and affordability (Cooper et al., 2000; Short et al., 2015). Picone (2016) explained that "the Internet has made pornography affordable (cheap or free), accessible (one click away on the Internet), and anonymous (instead of risking being seen at a store or movie theater)" (p. 5). Even though online activities relating to pornography use cause various psychological problems, such as addiction, sexually deviant behavior, and social isolation, it is not easy to prevent patients from online activities.

Most Internet users are at risk of exposure to Internet pornography. Unfortunately, many people are using pornography. About 20 years ago, 46.4% of men and 36.5% of women used the Internet for sexual activity for at least an hour per week (Cooper, Scherer, Boies, & Gordon, 1999; Picone, 2016). In 2017, 57% of young adults used pornography more than once a month. Furthermore, 49% of young people said that most of their friends use porn regularly, and 93% of boys and 62% of girls are exposed to Internet pornography during adolescence. In addition, one-fifth of the vast amount of pornography consumed by people under the age of 18 is consumed by people under the age of 10 (Isom, 2018). Among the Christian population, 36% periodically use Internet pornography. Furthermore, 33% of pastors respond they occasionally use pornography, and 18% of pastors regularly use pornography (Gardner, 2001). Among Christian young men, seven out of 10 have viewed pornography, and two out of 10 Christian young women have viewed pornography. One out of 10 young adult Christians uses Internet pornography for more than one hour per week (Baltazar, Helm, McBride, Hopkins, & Stevens, 2010; Nelson, Padilla-Walker, & Carroll, 2010; Picone, 2016).

The Impact of Sexual Shame on Interpersonal Relationships

   To understand a client's sexual shame, counselors should consider sexuality as a main factor that may influence negative emotions and behaviors (McClintock, 2001). The person who struggles with past unpleasant sexual experiences constantly lives in shame (Clark, 2017). Sexual shame not only damages self-esteem but also causes unreasonable behaviors and trials of manipulation to reduce or eliminate shame (Gilbert & Irons, 2009). Sexual shame is a decisive factor affecting the way people design their lives and the formation of social relationships. When an individual experiences shame in the family or community with some sort of sexual behavior or thought, he or she tends to learn how to change behavior over time in order to avoid conflict with social norms. If a person has a propensity to feel guilty and shameful merely because sexual thoughts come up, shame may ultimately hamper the natural process of sexual pleasure, excitement, or pleasure and make them feel repulsive (Clark, 2017; McClintock, 2001). Sexual shame can attack and destroy one's identity because sexual intercourse and sexuality are entangled in one's identity.

   Sexual shame's influence on a person's identity can have an impact on one's psychological productivity and health. For a person to have a mentally healthy life, mental problems relating to shame must be resolved. In this manner, counselors should understand that parent can play an important role in the prevention of sexual shame. In order to help a child to develop a sexually healthy sense, it is necessary for parents not only to provide love and protection to their child but also to understand the child's developmental stages and tasks (Seller, 2017). Therefore, parents should be aware of the children's curiosity relating to sexuality in advance. Then, in the right way, parents should be able to provide their children with instruction on right and wrong in regard to sexual subjects (Feiring et al., 2002). Unfortunately, many

children do not receive the help of their caregivers in this area. Furthermore, due to parents'

inadequate responses to children's curiosity about sexuality, children experience sexual shame

due to their parents. If a person struggles with the feeling of sexual shame, he or she loses his

confidence and becomes prone to condemn himself (Grubbs et al., 2015; Volk et al., 2016).

When children are overwhelmed by condemnation and shame, they are not able to build a close

relationship with their parents and maintain intimacy with others.

     A patient's behaviors such as watching pornography exacerbate existing shame, resulting

in more severe sexual shame (Volk et al., 2016). In a study of parents who use pornography and

therefore experience sexual shame, it was found that the parents who attend religious services

more frequently are more likely to have a negative relationship with their children than parents

who attend less frequently (Perry & Snawder, 2017). Furthermore, sexual shame hinders

individuals from expressing love beautifully through sexual activity. In addition, it can be a

barrier to healthy sexual function. Shame is a fundamental feature of most sexual symptoms

(Clark, 2017; McClintock, 2001).

Sexual Shame and Culture

     Culture covertly provides a message to people that sexual subjects should be hidden.

Shame has been regarded as a subject to be studied for the treatment of a client's mental and

sexual problems. Nevertheless, sexuality is a difficult subject to discuss in public (Perry &

Snawder, 2017). It is clear, however, that sexual shame has a profound impact on a person's life,

even though people do not discuss it publicly (Clark, 2017). Culture can be considered to play a

pivotal role in forming personality (Isom, 2018; Iwen, 2015). Therefore, a client's cultural

factors are no less essential than familial and relational factors. Culture can be carefully

described as a texture and foundation that binds people together (Clark, 2017; Kaufmann &

Clemnet, 2014; Perry & Snawder, 2017). People generally have a desire to be a member of a group. If the need to belong to a group is not met and this experience is repeated, the person feels shame and worthlessness.

In recent years, people have shown the tendency to be embarrassed when married couples or lovers express love to each other but to accept nudity or sexual violence seen through films or the media (Ahrold, Farmer, Trapnell, & Meston, 2011; Gilbert & Irons, 2009). In modern society, sex is commercialized and consumed by people (Gilbert & Irons, 2009). As a result, sex has been manipulated and abused by films, television shows, and Internet pornography. This phenomenon causes conservative religious people to view sex as dangerous. It is undeniable that there has been a significant change in culture over the last few decades toward open and tolerant talk around sexual issues (Clark, 2017). However, pornography use is still a stressful event because pornography use conflicts with the moral code of a wide range of cultures and religions. When religious people use pornography, they experience moral and religious stress (Short, Kasper, & Wetterneck, 2015; Thomas, 2013; Volk et al., 2016). Religious people use religion to solve this kind of stress and the effects of using pornography. In this respect, cultural attitudes and religious acceptance toward sexuality need to be further studied.

Religiosity and Pornography Use

Religion often stresses the belief that people should not drink excessively or use substances or obscenity (Perry & Snawder, 2017; Short et al., 2015; Thomas, 2013). Religiosity is generally considered to be inversely proportional to addictive behavior patterns such as substance abuse and gambling but directly proportional to morality (Grubbs et al., 2015). In the same perspective, it is expected that religious people do not struggle with Internet pornography use. Especially, people in conservative groups, such as religious organizations, are instructed not

to use any pornography. Thus, it is morally difficult for them to approach issues surrounding Internet pornography consciously. There is recent debate about the correlation between religion and the frequency of pornography use (Picone, 2016). Some researchers have not found a significant correlation between intrinsic or extrinsic religion and lifetime use of pornography (Baltazar et al., 2010). Others have found a negative correlation between the use of pornography and religion for both men and women (Braeken & Cardinal, 2008; Nelson et al., 2010; Short et al., 2015). The latter group emphasizes that there is a negative correlation between pornography use and religious activities and beliefs.

Those who do not use pornography are more likely to be active in religious activities, have a strong religious atmosphere in their homes, and be less depressed and healthier in interpersonal relationships (Grubbs et al., 2015). Hardy, Steelman, Coyne, and Ridge (2013) suggested that religion has an indirect effect on the use of pornography due to religious people's moral consciousness. Counselors expect that religious people are less exposed to and tempted by pornography and more interested in morality. However, Edelman (2009) found that pornographic materials are sold more in religious areas than in less religious areas. Many religious people confess the use of pornography, despite feelings of moral guilt. In this manner, even though some researchers have stated that there is a negative correlation between religion and use of pornography (Perry & Snawder, 2017), pastoral counselors and professional counselors should be aware of a weak but significant correlation between pornography use and religious people's acceptance and attitude of pornography.

Additionally, the influence of religiosity on sexuality should be considered a significant factor because a person's religious tendencies, which are influenced by religion group and the degree of religiosity, relates to sexual shame (Ahrold et al., 2011). Religious background and

understanding of sexuality influence pornography use through one's morality and attitude toward pornography (Picone, 2016). According to the research about the relationship between religion and sexuality, religious people are involved in fewer sexual acts and less sex outside of marriage (Murray et al., 2007; Murray-Swank, Pargament, & Mahoney, 2005). However, recent researchers have found that religious pornography users can suffer more from mental illness, addiction, (Carboneau, 2018; Perry & Snawder, 2017; Volk et al., 2016) and marital and relational problems than nonreligious pornography users (Perry & Snawder, 2017) because of their moral and religious condemnation (Makogon & Enikolopov, 2013). Morality and emotion play pivotal roles in maintaining psychological health.

Religious people's morality is generally formed by their theology and beliefs (Perry & Snawder, 2017). Studies on pornography use focus on pornography users who meet diagnostic criteria related to behavioral addiction, but only a handful of pornography users have had to deal with this issue (Cooper et al., 2000; Hilton, 2013; Volk et al., 2016; Wetterneck, Burgess, Short, Smith, & Cervantes, 2012). Researchers state that religious people experience suffering when their behavior does not meet moral and religious beliefs (Carboneau, 2018; Murray et al., 2007). The belief that pornography users have about their use is an important factor in determining whether pornography use will be negative or positive. Negative assessments and subsequent emotional distress are often related to one's personal beliefs (Perry & Snawder, 2017; Volk et al., 2016). Because many religions have vigorously opposed the use of pornography, religious people are vulnerable to shame and guilt about pornography use.

In this respect, it can be said that religious people experience more addiction and negative psychological pain because of their personal faith experience. In addition, along with sexual addiction, hypersexuality needs to be studied for religious people who struggle with sexuality for

over six months. Hypersexuality is considered an important factor causing distress and difficulty of social skill (Gilliland, South, Carpenter, & Hardy, 2011). Thus, religion plays a significant role in determining whether a person is accepting of his or her own use of pornography. Research on the origin and development of beliefs related to the psychological and relational health of users of pornography is important both theoretically and clinically (Volk et al., 2016).

The Role of Religious Education in Sexual Shame

Some Christians are dissatisfied with their failure to live up to their religious doctrines and beliefs. They compare themselves to ideal Christians who are devoted and may accomplish what they believe. The former group is exposed to shame and guilt due to religious condemnation (Short et al., 2015; Thomas, 2013). They are educated not to be involved in inappropriate sexual activities, including pornography use and premarital sex (Exline, 2002). Because of this emphasis on religious education, a person who has a conservative attitude toward sex while attending a fundamentalist church can suffer from sexual shame.

Individuals who attend a fundamentalist church but have a free attitude toward sex do not suffer greatly from sexual shame (Ahrold et al., 2011). Research on how parental faith affects children's faith formation focuses on parental relationships, family structure, and behavioral factors (Murray et al., 2007; Volk et al., 2016). Parents' belief patterns can predict their children's morality and faith formation (Murray et al., 2007). The research reports that the attitudes and behaviors surrounding parents' beliefs strongly influence the formation of children's faith (Volk et al., 2016). Parents directly or indirectly impact the faith of their children through various religious activities in family and community (Petts, 2014). Volk and his colleagues (2016) emphasized four factors that influence children's religious style: the

quality of the parents' faith, the characteristics of the relationship between parents and children, the style of parenting, and the family environment and structure.

When parents present the direction of faith and action to their children through religious education, children emulate their faith by observing their parents' behaviors relating to religious activities (Power & McKinney, 2013; Volk et al., 2016). Furthermore, parents' beliefs and religious activities influence children's social responsibility (Gunnoe, Hetherington, & Reiss, 1999). Even though there are sufficient studies that address a positive perspective on religious transmission from parent to child, researchers should be aware of recent studies about how the experiences and culture of a family relate to the mental suffering of an individual, especially with pornography use (Leonard, Cook, Boyatzis, Kimball, & Flanagan, 2012; Power & McKinney, 2013). Based on researchers' findings, in order to help a patient with sexual shame, the parent-child communication about religious norms about sexuality should be emphasized in both counseling sessions and empirical studies. Religious parents implicitly and explicitly provide values and education relating to the norms of the permissible degree of sexuality, such as homosexuality, premarital sex, and sexual behaviors.

Parents should take a responsibility to provide sex education because parent-child sex communication can play an essential role in the alleviation of the ban of sexuality discussion even in a conservative religious family (Malcom, 2014). Most religious families forbid mentioning pornography and sexuality, so children cannot ask for help when they are exposed to pornography and have difficulties with pornography (Volk et al., 2016). As a result, religious people who struggle with their pornography use have been forced to suffer alone by being held captive by guilt and shame (Abell, Steenbergh, & Boivin, 2006).

Sexual Shame and Psychopathology

Shame is a destructive emotion that can be excruciating for a person and one's family. A person with shame creates a fake-identity in order not to reveal one's true self because of the fear of others' evaluation. If the defense mechanism fails, the person receives a narcissistic injury (Brown, 2006; Dearing & Tangney, 2011). Sexual shame is deeply related to family and cultural background, religious environment, and childhood experiences (Sellers, 2017; Volk et al., 2016). Sexual shame negatively entices a person into the self-consciousness. Because those with sexual shame are overly concerned about revealing their true selves to others, they can easily experience various mental illnesses (Iwen, 2015; McClintock, 2001). The problem is that when this experience becomes chronic, they can develop psychopathology (Hastings, 1998). Without care for sexual shame, a person experiences lower levels of self-esteem. In particular, there is a significant correlation between the sexual shame of children and the formation of identity, ultimately, incorporating that shame into their core understanding of self (Freud, 1905/2000; Mollon, 2005).

Children who are struggling with the conflict between their sexual curiosity and the prohibition of discussion about sexuality try to meet an ideal model by meeting their parents' expectations (Clark, 2017; Sellers 2017). Unfortunately, they typically fail and become disappointed in themselves. They fall into the cognitive trap that they have sexual problems. In the course of the ideal model being frustrated, children form negative self-image that can cause diverse mental problems (Feiring & Taska, 2005; Gordon, 2017; Hastings, 1998). Furthermore, the negative self-image relating to sexuality induces a sexually abnormal tendency and anxiety in relationships. Children with a negative self-image generally suppress their sexual desire and neglect sexual problems. When, due to their culture, children cannot frankly reveal their

sexuality and curiosity to parents, they develop unnecessary guilt and psychological problems in the process of identity formation

Summary

Depending on a person's culture and personality, shame can significantly play a negative role in mental health and relational ability, which are integral components of people's social lives. Several studies introduce this debate. Shame can cause a variety of mental problems. When shame is caused by sexuality, a person suffers from sexual shame. Recently, online (Internet) pornography use has become more prevalent due to the development of technology. Clinical counselors and pastoral counselors should understand that the use of pornography can lead to various critical mental problems. This chapter emphasizes the need of further study and discusses shame, sexual shame, pornography use, religious influences, and various factors related to shame. This researcher hopes that readers of this chapter will understand that mental problems can arise from sexual shame. Chapter Three will provide information on the study's research design, the research process, participants, inventories used, and data analysis.

CHAPTER THREE: METHODS

Research Design

The purpose of this study is to improve the KISS, an instrument designed to measure sexual shame and to establish the reliability of this instrument. The developer of this inventory insisted that it can be used to help clients with sexual shame recover from their shame (Kyle, 2013). This present study emphasized supporting Kyle's research and refining this diagnostic tool to be more simple but effective by (a) recruiting various and sufficient participants, (b) using reliable inventories, and (c) performing effective data analytic strategy. The second purpose of this study was to ensure that a refined diagnostic tool (KISS-9) is related to constructs in theoretically consistent ways. Toward this aim, this research was designed to investigate the relationship between sexual shame, attachment style, and pornography use by using the KISS-9, the ECR-RS, and the CPUI-9. SPSS will be used to perform the factor analysis, particularly exploratory factor analysis (EFA) for stage I and confirmatory factor analysis (CFA) for stages II and III.

Participants

Participants were recruited through MTurk, hosted by the online company Amazon, in order to ensure anonymity and recruit plenty of participants. Participants are ordinary people living in North America. Selection of participants is limited to those who experience using pornography. Some scholars raise concerns about using MTurk for data collection, but a tool that ensures anonymity can be effective because it protects participants' feelings of security when they answer sensitive and secret questions about sexuality. In fact, more diverse and numerous participants were recruited due to the anonymity of the MTurk data collection.

Participants were limited to adults over 18 years of age who have used pornography once or in a while in the last six months. This study sought to recruit more than 500 participants for study 1 because a sample size of more than 500 people can be used to maximize the likelihood of a significant effect size (Warner, 2012). Those who did not complete questions were removed from the sample. The sample size was 640 ($N = 640$) in study 1 and 432 ($N = 432$) in study 2. The data of participants who fail to answer all survey questions will be excluded from the final analysis. In other words, participants who inadvertently answered, incompletely responded, or were identified as multivariate outliers were excluded from the study. The final sample size of the data collection is $N = 637$ for study 1 and $N = 431$ for study 2.

Instruments

Demographic information. This study used standard questions to collect participants' information. The questions consisted of the gender of the participant (male and female; no transgender option was provided), the marital status, age, religious affiliation, education, employment status, race, age, and frequency of pornography use.

Kyle Inventory of Sexual Shame. This study used the KISS (Kyle, 2013) to measure sexual shame. The KISS consists of 20 Likert scale questions to measure participants' past sexual experiences related to shame (e.g., "I replay painful events from my sexual past over and over in my mind," "I feel like I am never quite good enough when it comes to sexuality," and "I think people would look down on me if they knew about my sexual experiences"). Participants voluntarily responded to these statements using the six-point Likert scale from "strongly disagree" (1) to "strongly agree" (6). Scores on the KISS have been considered to show evidence for internal consistency (Kyle, 2013).

Experiences in Close Relationships–Revised (ECR-R) Questionnaire. The Relationship Structures questionnaire of the ECR-R (Fraley et al., 2000) was used to examine participants' relationship styles to others. This study's participants responded to the questions using a seven-point Likert scale from "strongly disagree" (1) to "strongly agree" (7). The ECR-R contains the first 18 items relating to attachment-related anxiety and the second 18 items relating to attachment-related avoidance.

Experiences in Close Relationships–Relationship Structure (ECR-RS) Questionnaire. The Relationship Structures questionnaire of the ECR-RS (Fraley, Heffernan, Vicary, & Brumbaugh, 2011) was used to examine participants' relationship styles to mothers and fathers. Participants responded to the questions using a seven-point Likert scale from "strongly disagree" (1) to "strongly agree" (7). This questionnaire is a self-reporting tool designed to assess attachment patterns in a variety of close relationships: mother, father, current partner, friend, and therapist. The same nine items are used to assess attachment styles with each of these five close relationships. (e.g., "It helps to turn to this person in times of need (R)," "I usually discuss my problems and concerns with this person (R)," "I don't feel comfortable opening up to this person," and "I prefer not to show this person how I feel deep down"). Items one to six are designed to measure participants' avoidant attachment, while items 7 to 9 are designed to measure their anxious attachment. This present study focused on attachment to one's mother and father.

The Cyber-Pornography Use Inventory-9. In order to develop an improved KISS inventory, this current research has associated the refined KISS with the CPUI-9 (Grubbs et al., 2015). The nine-item CPUI-9 was designed to measure online pornography use behavior. Participants rate each item on a seven-point Likert-type scale ranging from 1 (not at all) to 7

(extremely). The higher the score, the greater the difficulty with Internet pornography use.

Researchers report that the CPUI-9 has the appropriate psychometric results. The CPUI-9's

Cronbach's alpha of its total scale and its three subscales are: total scale $\alpha = .75-.81$; efforts α

$= .75-.81$; guilt $\alpha = .81-.89$; compulsivity $\alpha = .74–.83$ (Grubbs et al., 2015). Based on these data,

this present study will investigate the KISS-9's relationship with CPUI-9's total, emotional

distress, compulsivity, and access efforts.

Research Questions

Research Question 1

What are the latent constructs that emerge from a refined set of items derived from the

KISS?

Research Question 2a

Does a one-factor model have a close model fit?

Research Question 2b

Does a two-factor model have a close model fit?

Research Question 2c

Does a bifactor model have a close model fit?

Research Question 3

Are the refined KISS subscales related to other measures in a way that is theoretically

consistent with shame?

Data Processing and Analysis

Data collected by MTurk will be uploaded into IBM SPSS statistics version 25 with

PROCESS macro for SPSS. CFA and EFA were used for data analysis of this present study.

CFA confirms assumptions about the factor structure of a developed scale through comparison

with given empirical data, while EFA explores the relationship between factors and measurement variables without assumptions about the structure of a given scale. In the first study, EFA was used to refine the initial battery of 20 items of the KISS, which was developed to help diagnose and treat patients' sexual shame. The KISS will be reduced to nine more simple and efficient questions through EFA. This researcher will name the refined KISS obtained through EFA the KISS-9. In the second study, CFA was used to determine whether the refined KISS had a significant relationship with CPUI-9. This second study will cover three subquestions (2a to 2c) under RQ2. In the last study, CFA will be used to explore whether the refined KISS subscales related to other measures are theoretically consistent with shame.
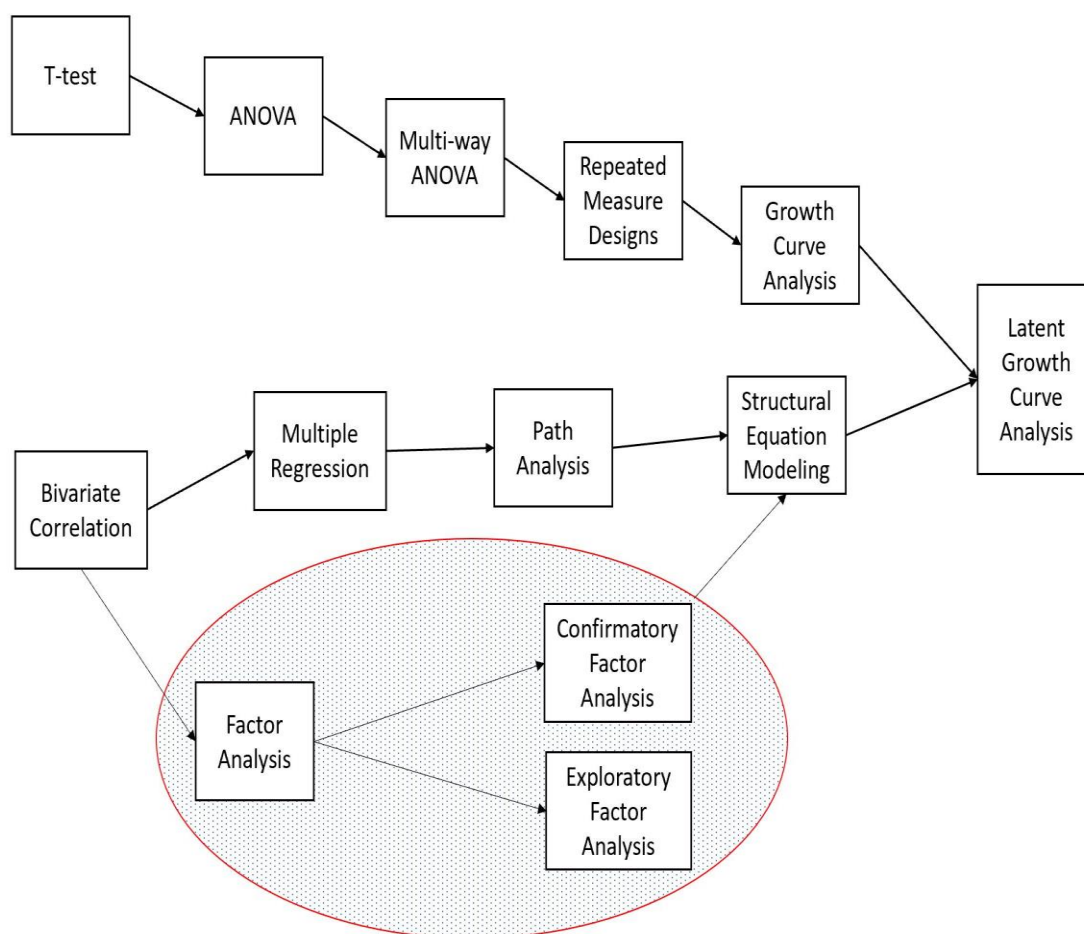
Figure 1. Structure and position of factor analysis.

Summary

This chapter introduced the survey inventories, the purpose of the research, the research questions, and the analytical process that will be used to produce the research results. To make this study meaningful, this researcher selected participants and empirically qualified inventories. In addition, this chapter explained how participants were obtained using the designed research plan, the data analysis procedure, and the data processing methods of EFA and CFA.

CHAPTER FOUR: FINDINGS

Introduction

The purpose of this study was to develop the KISS-9 and to investigate the relationship between sexual shame, pornography use, and relationship styles. If the refined KISS has validity and reliability, it can be used not only to assess a person's sexual shame, but also to play a pivotal role in proper treatments by helping counselors and clients understand the relationship among sexual shame, sexuality, and life events. Testing the validity and reliability of the refined KISS will provide data on the psychometric properties of the scale, which can then be used to further explore the relationship between sexual shame, pornography use, and attachment-based avoidance/anxiety. Professional counselors and pastoral counselors should understand these relationships in order to have better case conceptualization and facilitate better effective goal setting and treatment with clients. The KISS was developed to assess a person's sexual shame, but clinical data relating to its validity and reliability cannot be obtained because of items on the original KISS that relate to cause and effect (Kyle, 2013). Thus, the KISS-9 was developed. Further testing of its validity is required, which was part of the purpose of this study.

Data Screening

A sample of 640 participants in Study 1 was obtained through MTurk. The data were screened to remove participants whose responses would threaten the study's validity. Participants were asked to answer multiple demographic items, provide informed consent, and respond to questions about their sexual shame. The researcher removed participants who did not complete the questions and the informed consent correctly. The research obtained 637 participants ($N = 637$) for developing the KISS-9. For Study 2, the researcher obtained 432 participants through MTurk. The data were screened to remove participants whose responses

would threaten the study's validity. Participants were asked to answer multiple demographic items, provide informed consent, and respond to questions about their pornography use, relationship to their parents, and sexual shame. The researcher obtained 431 participants ($N =$ 431) for examining the validity of the KISS-9 and the correlation between participants' sexual shame (KISS-9), pornography use (CPUI), and relationship with parents (ECR-R, ECR-RS).

Participant Demographics

Demographics of the viable participants in Study 1 were reviewed after data screening ($N = 637$). Participants' ages ranged from 18 to 74 ($M = 35.49$, $SD = 11.143$). The majority of the sample was Caucasian/white (81.4%); 7.0% described their race as African American/Black, 5.3% Hispanic, Latino or of Spanish Origin, 3.0% Asian, 0.5% Native Hawaiian or other Pacific Islander, 0.3% American Indian and Alaska Native, and 1.9% chose "other." They reported their relationship status as follows: currently married or have a life partner (69.2%), single and never in a serious relationship (2.7%), single and not currently in serious relationship (5.9%), in a non-committed dating relationship (2.8%), in a monogamous dating relationship (12.0%), married but legally separated (2.3%), divorced (4.4%), and widowed (0.5%). Participants endorsed the following religious affiliations: Nondenominational Christian (17.5%), Protestant (15.0%), Catholic (13.3%), New Age/Wiccan (2.3%), Jewish (2.2%), Buddhist (1.4%), Mormon (0.9%), Muslim (0.6%), Jehovah's witness (0.5%), Hindu (0.2%), Taoist (0.3%), no religious affiliation (38.8%), and other (6.6%). The participants' demographic data for Study 1 are presented in Table 1.

Table 1

Participant Demographics for Study 1

	Age			
N	Minimum	Maximum	Mean	Std. Deviation

	N	Minimum	Maximum	Mean	Std. Deviation
What is your age?	637	18	74	35.49	11.143
Valid N (listwise)	637				

	Frequency	Percent
Gender		
Male	292	45.6
Female	348	54.4
Race		
Caucasian/White	521	81.4
African American/Black	45	7.0
American Indian and Alaska Native	2	0.3
Asian	19	3.0
Native Hawaiian or other Pacific Islander	3	0.5
Hispanic, Latino or of Spanish Origin	34	5.3
Other	12	1.9
No response	4	0.6
Relationship status		
Single (never been in a serious relationship)	17	2.7
Single (not currently in serious relationship)	38	5.9
Non-committed dating relationship	18	2.8
Monogamous dating relationship	77	12.0
Married/life partner	443	69.2
Married but legally separated	15	2.3
Divorced	28	4.4
Widowed	3	0.5
No response	1	0.2
Religion		
Protestant	96	15.0
Catholic	85	13.3
Christian (nondenominational)	112	17.5
Mormon	6	0.9
Jehovah's Witness	3	0.5
Muslim	4	0.6
Hindu	1	0.2
Jewish	14	2.2
Buddhist	9	1.4
New Age/Wiccan	15	2.3
Taoist	2	0.3
None	248	38.8
Other	42	6.6
No response	3	0.5

Demographics of the participants in study 2 showed that that 47.9% of participants were male, 52.1% were female. Participants' ages ranged from 18 to 71 (M = 34.3457, SD =

10.42844). The majority of the participants was Caucasian/White (83.1%); 5.6% described their race as African American/Black, 5.1% Hispanic, Latino or of Spanish Origin, 2.8% Asian, 0.2% Native Hawaiian or other Pacific Islander, 1.2% American Indian and Alaska Native, and 1.9% chose "other." They described their relationship status as follows: currently married or have a life partner (47.0%), single and never in a serious relationship (4.9%), single and not currently in serious relationship (13.9%), in a non-committed dating relationship (4.9%), in a monogamous dating relationship (23.1%), married but legally separated (0.9%), divorced (4.6%), and widowed (0.7%). Participants endorsed the following religious affiliations: Nondenominational Christian (21.1%), Protestant (16.2%), Catholic (13.7%), Mormon (1.2%), Jehovah's witness (0.2%), Muslim (0.5%), Hindu (0.2%), Jewish (1.4%), Buddhist (1.2%), New Age/Wiccan (1.2%), Taoist (0.5%), no religious affiliation (36.8%), and other (6.0%). Participants described their Belief in God by stating that "I believe there is a God" (52.5%), followed by "I sometimes believe there is a God" (17.1%), "I used to believe there was a God but do not anymore" (16.4%), and "I do not believe there is a God and I cannot say that I have ever believed in a God" (13.7%). The participants' demographic data for Study 2 are presented in Table 2.

Table 2

Participant Demographics for Study 2

Age					
	N	Minimum	Maximum	Mean	Std. Deviation
What is your age?	431	18.00	71.00	34.3457	10.42844
Valid N (listwise)	431				

	Frequency	Percent
Gender		
Male	207	47.9
Female	225	52.1

Race

Caucasian/White	359	83.1
African American/Black	24	5.6
American Indian and Alaska Native	5	1.2
Asian	12	2.8
Native Hawaiian or other Pacific Islander	1	.2
Hispanic, Latino or of Spanish Origin	22	5.1
Other	9	2.1

Relationship status

Single (never been in a serious relationship)	21	4.9
Single (not currently in serious relationship)	60	13.9
Non-committed dating relationship	21	4.9
Monogamous dating relationship	100	23.1
Married/life partner	203	47.0
Married but legally separated	4	0.9
Divorced	20	4.6
Widowed	3	0.7

Religion

Protestant	70	16.2
Catholic	59	13.7
Christian (nondenominational)	91	21.1
Mormon	5	1.2
Jehovah's Witness	1	0.2
Muslim	2	0.5
Hindu	1	0.2
Jewish	6	1.4
Buddhist	5	1.2
New Age/Wiccan	5	1.2
Taoist	2	0.5
None	159	36.8
Other	26	6.0

Belief in God

I believe there is a God.	227	52.5
I sometimes believe there is a God.	74	17.1
I used to believe there was a God but do not anymore.	71	16.4
I do not believe there is a God and I cannot say that I have ever believed in a God.	59	13.7
No response	1	0.2

Data Analysis

After data were collected through MTurk, by the use of IBM SPSS, data analysis was

performed to ensure validity by removing participants who would increase the probability of

threats to validity. An EFA was conducted to refine the initial battery of 20 items of the KISS, which was reduced to nine efficient questions (the KISS-9). By using Maximum Likelihood Extraction with Oblique Rotation, the original battery of 20 items of KISS was reduced. The KISS has some items relating to cause and effect that confound rather than distinguish conceptually distinct feelings of sexual shame irrespective of cause: (1) "I feel ashamed about having sex with someone when I didn't want to," (2) "I feel ashamed about a time when I had sex that was not totally consensual," (3) "I feel ashamed about being unfaithful sexually promiscuous," and (4) "I feel ashamed about having same-sex attractions." The researcher extracted the four questions which related to the cause and effect of sexual shame. The EFA was conducted to check the items more than 0.8 from the items extracted by recording a value of 0.4 or more.

For developing the refined KISS, the researcher also considered the three categories of the initial KISS: thoughts about others, thoughts about the past, and thoughts about self. The KISS is comprised of some items relating to thoughts about others: (1) "I sometimes avoid certain people because of my past sexual choices," (2) "I have an overpowering dread that my sexual past will be revealed in front of others," (3) "I feel afraid other people will find out about my sexual defects," and (4) "I think people would look down on me if they knew about my sexual experiences." The items for thoughts about past are: (1) "I sometimes try to conceal the kind of person I am in regard to my sexual experiences," (2) "I replay painful events from my sexual past over and over in my mind," (3) "I scold myself and put myself down when I think of myself in past sexual situations," (4) "I feel satisfied with my sexual choices and experiences," (5) "When I think about my sexual experiences, I feel defective as a person, like something is inherently wrong with me," (6) "I feel good about myself with regard to my past sexual choices,"

and (7) "I feel empty or unfulfilled when I think of my sexual experiences." Except "I replay painful events from my sexual past over and over in my mind," all items relating to thoughts about past were extracted from the initial KISS (see Table 3).

The KISS includes subscales relating to thoughts for self: "I feel like I am never quite good enough when it comes to sex," "I feel ashamed of my sexual abilities," "I feel ashamed about my sexual fantasies," "I feel ashamed of my body when I am in a sexual situation," and "When it comes to sex, I feel like I am a worthy person who is at least equal to others."

Maximum Likelihood Extraction of the Initial KISS

The EFA was conducted to check the items more than 0.8 from the items extracted by recording a value of 0.4 or more. By using these criteria, 11 items that were less than 0.4 or close to 0.4, or if the commonality is less than 0.4, were removed from the 20 items of the initial KISS. The KISS-9 has internal consistency (Cronbach's α =.81 to .87; see Tables 5 and 6).

Table 3

Final Factor Structure (Pattern Matrix) using Maximum Likelihood Extraction with Oblique Rotation

Item	1	2	r^2
I have an overpowering dread that my sexual past will be revealed in front of others.	.935		.87
I sometimes avoid certain people because of my past sexual choices.	.689		.47
I feel afraid other people will find out about my sexual defects.	.633		.40
I replay painful events from my sexual past over and over in my	.547		.30

Item	1	2	r^2
mind.			
I think people would look down on me if they knew about my sexual experiences.	.426		.18
I feel like I am never quite good enough when it comes to sex.		.860	.74
I feel ashamed of my sexual abilities.		.763	.58
I feel ashamed of my body when I am in a sexual situation.		.676	.46
I feel ashamed about my sexual fantasies.		.513	.26

Factor 1: Thoughts about others. The first factor consists of five items that assess to what degree participants feel sexual shame relating to thoughts about others. The first factor of the KISS-9 are five items that follow: (1) "I have an overpowering dread that my sexual past will be revealed in front of others" (a value of .935), (2) "I sometimes avoid certain people because of my past sexual choices" (.689), (3) "I feel afraid other people will find out about my sexual defects" (.633), (4) "I replay painful events from my sexual past over and over in my mind" (.547), and (5) "I think people would look down on me if they knew about my sexual experiences" (.426). The first factor of the KISS-9 is positively related with the ECR-R anxiety ($r = .491$) and ECR-RS anxiety ($r = .330$), while it is not significantly related with ECR-R avoidance ($r = .043$) and ECR-RS avoidance ($r = .150$).

Factor 2: Thoughts about self. The second factor contains four items that assess to what degree participants feel sexual shame relating to thoughts about self. As mentioned in Chapter Two, shame is a negative emotion associated with self-consciousness and feelings of inferiority and powerlessness (Gilbert et al., 1996; Gilbert & Irons, 2009). The second factor of the KISS-9

are four items as following: (1) "I feel like I am never quite good enough when it comes to sex" (.860), (2) "I feel ashamed of my sexual abilities" (.764), (3) "I feel ashamed of my body when I am in a sexual situation" (.676), and (4) "I feel ashamed about my sexual fantasies" (.513).

Confirmatory Factor Analysis for the KISS-9

In order to develop the refined KISS, this research presented three questions: (1) "Does a one-factor model have a close model fit?" (2) "Does a two-factor model have a close model fit?" and (3) "Does a bifactor model have a close model fit?" Based on these research questions, this study's order of analysis was to assess the one-factor, two-factor, and bifactor models. MPLUS was used to assess model-fit for all CFAs. The Standardized Root Mean Residual (SRMR) and Root Mean Square Error of Approximation (RMSEA) were used to assess absolute fit. In addition, the Comparative Fit Index (CFI) was used to assess the incremental fit. Extractions for close fit are $<.08$ for SRMR, $<.06$ for RMSEA, and $>.95$ for CFI (Hu & Bentler, 1998, 1999). The result of one-factor CFA shows that SRMR (.080), RMSEA (.141) and CFI (.810) were not indicative of close fit. The two-factor CFA yielded a close fit for SRMR (.055) but not for RMSEA (.087) nor CFI (.930). However, the bifactor CFA had a close fit for SRMR (.028), for RMSEA (.048), and CFI (.984; see Table 3). The pattern of model fit with the one-factor and two-factor was not similar to the refined KISS, but the pattern of model fit with the bifactor models was similar to the refined KISS. The subscales of the KISS-9 were internally consistent.

Table 4

Fit Indices for KISS-9 CFA Models

Model	X^2_{SB}	*df*	SRMR	RMSEA$_{SB}$	CFI$_{SB}$
one-factor	257.448	27	.080	.141	.810

two-factor	11.389	26	.055	.087	.930
bifactor (2x1)	38.243	19	.028	.048	.984

Note: X^2_{SB} = Satorra-Bentler (SB) adjusted chi-square; SRMR = standardized root mean square residual; $RMSEA_{SB}$ = the SB scaled root mean square approximation; CFI_{SB} = the SB scaled comparative fit index.

Validity of the KISS-9

Results show that the refined KISS-9 has good internal consistency (Sample 1's Cronbach's α =.82 for KISS-9 others, .82 for KISS-9 self, and .87 for KISS-9 total. Sample 2's Cronbach's α =.81 for KISS-9 others, .82 for KISS-9 self, and .86 for KISS-9 total; see Table 4 for Sample 1 & Table 5 for Sample 2). Research question three is focused on the relationship between the KISS-9 and the CPUI-9 and attachment-based anxiety or avoidance. First, consistent with previous literature, this researcher would expect the KISS-9 and its two subscales to be positively related to the CPUI-9 and all its subscales (Grubbs et al., 2015). As expected, the KISS-9 was positively related to all three CPUI subscales in both samples (see Tables 4 and 5). Second, given the content of the KISS-9 subscales, this researcher hypothesized that the KISS-9 total would be differentially related to the CPUI-9 subscales. In particular, this researcher expected that the KISS-9 total would have a stronger relationship with CPUI negative affect compared to the CPUI efforts and CPUI compulsivity subscales (Grubbs et al., 2015). While this finding was supported, the difference between efforts and negative affect in the second sample was negligible. This suggests that the KISS-9 has good internal consistency and that it has good convergent validity; further work needs to be accomplished to assess its discriminant validity.

Table 5 Pearson's *r*s, Means, Standard Deviations, and Cronbach's αs for Sample 1

Scale	1	2	3	4	5	6	7	8	9
KISS9-Others	1								
KISS9-Self	.636**	1							
KISS9-Total	.893**	.915**	1						
CPUI: Compulsivity	.232**	.142**	.204**	1					
CPUI: Negative Affect	.260**	.345**	.337**	.151**	1				
CPUI: Efforts	.308**	.144**	.245**	.375**	.188**	1			
CPUI: Total	.380**	.328**	.390**	.639**	.754**	.682**	1		
ECRR: Anxiety	.491**	.535**	.568**	.068	.201**	.138**	.209**	1	
ECRR: Avoidance	.043	.034	.043	-.022	.123**	-.012	.062	.109**	1
M	2.657	2.794	2.726	3.027	1.988	1.520	2.178	3.453	4.228
SD	1.310	1.460	1.253	.920	1.460	.998	.790	1.056	.442
Cronbach's α	.82	.82	.87	.82	.77	.86	.79	.94	.92

Table 6 Pearson's *r*s, Means, Standard Deviations, and Cronbach's αs for Sample 2

Scale	1	2	3	4	5	6	7	8	9
KISS9-Others	1								
KISS9-Self	.572**	1							
KISS9-Total	.900**	.872**	1						
CPUI: Compulsivity	.326**	.345**	.377**	1					
CPUI: Negative Affect	.375**	.365**	.418**	.631**	1				
CPUI: Efforts	.359**	.374**	.413**	.579**	.509**	1			
CPUI: Total	.416**	.427**	.474**	.872**	.809**	.851**	1		
ECRRS: Anxiety	.330**	.434**	.427**	.258**	.341**	.186**	.299**	1	
ECRRS: Avoidance	.150**	.245**	.219**	.201**	.159**	0.074	.167**	.523**	1
M	2.945	3.039	2.992	2.235	1.730	2.217	2.061	3.171	2.608
SD	1.404	1.562	1.308	1.549	1.233	1.721	1.271	1.070	1.296
Cronbach's α	.81	.82	.86	.89	.84	.92	.91	.90	.90

Summary

A sample of 640 participants who experienced sexual shame was used to develop the KISS-9, and a sample of 432 adults who reported their experiences about sexual shame and pornography use was used to examine the relationship between those factors and relational styles in this study. EFA was used to answer the first research question: What are the latent constructs that emerge from a refined set of items derived from the KISS? By using Maximum Likelihood Extraction with Oblique Rotation, this research found a final factor structure (pattern matrix) relating to sexual shame from this process: thoughts about the self and thoughts about others. based on this finding. The second set of questions was answered by using CFA: Does a one-factor model have a close model fit? Does a two-factor model have a close model fit? Does a bifactor model have a close model fit? The results showed that the bifactor CFA had a close fit model for SRMR (.028), for RMSEA (.048), and CFI (.984), while the one-factor CFA and the two-factor CFA did not yield a close fit model. The third research question was, "Are the refined KISS subscales related to other measures in a way that is theoretically consistent with shame?" The results showed that the KISS-9 was positively related to all three CPUI subscales in two samples. Furthermore, the KISS-9 total would have a stronger relationship with CPUI negative affect compared to the CPUI efforts and CPUI compulsivity subscales. In conclusion, the KISS-9 can be used to assess a patient's sexual shame in clinical counseling settings because of its good internal consistency and good convergent validity.

CHAPTER FIVE: SUMMARY, DISCUSSION, AND RECOMMENDATIONS

This study is based on Kyle's (2013) previous work that emphasized the influence of people's thoughts and feelings about sexual shame has on their mental health . The KISS was designed to assess sexual shame so that those who help individuals struggling with shame relating to sexuality could provide better assessments and treatments to their clients. This study focused on identifying the latent factors of the KISS-9 and assessing its reliability and validity. Shame consists of the self-conscious evaluative emotions. Sexual shame is a feeling of shame associated with sexuality. In this manner, a person's thoughts about others (factor 1) and the self (factor 2) should be considered as a pivotal factor influencing one's feeling of shame relating to sexuality. Once a person's dysfunctional experiences and feelings associated with sexual shame internalize, the individual's thoughts for the self negatively influence his or her ability to trust, communicate, and form physical and emotional closeness. Chapter Four provided the results and descriptions of the data analysis relating to the KISS-9 and its subscales, factor 1 and factor 2. This chapter provides the findings and their significance. It also includes discussion of each of the research questions investigated in the study. Furthermore, implications for professional counselors, limitations of the study, and suggestions for future research are described.

Summary of Findings

Participants were recruited through MTurk. A sample of 637 participants for Study 1 and a sample of 431 participants for Study 2 completed a survey that included demographic information, the KISS, CPUI-9, ECR-R, and ECR-RS. Of the participants who completed the survey, 637 participants in Study 1 and 431 participants in Study 2 were retained through data screening. In Study 1, the participants were between the ages of 18 and 74 ($M = 35.49$, $SD = 11.143$) and most often female (54.49%), White/Caucasian (81.4%), married or had a life partner

(69.2%), and nondenominational Christian (17.5%). In Study 2, the participants were between the ages of 18 and 71 ($M = 34.3457$, $SD = 10.42844$) and most often female (52.1%), White/Caucasian (83.1%), married or had a life partner (47.0%), nondenominational Christian (21.1%) and brief in God (52.5). This study included three research questions, which are further discussed below.

Research Question 1

The first research question sought to identify the latent constructs that emerge from a refined set of items derived from the original KISS (Kyle, 2013) that has been used to measure sexual shame. The original KISS consists of 20 Likert-scale questions that measure participants' past and present sexual experiences related to shame (e.g., "I replay painful events from my sexual past over and over in my mind," "I feel like I am never quite good enough when it comes to sexuality," and "I think people would look down on me if they knew about my sexual experiences"). First, the researcher removed four items that were related to cause and effect. Then, by conducting EFA, seven items of the original KISS (20 items) that were less than 0.4 or close to 0.4, or had commonality less than 0.4 were removed.

Results showed that there were two factors: (1) thoughts about others, and (2) thoughts about the self. The first factor had five items as following: (1) "I have an overpowering dread that my sexual past will be revealed in front of others" (a value of .935), (2) "I sometimes avoid certain people because of my past sexual choices" (.689), (3) "I feel afraid other people will find out about my sexual defects" (.633), (4) "I replay painful events from my sexual past over and over in my mind" (.547), and (5) "I think people would look down on me if they knew about my sexual experiences" (.426).

Additionally, the second factor had four items as following: (1) "I feel like I am never quite good enough when it comes to sex" (.860), (2) "I feel ashamed of my sexual abilities" (.764), (3) "I feel ashamed of my body when I am in a sexual situation" (.676), and (4) "I feel ashamed about my sexual fantasies" (.513). This study found that 9 items of the KISS-9 have statistically internal consistency (Cronbach's α =.81 to .87). This finding suggests that the KISS-9 may be an instrument that can assess a person's sexual shame so providers may offer appropriate treatments relating to feelings of sexual shame.

Research Question 2

Under the second research question, which sought to determine whether the KISS-9 maintained a close model fit, three models were examined: (1) a one-factor model, (2) a two-factor model, and (3) a bifactor model. By using the SRMR, RMSEA, and the CFI, this study found that the pattern of model fit with the bifactor model was a close model fit with the KISS-9, while the pattern of model fit with the one factor and two factor models were not: (1) The one-factor model that had SRMR (.080), RMSEA (.141) and CFI (.810) were not indicative of close fit, (2) the two factor model yielded a close fit for SRMR (.055) but not for RMSEA (.087) nor CFI (.930), and (3) the bifactor model had a close fit for SRMR (.028), for RMSEA (.048), and CFI (.984) . The consistency of the subscales of the KISS-9 was found. For providing better treatments, counselors should be equipped with appropriate information and assessments about shame and sexual shame. Counselors need to understand that clients with low self-esteem caused by shame are vulnerable to mental problems like anger, contempt, jealousy, and depression because they are overly anxious to others' evaluation (Gilbert et al., 1996). Clients with sexual shame are not able to properly respond to external stimuli and are weak in resilience. Furthermore, results showed that the KISS-9 could be used to assess clients' sexual shame. In

this manner, there is hope that professional counselors and pastoral counselors can use this new instrument (the KISS-9) to assess clients' feeling of shame relating to sexuality.

Research Question 3

The third research question sought to determine whether the refined KISS subscales related to other measures in a way that is theoretically were consistent with shame. With this question, the research sought to determine whether there is a significant relationship between sexual shame, pornography use, and relationship styles. Sexual shame was found to be significantly correlated with pornography use and anxious attachment but not significantly related to avoidant attachment. Particularly, as expected in the first sample, the KISS-9 was proven to have a stronger relationship with CPUI negative affect compared to the CPUI efforts and CPUI compulsivity subscales. The difference between the CPUI efforts and the CPUI negative affect in the second sample was negligible. The KISS-9 was shown to have good internal consistency and good convergent validity. In this manner, this research suggests that further work needs to be accomplished to assess its discriminant validity.

Results showed that there is a significant relationship between pornography use and sexual shame. Pornography users are generally not able to build intimate relationships with others because of their sexual shame, while those who do not use pornography are less depressed and healthier in interpersonal relationships. In addition, as mentioned in Chapter Three, religious beliefs and understanding of sexuality may influence pornography users' relationship style. In this manner, it was meaningful to find that sexual shame was significantly related to anxious attachment but not significantly related to avoidant attachment.

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Limitations

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There are a number of limitations to this study. The first limitation of this study was the

assumption that the original KISS measures one's sexual shame as a reliable and valid instrument. Despite the support in the literature, it remains an assumption that the original KISS measures feeling of shame relating to sexuality and has reliability and validity. The KISS-9 is an adaption of the original KISS. Second, this study was limited to a population of mostly White/Caucasian individuals (81.4% for Study 1 & 83.1% for Study 2). The findings cannot be generalized to various ethnic groups. The third limitation is about the participants who were assumed to have the cognitive ability to self-reflect on their experiences. It was further assumed that they understood the questions and could formulate responses to the questions that articulate their experiences. Since the data are self-reported by the participants, their information could be reported inaccurately.

The fourth limitation is that the participants' report of their sexual shame was based on their interpretation. This creates an assumption that the participants can identify their feelings and thoughts about sexual shame. A final limitation is the participants' familiarity with using electronic devices and the Internet. Participants who have the competency to find and use MTurk are assumed to have competency with other Internet-based activities. The frequency of their interactions with the Internet may increase their susceptibility to access sexual content that possibly induces sexual shame. Another assumption relating to MTurk is that it provides a high-diversity sample of participants who use pornography. This sample may not be generalizable to all pornography users. Also, MTurk users have been reported to have lower self-esteem, lower emotional stability, and lower extraversion (Goodman, Cryder, & Cheema, 2013). MTurk users are also typically young and well educated (Paloacci et al., 2014) making them less representative of the overall population.

Discussion and Recommendations

In this section, suggestions for future research based on the results of this study are provided. More clinical research should be conducted to obtain the validity and reliability of the KISS-9 with sufficient participants. Furthermore, implications for professional counselors and counseling researchers will be provided to help them understand practical applications to clinical and pastoral settings.

Suggestions for Future Study

Future research should continue to explore the multiple findings produced by this study. The first consideration is about future outcomes with the KISS-9 and its validation through testing and additional future research. For the additional validation, this research suggests that more studies with a CFA relating to the KISS-9 should be conducted to test the one-factor and two-factor models with specific subgroups. CFA can play a significant role in confirming assumptions about the factor structure of a developed scale through comparison with empirical data. Furthermore, future study may need to recruit various ethnic groups for obtaining the KISS-9's validation.

Further study may need to investigate the relationship between various religious participants, sexual shame, and relationship style with others. The KISS-9 consists of factor 1 (thoughts about others) and factor 2 (thoughts about the self). Religiosity can be considered as a factor influencing a person's thoughts about others relating to sexual shame because religiosity is generally considered to be inversely proportional to addictive behavior patterns but directly proportional to morality (Grubbs et al., 2015). A negative correlation between the use of pornography and religious activities and beliefs has been reported (Braeken & Cardinal, 2008; Nelson et al., 2010; Short et al., 2015). Professional counselors should be aware of that religious

pornography users can suffer more from mental illness, addiction, and relational problems than nonreligious pornography users (Perry & Snawder, 2017; Volk et al., 2016) because of their moral and religious condemnation (Makogon & Enikolopov, 2013).

Religious people experience suffering when their behaviors do not match their moral and religious beliefs (Carboneau, 2018; Murray et al., 2007). Thoughts about others relating to sexual shame play pivotal roles in maintaining psychological health. In this manner, this researcher suggests that the relationship between sexual shame, life events relating to sexuality, religious beliefs, and religious activities should be studied. Additionally, future study should include more ethnic groups in order to validate the KISS-9. This researcher also suggests that the relationship between sexual shame and self-esteem should be studied with various mediators and moderators, such as God attachment (Clinton & Straub, 2010), God image (Exline, Park, Smyth, & Carey, 2011), religious doubt (Krause, 2015).

Furthermore, the relationship between sexual shame and mental problems, like depression and addiction, should be studied. Sexual shame has been considered as a factor influencing a person's identity and self-esteem, which are important factors helping individuals to develop coping skills for depression (Gilbert & Irons, 2009). Professional counselors and pastoral counselors should understand that people with low self-esteem often struggle with depression because of their lack of ability to respond to external stimuli and the weakness in resilience.

Counselors need to know that depression is a common result of shame (Gilbert, 2000). A person with shameful feelings relating to sexuality may struggle with shameful thoughts that can trigger one's depressive mood. Additionally, early shame experiences are considered a significant factor in depression. In this manner, future studies may investigate the relationship

between sexual shame, self-esteem, relational attachment, and depression.

Implications

This study's findings have more implications for counselors than simply those regarding sexual shame and pornography use. This study provides a foundation for additional considerations of how a person with sexual shame improves his or her relationships with others by offering an understanding of the influence of religiosity on sexual shame. The primary finding of this study is that attachment-based anxiety, sexual shame, and pornography use are significantly correlated. This researcher has helped many Asian American Christians who struggle with shame and sexual shame. Most of them are influenced by their culture, which makes them fearful of others' evaluation. In this manner, this counselor should understand how the culture of his clients and church members impacts their anxiety and self-esteem so he may provide better assessments and treatment. In particular, these clients have been taught not to be involved in inappropriate sexual activities, like pornography use, homosexual relationships, and premarital sex. Some Christians struggle with a feeling of failure and shame because they fail to live up to their religious beliefs. The primary finding of this study may help counselors understand the relationship sexual shame and anxiety and therefore provide better treatment to religious clients influenced by shame culture. As a pastoral counselor, this researcher suggests that various small group dealing with sexuality should be performed by using the KISS-9.

The clinical implications for treating people with sexual shame should be considered. Clinical counselors and professional counselors should be aware of the absence of diagnosis associated with sexual shame in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Therefore, unfortunately, there are no evidence-based assessments and treatments for sexual shame. Due to this lack of support through this manual, the treatment of sexual shame is

managed in various ways that may be ineffective or unethical. Counselors should understand that better treatments for sexual shame and pornography use can be developed by investigating additional research on the impact of sexuality.

Chapter Conclusion

This chapter provided a summary of the findings, limitations and assumptions, and recommendations, including suggestions for future study and implications for counselors. Three main findings were described. First, the KISS-9 may be an instrument that can assess a person's sexual shame so that counselors may provide appropriate treatment for feelings of sexual shame. Second, the validity and consistency of the subscales of the KISS-9 were found so that professional counselors may use this new instrument (KISS-9) to assess clients' sexual shame. Third, the KISS-9 was proven to have a stronger relationship with CPUI negative affect compared to the CPUI efforts and CPUI compulsivity subscales. Based on the finding that the KISS-9 has good internal consistency and good convergent validity, future research relating to validation of the KISS-9 through additional testing, using this scale with other populations, and the inclusion of additional variables are suggested. This study also provides various implications for counselors to help individuals suffering from mental problems relating to sexual shame.

Summary of Study

The investigation into the literature about shame, sexuality, sexual shame, attachment-based relationship style, pornography use, and religiosity was required to develop an inventory to assess sexual shame. The original KISS is comprised of some items regarding cause and effect rather than the conceptually distinct feelings of sexual shame irrespective of the cause. Additionally, the original KISS has not really been validated on multiple samples. It was developed as a part of a broader clinical study on people who were experiencing sexual shame.

Refining the original KISS was required to develop an inventory with validation and consistency. In this study, the separation of cause and effect was key to understanding the factors that may moderate the relationship between a specific potential cause of shame and feelings of sexual shame.

Refining the original KISS that contained 20 items produced the KISS-9. This research found two factors that came out of the development of the KISS-9: thoughts about others and thoughts about self. This study also found support for a strong relationship between sexual shame and pornography use/negative affect. Furthermore, this study found that there is a significant correlation between anxiety, pornography use, and sexual shame, while the relationship between avoidance, pornography use, and sexual shame is not significant. Through MTurk, this study recruited 640 participants for Study 1 and 432 participants for Study 2 who were kept after screening. Factor analysis (EFA and CFA) refined 20 items of the original KISS to nine items of the KISS-9 that were found to have the validity and consistency of its subscales. The KISS-9 has potential to increase the larger body of knowledge about sexual shame.

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APPENDIX A: Demographic Survey

1. Gender:
_____ Female _____ Male _____ Other, Please specify: _____

2. Age: _____

3. Ethnicity:
_____ Multi-ethnic/racial _____ Native American _____ African American
_____ Asian American _____ Caucasian/Euro-American
_____ Hispanic or Latin American _____ Other, Please specify: _____

4. Relationship status:
_____ Single (never been in a serious relationship)
_____ Single (not currently in serious relationship)
_____ Non-committed dating relationship
_____ Monogamous dating relationship
_____ Married/life partner
_____ Divorced
_____ Widowed

5. Religion:
_____ Protestant _____ Catholic_____ Christian (nondenominational)
_____ Mormon _____ Jehovah's Witness_____ Muslim
_____ Hindu _____ Jewish_____ Buddhist
_____ New Age/Wiccan _____ Taoist_____ None
_____ Other, Please specify: _____

APPENDIX B: Belief in God

Directions: Select one statement.

Which of these statements comes closest to expressing what you believe about God?

_____ I don't believe in God.

_____ I don't know whether there is a God and I don't believe there is any way to find out.

_____ I don't believe in a personal God, but I do believe in a Higher Power of some kind.

_____ I find myself believing in God some of the time but not at others.

_____ While I have doubts, I feel that I do believe in God.

_____ I know God really exists, and I have no doubts about it.