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TRAINING AND CONSULTING

The Four Faces Of Shame:

Withdrawal, Attack Self, Avoidance, Attack Other – Healing Attachment Wounds

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Prof. Martin Dorahy, PhD

14 - 15 July 2023 | 9.00am - 1.00pm AEST

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Contents

Part 1 Outline

- Shame in relation to primary and secondary emotion
- The psychology of shame
- Shame and chronic (developmental) trauma
- Locus of control shift
- Ambivalent attachment to the perpetrator
- Shame compass

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Challenges in complex trauma and dissociation

- Self-regulation based on **dissociation** & **hypervigilance** *Survival defenses*
- Relatedness based on **enmeshment** & **detachment** *Attachment defenses*
- Expectation of validation of **self as damaged, future as hopeless** *Shame defenses*

Courtois & Ford, 2013 *italics Halpern 2018*

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Shame defined

- "Shame can be defined simply as the feeling we have when we evaluate our actions, feelings, or behavior, and conclude that we have done wrong. It encompasses the *whole of ourselves*; it generates a wish to hide, to disappear or even to die" (M. Lewis, 1992, p. 2)
- Shame is the affect of inferiority (Kaufman, 1989)
- 'Seeing oneself negatively in the eyes of others' (Scheff, 2003, p. 244)
- 'Shame is an experience of one's felt sense of self disintegrating in relation to a dysregulating other' (DeYoung, 2015. p. xii).
- Shame is inherently a social emotion and signal threat to the social bond/relationships (Lewis, 1971; Scheff, 2003)
- **SHAME IS RELATED TO THE SELF**

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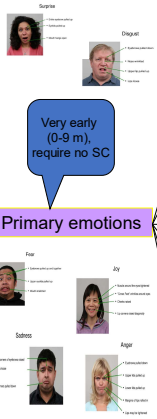
Primary and secondary Emotions



Very early (0-9 m), require no SC

Primary emotions

- Joy
- Distress
- Anger
- Fear
- Disgust
- Surprise

12-18m

Shame

36 m

- Guilt
- Pride
- Embarrassment
- Jealousy

Self-awareness; self-rep.

Facilitate social goals

Emerge later

No universal facial expressions

More cog. complex

Secondary (self conscious) emotions

Present later (12-24 m), require SC

Lewis, 1992; Tracy & Robins, 2007

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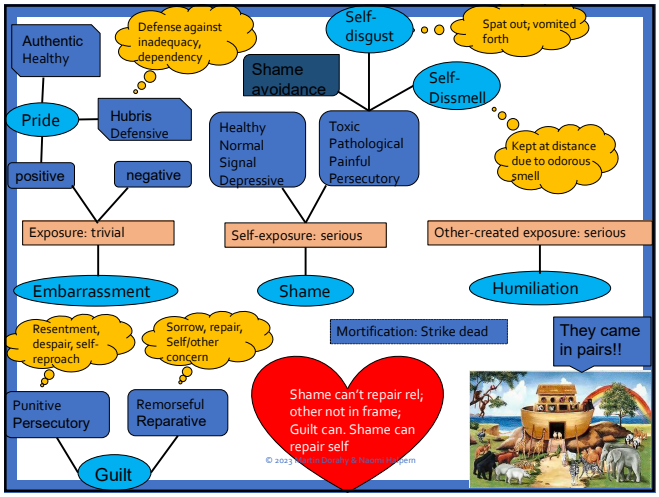

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Shame functions (Scheff, 2003)

- Shame is master emotion because it has more functions than most other emotions
  - Key component of conscience (moral sense)
  - Arise in threat to a bond (signals trouble in a relationship)
  - Regulates expression of other emotions, and also awareness of other emotions
  - Increase social bonds
    - Acknowledgement of shame increases social bonds
    - Lack of acknowledgement (e.g., anger), increases alienation.

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2 models on mechanism/origin of shame

- Evolutionary: shame as basic emotion present very early in life.
  - E.g., embarr-shame-humil;

Tomkins 1963

- Shame has adaptive value.
- Tomkins: Shame as inhibitor of positive feelings
- Gilbert: Shame signals threat or loss of social acceptance

- Cognitive-attributional: Shame comes online between 18m-3years with development of cognitive representations of self
- Tend to emphasis shame's maladaptive character.
- Guilt adaptive, shame maladaptive.

M. Lewis; Tangney

Self Excluded

Self as failure

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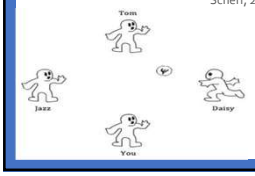
Shame & Exclusion

- Signals risk to social bond – action disapproving in eyes of others – The pain of feeling excluded and unvalued (Elison et al., 2014)
- It is hard wired by evolution to alert us to breaches in relationships, bonds and connections with others.
- Also signals to other person we recognise threat and care enough to feel shame
- Shame evoked by exclusion

Scheff, 2000; Webb, 2010



Exclusion from relationship/group we want to be part of

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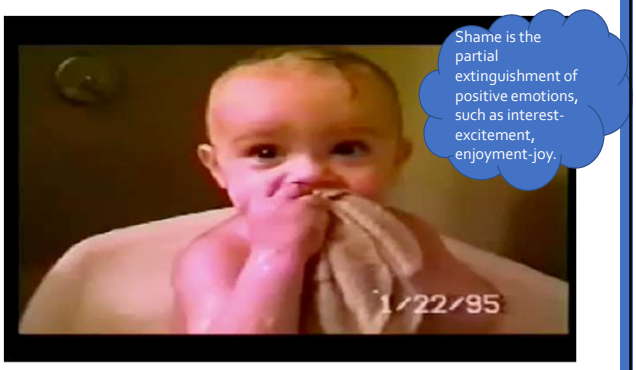
Shame-Humiliation



Shame is the partial extinguishment of positive emotions, such as interest-excitement, enjoyment-joy.

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Failure & shame

- Self-perception of failure is a key driver of shame in combination with sense of self as defective, dirty, weak.
- Failure:
  - Loss of control of bodily functions
  - Loss of control of impulses and social poise
  - To achieve goals
  - Master set tasks – set internally or externally

Garfinkel, 2012

Not measuring up to a goal we want to achieve

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Shame evokers

Evolutionary/ innate

Threat to social self

Developed

Social exclusion

Related but independent

Not 'measuring up' (exposure of weakness, unloveability)

Exclusion in isolation

Exclusion can lead to cognitions of not measuring up

Not measuring up (to own or others standards) can lead to exclusion (real or perceived)

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Shame and trauma

- Shame intimately linked to traumatic events, especially those of a relational nature (Andrews, Brewin, Rose & Kirk, 2000; Dorahy, 2010; Dorahy & Clearwater, 2012; Harvey, Dorahy, Vertue, & Duthie, 2012; Feiring & Taska, 2005).
- Relational trauma characterised by dominance, subordination and control evokes a strong shame response
- The caregiver's shaming/humiliating attacks (overt or subtle) on child, evoke in the child the perception that they were unable to fulfil the needs of the parents.
- The child is humiliated for being a child and not living up to the (unconscious) expectations/needs of the caregiver.
- Child own need for care is not seen

Garfinkle, 2012.

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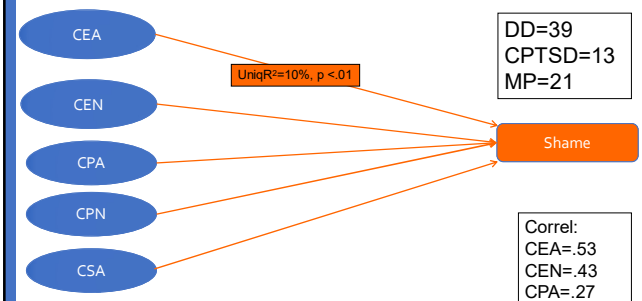
Shame & abuse in trauma samples



DD=39
CPTSD=13
MP=21

Correl:
CEA=.53
CEN=.43
CPA=.27
CPN=.40
CSA=.41

Abuse: Rsq = 29%, $F(5,65) = 6.58$, $p < .001$

Dorahy, Middleton et al., 2016

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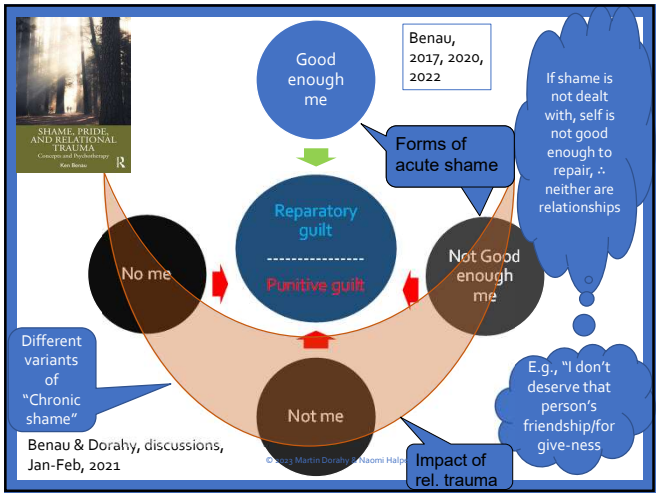

Benau & Dorahy, discussions, Jan-Feb, 2021

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Causes of shame in traumatized people

- Subjugation (Herman, 2011)
  - dominated by the other, will defeated, mental defeat
    - Boundary violation
    - Child abuse, parental dominance (e.g., narcissistic parent)

Self defeated or demolished

Agency destroyed

- Non-recognition (Bromberg, 2017)
  - Child relies on other to develop a sense of self. If child is invisible they learn at a deep, procedural level they are worth nothing more than invisibility. Expression of wishes, thoughts, feelings, behaviours are shameful

"shame erodes selfhood to the point that any form of assertive action gives way to dutiful compliance"
Middleton, Sachs & Dorahy, 2017

Self invisible or unseen

Agency ineffective

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Emotional abuse & neglect

Emotional abuse/mistreatment &/or neglect

Bromberg, 2011, 2017

Meares, 2012; Meares et al., 2012

Non-recognition & disconfirmation of self-experiencing → "The cumulative nonrecognition of entire aspects of self as existing"

"Attacks upon value" → Central 'feeling' of self develops as unworthy, invalid

Shame

- Fundamental human motivation: Desire for positive self-view/image
- Shame is evoked when the positive view of self is threatened. De Hooge et al., 2010

Fusion of shame and need/desire

Shame

Childs need for loving recognition → Ignored, despised, not recognised

Shame created in early caregiver/child interactions

Bromberg, May 9th, 2016

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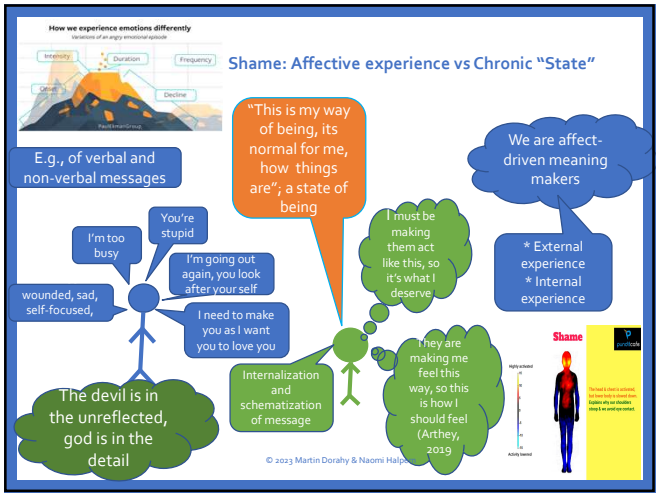

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SHAME: Behavioural, verbal and enacted markers of shame in therapy

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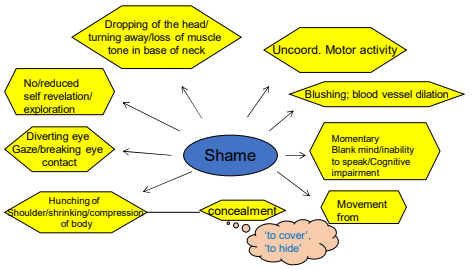
Behavioural markers



Inhibition of interest-excitement & Enjoyment-joy systems

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Shame in therapy: Hiding in plain sight

Garfinkle, 2012

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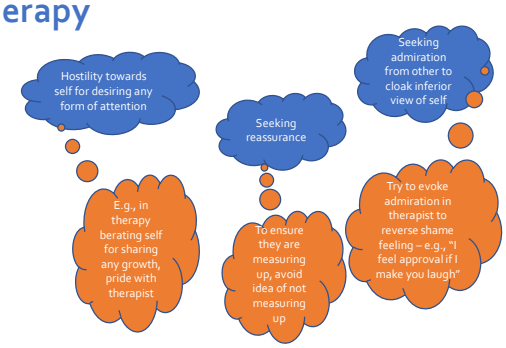
Shame manifestations in therapy



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Locus of control shift

"I am bad" = compensates for feelings of helplessness, powerlessness

"I am bad" = attempts to manage pain, grief and anger

It's my fault because I am bad. Therefore,

I can change and be good – then I will be lovable and the abuse will stop =

illusion of power

Enables maintenance of attachment bond

Ross & Halpern, 2009

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The attachment dilemma

- Biological drive to **attach** or **seek proximity**
- Biological **withdrawal reflex** from danger
- Drive to attach and withdraw from danger creates a **double-bind**
- One drive may **override** the other or the child may **oscillate** from one to other.
- Seeds for **disorganized attachment**

Ross and Halpern, 2009

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Disorganized attachment

80% of traumatised children have disorganised attachment patterns.

Carlson & Cicchetti, (1994), cited van der Kolk (2003)

Adult fearful-avoidant attachment style

Extreme inconsistency of behaviour in romantic relationships.

Shame easily activated: four faces / switch.

Poor emotional regulation – fear of emotional intimacy.

Suspicious of others intentions - extreme fear of abandonment = difficulty connecting to and trusting.

Seeks extreme closeness or distance with no in-between - pushes away and shuts down.

Feels exploited - used in relationships.

Emotionally aggressive behaviour toward partners.

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Ambivalent attachment to perpetrator

- Unable to hold contradictory feelings: love and hate .
- Stuck in black and white thinking.
- Identifies with the aggressor: self-blame, self-harm and shame.
- Identifies as passive victim: not worthy of love and shame.
- Splitting: "I hate you - don't leave me"!

Ross & Halpern, 2009

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Internal Karpman's triangle

Bad things happen because I am bad

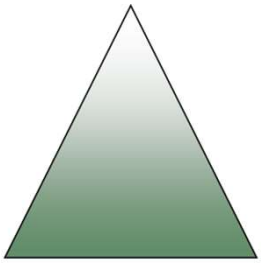
Victim

I am bad because I do bad things

Persecutor

I can fix it

Rescuer



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Shame compass

Nathanson, 1992

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Withdrawal

- Distress and fear
- Avert eye contact
- Blushing to flushing
- Difficulty speaking
- Withdrawal and isolation
- Sexual abstinence or psychological sexual difficulties

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Attack Self

- Self-disgust
- Self-deprecating humour
- Self-harm
- Suicide ideation and attempts
- Sexual masochism
- Somatization

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Avoidance

"It's not me it's you"!

Risk taking, notoriety, excessive seductive behaviour (not necessarily sexual).

Avoids shame through excitement, fear and pleasure.

Substance abuse or other hedonistic distractions.

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Attack Other

"Someone must be made to feel lower than I feel"

Put-down, ridicule, contempt, character assassination

Bullying - physical aggression

Rage - *humiliated fury*

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5th Shame response: Dissociation

- Freeze (can't think or move)
- Numb (shut down)
- Space or zone out
- Can't hear, speak, respond
- Difficulty with recall

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The Four Faces of Shame:

Withdrawal, Attack Self, Avoidance, Attack Other

'Healing Attachment Wounds'

Presented by

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Part 2 Outline

- Dissociation and shame
- Common shame dynamics - therapeutic considerations
- Trigger loop
- Working with shame responses

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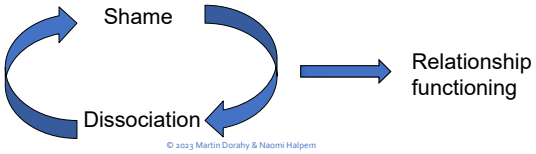
Connection between shame and dissociation

Shame → Dissociation

Dissociation → Shame



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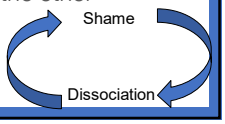
Shame and dissociation – a cyclical connection

"Shame…states temporarily "solve" the problem of chronic, particularly traumatic, disembodied leave taking [LT; i.e., depersonalization & derealization] and structural dissociation (SD) by giving the child and later adult RT survivor an intermittently embodied and "felt" subjective experience. Since traumatic shame…states and the pain of finding little to no value in oneself and relationships is unbearable, chronic, disembodied LT and SD may beckon … This can and often does lead to a psychodynamic movement back and forth between triggered, intrusive, unbearably painful shame…states, on the one hand and chronic, traumatic, disembodied LT and SD, on the other"

- Benau, 2022



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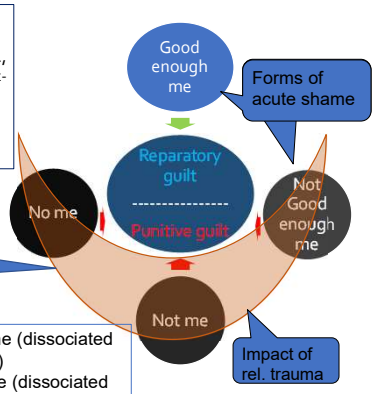
Benau, 2017, 2020, 2022 – shame and dissociation

Dissociation
-*Structural dissociation* – e.g., compartmentalization
-*leave taking* – i.e., detachment



* Not me shame (dissociated aspects of self)
* No me shame (dissociated whole self/being)

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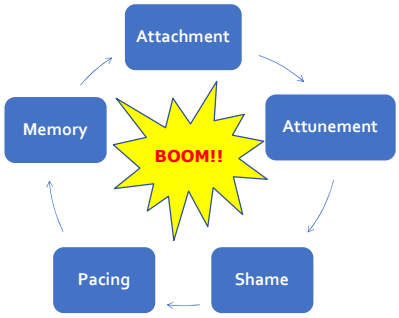
Trigger loop activation



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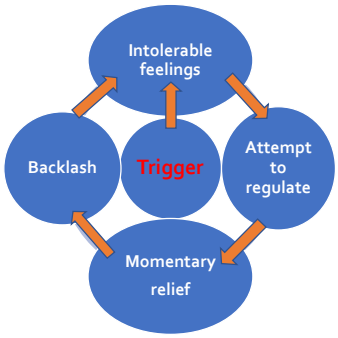
Trigger loop



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Chronic shame as protection against perceived acute shame from failure and exclusion

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Acute and chronic shame in relational trauma

"Acute shame is arguably the most painful of affects as there is an instant deflation of rewarding affects, usually attachment-based."

"Chronic shame attempts to limit the re-experiencing of the relational trauma, i.e., the massive affective deflation of attachment failure."

Hohfeler, 2018

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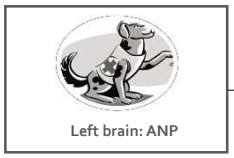
Structural Dissociation adapted from Fisher, 2012

Variation on Traumatized Parts Halpern, 2019



Left brain: ANP

Right brain: EP

Fight	Flight	Hyper & Hypo Freeze	Collapse	Attach
				
'Bodyguards' watch and wait for opportunity to defend		Autonomic alarm	Compliant, non-threatening avoids rocking the boat	Takes any 'crumbs' fallen from the table

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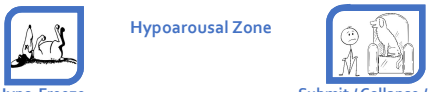
Each part has a different tolerance

Hyperarousal Zone

Attach Flight Hyper-Freeze Fight

WINDOW OF TOLERANCE



Hypoarousal Zone

Hypo-Freeze Submit / Collapse / Pleaser

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Shame-filled parts

I am inherently bad

Rendered powerless

What was done to the person

What they did to survive

Blamed by other parts

Avoidance of anger and grief

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Rage filled parts

Sometimes the **most wounded** OR they **protect a more wounded part** OR they use rage to **defend from other feelings** such as shame, vulnerability or grief.

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Grief filled parts

- What happened
- What didn't happen
- What has been lost in the past
- What may never be able to be
- Abandonment
- Avoidance of rage and anger

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The 3 E's for working with feelings and emotions and developing tolerance

Educate
- Emotions are hard wired
- Feelings are connected to thoughts and prior experience
- **Feelings are real but not reality**

Explain Objective to feel but not be overwhelmed by feelings

Explore conflict between parts, how does a feeling help and what does each part need to feel supported?

"Who inside knows something about this? Who can help?"

adapted from Caldwell-Engle

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Approaching feelings and emotions

- Careful approaching of triggers: be present to feelings – sensations – memory to allow processing and integration
- Approach and move away
- Stay within the "therapeutic window"
- Therapist's support & empathy (being mindful of attachment style)

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Building blocks

- Facilitate skills to develop **internal communication** and

Ross and Halpern, 2009

- an **attachment** to **Emotional parts** that are **disowned** and **disconnected** from each other and the **Apparently Normal parts**

Fisher 2017

- Develop **empathy, compassion** and foster **internal earned secure attachment, healing of wounds** and new ways to support **internal** and **external** stress and conflict.

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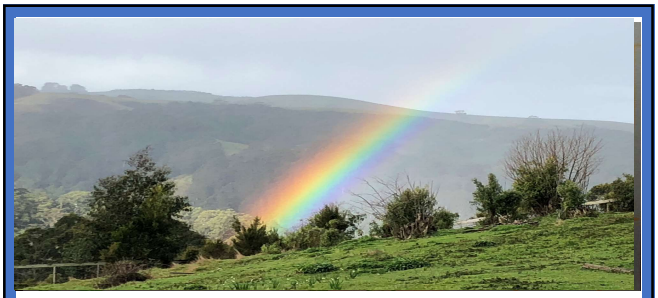

Meeting place (talking through to parts)

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Verbal and written communication

Talking through to parts

- "What if" cascade
- Assists with co-consciousness, identifying parts, function, relationships between parts
- Does another part have another point of view, think, feel differently?
- Is anyone else listening / do they have a point of view?
- Are you aware of any other thoughts, feelings, sensations?
- Who inside knows something about this, can help with this?

Written communication

- Parts worksheet
- Round table discussion – agree on 'rules of engagement'
- Written dialogues (alternate between dominant and non-dominant hand)

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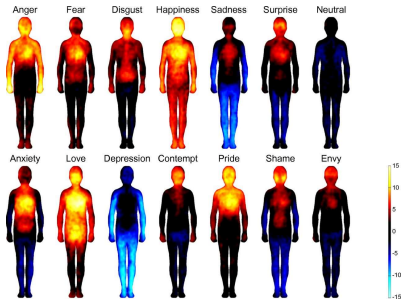
Emotions in the body



Nummenmaa, Hari, Glerean, Hietanen (2014)

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Shame manifestation in the body

Head: 'I'm bad" - rumination – suspicion – anger – guilt

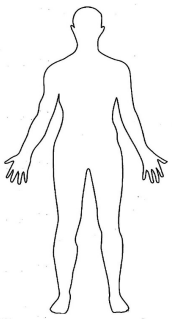
Eyes: look down / away

Throat: constriction – can't speak

Heart: grief – emotional pain

Stomach: churned up – sick - unsettled

Genitals: conditioned sexual responses – anger - grief



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Communication through artwork
"Telling without talking" (Cohen & Cox, 1995)

- **Inner landscape**:
  "can you show me what it look like inside"
  "where does that part of you live inside – can you draw it?"
- Can X draw "something" about that experience?
- Can Y draw "something" in reply to X's experience?
- Ask questions – let the client interpret

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Internal world

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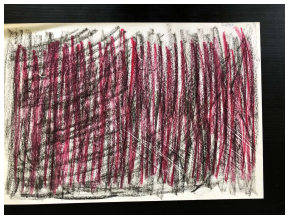

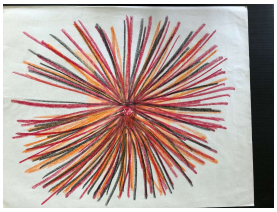

Shame

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Shame

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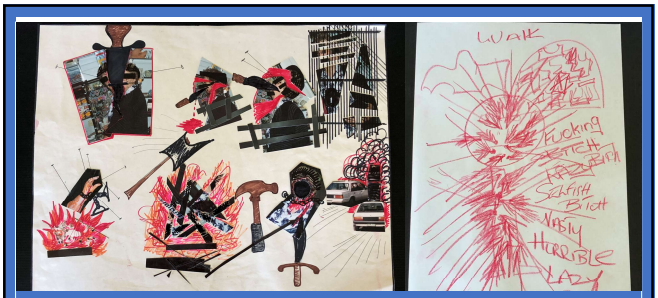

Anger

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Anger

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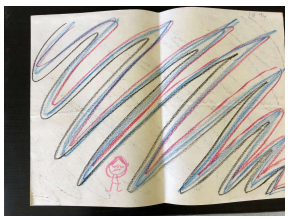

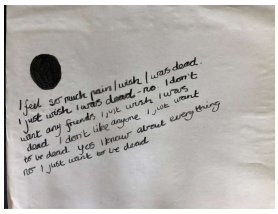

Grief

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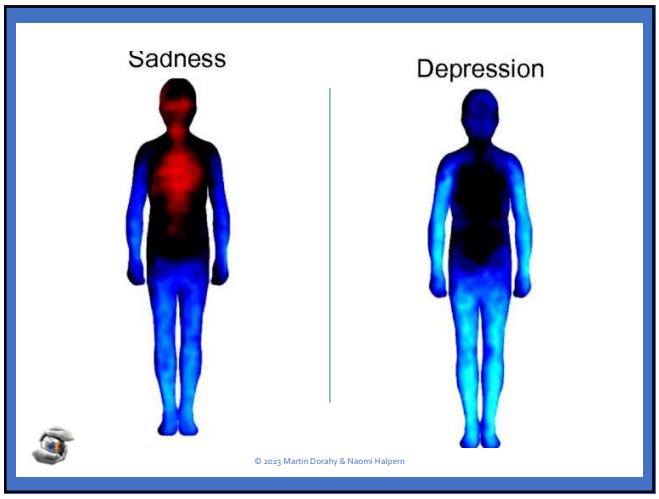

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Even the word 'shame' can be too much

- Naming shame is important — Lewis, 1971
- But, in some cases using the word 'shame' can be too strong — Herman, 2011
  - Thus start with 'mortified', 'embarrassed', 'lowest of the low' — Herman, 2011
- "It can be deeply shaming just to admit to feeling shame" — DeYoung, 2015, p. 3

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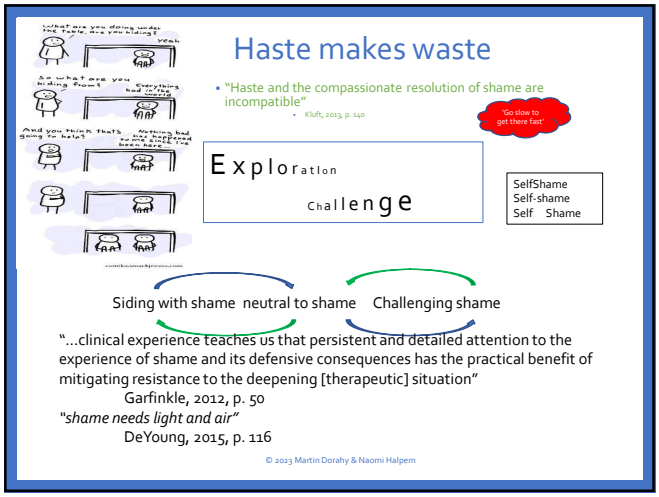

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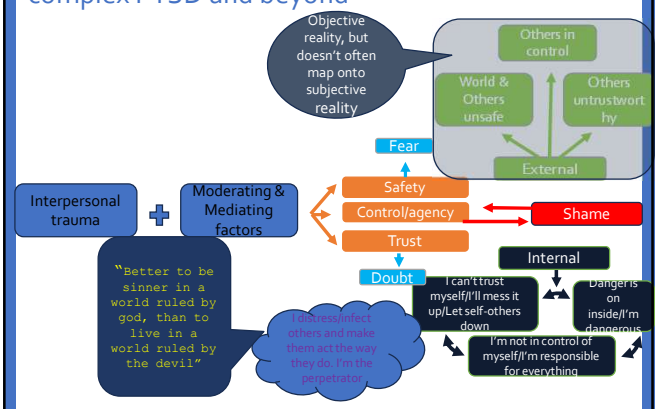
Three central factors at beginning of therapy for complex PTSD and beyond



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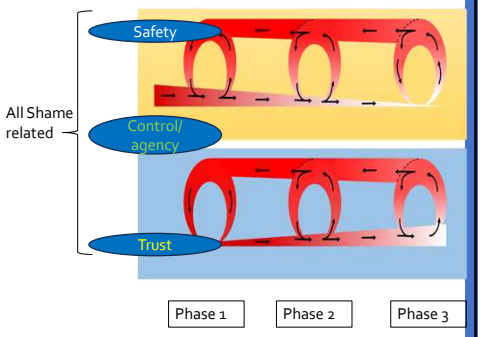
* Anxiety
* Fear of connection/ intimacy
* Shame
* Dissociation
* Trauma memories
* Ambivalence
* Avoidance of feelings, wishes, fantasies, needs & dissociative parts

* Insight
* Agency- Sense of control over internal experiences and external events
* Ownership of experience
* Boundedness
* Trauma memories – amnesia
* Verbal coherence
* Mentalising



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Complex trauma therapy objective

"…the creation of safe places *(**autonomic**)* for sharing where the unspeakable can be given voice *(**pre-frontal cortex**)*, where feelings can be felt *(**limbic**)*, and where sense can be made out of what seemed previously senseless *(**pre-frontal cortex**)*".

Atkinson, J. Trauma Trails 2000 - *Italics* Halpern, 2018

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Reflections about shame responses

Our shame response is shaped by early attachment relationships, events and personality characteristics. We may have a 'go to' shame response but other response(s) may be activated depending on circumstances and triggers. For example, we may have one shame response with our partner or family and another response(s) with friends, clients or colleagues. This is not an assessment but a tool to reflect on your shame response(s). Think about different situations where shame has been activated and reflect on your response(s). Which response is predominant and in what settings? Make a note of thoughts, feelings and observations. ***Be compassionate with yourself.***




Withdrawal		Avoidance		Attack Self		Attack Other	
Wish I could be invisible	☐	Others fault or problem	☐	"I'm an idiot"	☐	Put down – blame others	☐
Avert eye contact	☐	Tough it out – don't care	☐	Self-deprecating humour	☐	Fly into a rage	☐
Flushing	☐	Puff yourself up	☐	Negative self commentary	☐	Retaliation - revenge	☐
Withdraw from others	☐	Distract - risky activity	☐	Self-punishing behaviour	☐	Lash out verbally	☐
Difficulty speaking	☐	Substance misuse	☐	Self harm	☐	Lash out physically	☐
Other:	☐	Other:	☐	Other:	☐	Other:	☐
Score:		**Score:**		**Score:**		**Score:**	

Reflection: _____

The Psychodynamics of shame in abused adults

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The Psychodynamics of shame in abused adults

When working with adults who have experienced a history of child abuse and neglect, one need not look far to see shame. Its postural manifestations, different behavioural adaptations and defenses mobilised against its acute affective expression are commonly noted in therapeutic work (Andrews, 1998; Nathanson, 1992; Talbot, 1996). Shame is often evident when the patient first presents, revealing itself for example in eye gaze diversion, head cast downward, postural slumping, and concern about disclosing current problems and historical experience for 1) exposing one's own weakness, and/or 2) fear of the therapist's (shaming) reaction. Shame continues to play a role in the client's presentation long after the first session and requires therapeutic attention (DeYoung, 2015; Herman, 2011; Kluft, 2007). After outlining two primary pathways to shame and their presence in those exposed to child abuse and neglect, this chapter focuses on two therapeutic issues associated with chronic shame, one intrapersonal of the self (i.e., intrapersonal self), the other object relational (i.e., intrapersonal self-other), that typically stunt progress to successful outcomes in therapy for adults living with the psychosocial outcomes of maltreatment early in life.

Pathways to shame

Broadly speaking, and drawing on the literature from several different frameworks in psychology, shame can be understood as the emotional outcome of 1) being excluded (especially from a group or relationship one wishes to join or remain in) and 2) failure at a goal one wishes to achieve or standard one wishes to keep (Gilbert, 2007; M. Lewis, 1992; 2014; Nathanson, 1992; Tangney & Dearing, 2002; Tomkins, 1963/2008). These pathways to shame are independent in that one may happen in the absence of the other. Examples include, the infant who, well before they have the capacity to make evaluations of failure or success,

is crushed when their look of excitement towards the attachment figure is met with absent eyes or an unmatched/unanticipated response; the sports star who is ostracised from their group or society-at-large for some moral misdemeanour they believe was not a failing on their part but a perfectly legitimate action; or the 10 year old who despite being lovingly contained by his parents feels the raw exposure of shame when he fails to control his bladder in their presence. Yet, often enough, these two pathways work in tandem, or one activates the other (e.g., the person who feels shame due to 'failure' in an interview for a much-wanted job and by default is excluded from the organisation they wish to join or an employee whose historical failure at fidelity in a relationship with a colleague comes to light and he is ostracised from his work mates).

The 'failure' and 'exclusion' pathways to shame may be actual or perceived, in that the person may experience having failed or been excluded when they have not. Shame experiences of the perceived kind are cognitively-mediated. Yet for example, in the case of exclusion (such as the child's joy being met by an ignoring other, or a person being rejected by a partner), the resultant shame does not need a cognitive mediator, the act of exclusion alone drives the affective response, though later cognitive appraisals may amplify (e.g., "I was a useless partner, no wonder they left") or reduce (e.g., "it was impossible for me to become the person my former partner needed") the intensity of the experience. With a fundamental human desire to have a positive self-image (DeHooge, Zeelenberg, & Breugelmans, 2010), both exclusion (from a desired connection) or failure (in a desired goal) are jointly characterised by the person experiencing their sense of self exposed to an actual or perceived other/s in an inferior light (e.g., the self being invisible to others; the self exposed as failing to achieve or bond). Thus, at its very core, shame is a relational emotion (Benau, 2017; DeYoung, 2015; Kaufman, 1989), manifest in visual and behavioral expressions that

cut connection (e.g., gaze diversion) and promote its painfully isolating and private affectivity (Nathanson, 1992; Tomkins, 1963/2008).

In sum, the central ingredients of acute shame are a drive towards attaining something (goal or connection) and that drive being thwarted in the actual or perceived presence of another/others (e.g., Tomkins, 1963/2008). If there is no drive towards something or if another (actual or perceived) is absent, shame will not be manifest. For example, if a perpetrator is successful in keeping their goal of secrecy and others do not learn of their abusive behaviour acute shame will be circumvented. Similarly, acute shame will be avoided if a person has no drive towards relational connection or personal goal aspiration (hence clients attempting to dampen the desire to connect). As Tomkins' (1963/2008) points out, "[t]he sting of shame can be removed from any defeat by attenuating the positive wish" (p. 361).

Pathways to shame in abuse and neglect

Shame is ubiquitous in adults with a history of child abuse and neglect (e.g., Dorahy & Clearwater, 2012; Feiring & Taska, 2005; Talbot, Talbot, & Tu, 2004), and in those exposed to relational trauma more generally (e.g., interpersonal violence, rape) (e.g., DePrince, Chu & Pineda, 2011). In such cases one or both of the two pathways to shame are intrinsically present.

Abuse and a sense of failure: Herman (2011) notes that relational traumas involving acts of commission are characterized by subjugation, coercion and domination, all of which are acute triggers for shame. Here the self is defeated in a physical sense and a psychological sense, agency is destroyed and will is broken. Middleton, Sachs and Dorahy (2017) note that 'shame erodes selfhood to the point that any form of assertive action gives way to dutiful compliance" (p. 13-14). In those who have developed a relatively positive view of self, shame-inducing subjugation experiences threaten the capacity for a healthy differentiation of self and other, and an account of the experience that recognises compassionately the helplessness of the person's

role and the dominant power of the other. Compliance in the form of accepting the other's implicit (if not explicit) call to take responsibility for what occurred may be hard to resist. In cases where selfhood has already been eroded by shaming experiences, or where shame has imbued the development of self, seeing oneself as responsible for the actions of the other and the experience as a whole, due to any number of failures (e.g., failure to control self, failure to hide, failure to take good enough care of the other person), becomes a narrative seemingly impossible to resist as it 'fits'. It captures the failures of the self as the central point of explanation in the story and matches neatly with the shame-permeated view of self as inferior and defective. As Chefetz's (2015) patient Alice painful explained, "I believe my father used to punish us for who we were…the shame is who I am" (p. 365). A client who spent years of her childhood being sexual abused by her stepfather, while her passive mother remained oblivious and then ignored her disclosure, stated at the end of the first therapy session that was beginning to examine her step-fathers actions, "I know he was bigger and stronger, and lied to me, but it was my fault, I shouldn't have had my swim suit on when he got home".

Neglect and a sense of exclusion: Bromberg (e.g., 2017) has written about the trauma of neglect in the form of non-recognition[1] of the child by the caregiver, acts of omission. Numerous authors have argued the importance of eye gaze and attuned attentional deployment towards the developing infant for the construction of a healthy sense of self. Shame is evoked in their absence (e.g., Bateman & Fonagy, 2009; Schore, 2019; Schimmenti, 2012). For example, Schore (1998), among others, outlines that shame first occurs within the infant-mother dyad, when the reciprocity of eye gaze and visuoaffective communication expected by the child is unfilled by the mother. Failure to be seen or recognized communicates an immediate sense of exclusion prompting shame feelings, and a sense that

[1] Non-recognition can also come from abuse (i.e., ignoring child's need for safety, not recognising their fear, etc)

one's affective needs are shameful (Schimmenti, 2012). As Bromberg (2017) argues, a child relies on another/others to develop a sense of self. If the child is invisible (i.e., excluded from connection) they learn at a deep, procedural level they are worth nothing more than invisibility.

Such exclusion initially shames the self through the "absence of connectedness" (DeYoung, 2015, p. 120) and then the shamed self becomes a reason for exclusion. To elaborate, any desire to connect brings with it the expression of wishes, thoughts, feelings, and behaviours that might facilitate such connection, which renders the person visible and therefore vulnerable, as such attempts to connect in the past have led to exclusion-induced shame. These expressions of self (e.g., desires, thoughts) became the understood reason for the exclusion of self. For example, the person comes to believe their desires, wishes, and aspirations are unacceptable, and will lead to subsequent rejection if they are manifest. Thus, the shame such rejection brings is therefore explained from an ego-centric perspective. Now the exclusion is not framed as the cause of shame but the individual's unacceptable self which lead to the exclusion.

With this foundation, remaining invisible in terms of hiding one's desires, hopes, and needs becomes the foundation of engaging with others – it maintains a chronic sense of shame, but offers protection from the acute, visceral shame of having ones ('shameful') desires visible (e.g. showing ones wish to connect with the therapist) and being rejected for it (Bromberg, 2017; Schimmenti, 2012). As one client who grew up with a dismissive and largely absent mother outlined, "I never felt like an equal with my mum, she was a busy academic and not there much. And I never felt I had any authority in a discussion…because…I don't have any qualifications, any milestone achievements, that means I don't stand on a level playing field for her and felt belittle just in her presence. She never saw me, and I became incredibly adept at concealing myself from her".

In short, relational traumas involving acts of commission facilitate shame most pressingly through physical and mental defeat (subjugation), and appraisals of self as failed; avoiding efforts to connect for fear the failed self will be rejected may follow. Relational acts of omission by nature preclude the self from connection and initially facilitate shame via a sense of exclusion (i.e., this can occur even before self-appraisal processes are in place). Experiencing the other treating the self as invisible provides a framework for understanding the self as not worthy of being seen (Bromberg, 2017). The person then comes to understand their motivations and subjectivity (e.g., thoughts, feelings, wishes) as the reason for exclusion. The self is now defective and unacceptable to others and the reason they are excluded (the self fails to 'attract' others on account of their repugnance). What started as another not seeing or excluding the self, now becomes the self not being bearable to see and requiring exclusion. Exclusion, if the person ever braves the desire to move towards connection, still drives shame, but an explanation for why the exclusion occurred resides in the person's shameful self. Shame that started from exclusion now becomes shame resulting from the failed self. Hence, cognition about the failed self, so evident in those abused, becomes manifest in those neglected and characterizes chronic shame.

The allure of chronic shame

Clients traumatized in interpersonal settings where subjugation leads to a perceived sense of failure and/or non-recognition creates the experience of being excluded, are often strongly wedded to the sense of (chronic) shame they feel (DeYoung, 2015). It is not predominantly seen as a toxic force reducing esteem, connection, and a sense of effective agency in life, but rather a vital aspect of who they are which allows them to negotiate life in a safer manner. As one patient with a history of chronic neglect explained, "if I don't try anything or do anything my life remains predictable and consistent – nothing bad can happen, I can't fail anything and I can't get hurt". Two elements of this (perceived) safety will be

noted in this paper. The first is related to the intrapersonal self, the second to the intrapersonal self-other.

Intrapersonal self: Turning to the intrapersonal self aspect, as noted above, chronic shame can be held onto tightly for the protection it provides from a full visceral dose of acute shame, or what is sensed as "ego-destructive shame", the annihilation or collapse of the self (Bateman & Fonagy, 2009, p. 96; Schore, 2019). Chronic shame is primarily a cognitively-driven experience where the self is appraised as defective, a failure, unable to achieve and best not aspiring towards anything or starting something as it will end in shame-inducing deflation (i.e., acute shame). Alternatively, in its immediacy acute shame is much more an affectively-driven experience, it cripples the body with what Gilbert (1997) calls "one of the most powerful, painful and potentially destructive experiences known to humans" (p. 113), and what Morrison (2011) describes as "perhaps the most agonising of human emotions…" (p. 23). It prompts immediate psychological (e.g., dissociation; Bromberg, 1998; Dorahy et al., 2017; Kluft, 2007) and/or behavioural (e.g., withdrawal, criticising another; Elison et al., 2006; Nathanson, 1992) action to quell or ameliorate it. Chronic shame, with its flattened affective tone and ongoing undermining of the self, impedes positive feelings like excitement or joy, and buffers against the sharp immediate affective rise of shame by ensuring such positive feelings are not crushed by failure or rejection (Tomkins, 1963/2008). As one patient noted when describing himself as passive in his life,

> "If I stay in the passenger seat and don't think about what I want to achieve, all the thoughts of what could go wrong, what happens if I'm in an accident, what happens if I don't pass this, are not there as much... It ensures nothing goes wrong, like the whole 'nothing ventured nothing gained' sort of thing, but also nothing lost"

If one extinguishes the desire for connection with another (e.g., a therapist) by feeling unworthy of that connection, rejection is minimised and acute shame is staved off. Similarly,

if one douses motivation to engage in any goals or makes no effort to pursue any direction in life (e.g., waiting for the therapist to lead the therapy) the feeling of acute shame for 'failing' what was started is stymied. Thus, chronic shame is perceived as beneficial at a level that allows it to be maintained, even though the patient may quickly dismiss any advantage of living so distant and eroded, or non-reflectively comply with the therapist's observation that such a position is undermining the person's ability to function in a healthier manner.

With chronic shame so aligned to the person's sense of self, the therapist is somewhat limited in the interventions available in order to reduce an empathic failure and alliance rupture (e.g., Dearing & Tangney, 2011), while increasing minimally at least curiosity, reflective functioning and therapeutic engagement (Bateman & Fonagy, 2009; Steele, 2019). Any form of challenge at this stage to the 'logic' of the psychological set-up of chronic shame and its advantages for living life is likely to be experienced as invalidating and attacking, setting the therapist in an opposing position to the patient. Here the patient has no distance from the chronic shame to see it as distinct from self. As Chefetz's (2015) Alice states, "the shame is who I am" (p. 365). It is not yet the "enemy" (DeYoung, 2015). It is 'self', not an element of self that can be stepped back from and explored. It is not only fused with self, but helps the self avoid further pain. The fusion ensures it cannot be viewed from multiple angles and the 'good' it serves is the primary lens from which it is viewed, even if part/s of the self may consciously deny its helpfulness. The patient notes "this is me, not a part of me I've acquired from experiences in life", with the immediate tenor of the therapy firmly focused on the first clause ("this is me"), but wanting to move to the second clause (i.e., an element of self acquired from experience that can be stepped back from, reflected on, and explored). Yet, the therapist risks a misalliance or the increase of resistance if they treat it as separate from self and unhelpful, pathological, toxic or something that needs to be eliminated or resolved (DeYoung, 2015).

Aligning with the shame, dispassionately speaking to it benefits as they become known in the therapeutic dialogue, provides an external 'mouth piece' for the shame narrative to be 'heard'. This position of siding with the shame allows the person to hear it and contemplate it, so it moves from a non-reflected mentation to a shared idea that requires attention, clarification, and contemplation (Abbass, 2015; Bateman & Fonagy, 2009; Steele, 2019). Here, chronic shame narratives like, "I'm best not to try as I only fail", or "opening myself to relationships will only lead to rejection" have an opportunity to be 'put on the table' and dissected with curiosity about their meaning, their truth and their impact. The therapeutic position of aligning with or speaking the shame (e.g., "failure is protected against if you don't engage and try anything") can be interspersed with more neutral, curious enquiry about the shame, where the affect and its cognitions are neither sided with nor challenged, so as to assist exploration and ongoing reflection.

As distance begins to be created between the person and their chronic shame, more challenge can be introduced where the therapist de-aligns with the shame (DeYoung, 2015), and offers the opportunity for the patient to join them, or follows the patient as they begin to de-align with the 'logic' of the chronic shame, so as to align with the patient in opposition to shame. This position forces greater distance between the patient and the shame, while also testing the degree to which the patient is able to separate from the chronic shame, see the consequences of it for growth and connection, its impaired protective reasoning, and once out of its grasp, experience less fear of acute shame as agency, desire, hope and possibility burgeon. Staying with the logic of the chronic shame can then be seen for what it is, a means to ensure failure, rather than a way to protect against it. So, for example, waiting rigidly for the therapist to lead therapy for fear of 'messing up' or being exposed secures therapeutic collapse and ensures lack of connection. Examples of the three therapeutic positions

associated with chronic shame depending on the person's attachment to the shame narrative are outlined here, along with potential associated interventions[2]:

Aligned with shame (with no separation between self and chronic shame)

P: "If I wait for you and therapy goes to shit, I wouldn't have failed."

T: "Yes, if therapy is not helpful to you, you can leave here knowing it wasn't to do with you. In that sense waiting ensures that you never feel like a failure". Or as reflection increases and a little distance between self and chronic shame is occurring: "If you wait for me to take the lead, you can reduce the chances of feeling like a failure when this therapy is unsuccessful" (these interventions align with shame and also begin to demonstrate its 'logic').

Neutral to shame (no or burgeoning separation between self and shame)

P: "If I wait for you and therapy goes to shit, I wouldn't have failed."

T: Yes, waiting leaves things where they are for you, you neither fail nor succeed.

De-aligned with shame (with separation now created between self and shame)

P: "If I wait for you and therapy goes to shit, I wouldn't have failed."

T: "And holding back on getting engaged here with me ensures that everything remains the same, success is thwarted, and you'll still be living the same depleted life."

Intrapersonal Self-Other: Abuse in the context of a caregiving relationship (e.g., where the person abusing is also the person providing care; what Badouk Epstein, 2018, from

[2] I integrate the ideas of Dr Steve Arthey into this section. He has through his technical and theoretical advances, and pedagogic clarity, educated me via supervision and training around these therapeutic processes and positions, which he and others call the syntonic position (aligning with detrimental process), the neutral position (neutral to the detrimental process), and the dystonic position (de-aligning with detrimental process).

an attachment perspective calls the 'scaregiver') activates a range of distinct and competing feelings in the child towards the caregiver (Ross & Halpern, 2009). The act of abuse itself reflects one person in a more powerful position subjugating, dominating and breaching the boundaries of the other; a scenario ripe for the development of shame (Herman, 2011). However, such an act also reflects the intentional actions of one against another, where an audience of at least one can see the subjugated state of the person being dominated, and the dominated person is aware that their subjugated state is visible to another: One fails to engage agency and fulfil their will (e.g., to escape, to maintain their boundaries, to be 'strong' etc) in the presence, and on account, of the other. Such dynamics (exposure of one's failed efforts in the presence and on account of another) characterises acts of humiliation (Elison & Harter, 2007; Klein, 1991; Miller, 1988). Intimately connected to humiliation is rage towards the humiliator/s, or displaced variants of such rage (Gilbert, 1998; Lewis, 1971). With humiliation the other remains part of, or more accurately, central to, the narrative of what occurred. In fact, the other and their actions that created pain remains highly visible in the account of what happened and why it happened. The (humiliating) *other is the protagonist* or principal character in the narrative. The victim of a humiliating (abusive) act retains an understanding of the humiliator's willed actions to degrade, violate, break, weaken, and remains cognisant of the impact it had. Feelings like rage toward to the humiliator can be acknowledged at least to self, and the humiliator's actions are seen as directed and motivated by their own wishes and intentions, separate from the victim.

Chronic shame has a different 'playbook', somewhat opposite with regard to the (abusive) other. Narratives supporting chronic shame have the *self as the protagonist*, or principal character, with the other (the scaregiver) in a more peripheral role, if they feature at all in specific or life narratives (see also Fairbairn, 1943). The (abusive) other is largely whitewashed from the script. Clients abused by 'scaregivers' routinely have themselves

accountable for the actions of the abusing other. For example, a dissociative identity disorder (DID) patient noted that despite learning to be invisibly quiet she was never quiet enough as her father continued to abuse her. His actions were 'innervated' by her behaviour, the cause of them. Her failure to be 'quiet' activated in him aggression towards her that was justified on account of her 'noisiness'. She was unable to be what he required and his actions were a necessary by-product of her inadequacies. She didn't reach the mark. Fleshed out in more detail elsewhere (Dorahy, 2017), this chronic shame narrative with the self front and centre in accounting for the abusive actions of others toward self, allows the (abusive) other to be protected from feelings directed towards them (internally in the object relationship, and externally in terms of acknowledging to oneself strong feelings towards the other), especially those of a complex nature where positive (e.g., love) and negative (e.g., rage) intermingle (e.g., Abbass, 2015).

Where the psychological set-up with regard to understanding abusive experience has the client with chronic shame-inducing agency (e.g., it was my failing that lead dad to do what he did), the agency of the (abusive) other is not contemplated and the feelings towards them are not entertained or felt. Thus, feelings like rage at being used to fulfil the needs of the other are kept at bay.

Neither the narrative fostering humiliation, with the other dominant, nor the narrative supporting chronic shame, with the self central, offer a therapeutic way forward. Neither allow the person to entertain both parties in the experience; the actions and reactions of both other and self. Humiliation takes the person towards anger in the absence of other feelings, shame cuts off anger towards the other. Thus, the range of felt emotions towards the abusive other is hidden from both view and visceral experience. Chronic shame narratives based in abusive experiences, where the self has agency and the (abusive) other is a non-agentic operative responding to the self's failures, are born out of the egocentric perspective of the

child, and become solidified by a motivation to protect the scaregiver[3] and 'protect' the self from complex relational feelings by living with chronic shame.

Therapeutic work in such cases requires the 'other' to be (re-) introduced back into the narrative. The success of such work is likely to be reduced if the dynamics in the above section of this paper are not sufficiently addressed beforehand, and the person views the (chronic) shame narrative as protective again acute shame experiences. The likelihood of being able to entertain the other and resolve the feelings towards them that chronic shame cloaks is impeded if the patient believes chronic shame is protecting them from acute shame. In the client's mind, protection from acute shame in the moment is more important than addressing unresolved feelings from the past (regardless of their impact on current functioning). In addition, based on the logic of chronic shame, acute shame is threatened when contemplating the role of the other in abuse-related emotional pain, as in the presence of the therapist the patient is seen as no longer protecting the (abusive) other and the system they operate/d in (e.g., family). Thus, re-introducing the other without having dealt with the logic of chronic shame, raises the spectre of acute shame from failing to protect the other from feelings rising towards them (e.g., "If I allow myself to think that he might have hurt me to satisfy his own needs, I think I'll feel crushed and disappointed in myself for believing he had some part to play in all this"). Dealing with the logic of chronic shame as an emotional life-preserving shield against the intimacy of immediate self-crushing agony allows the individual to understanding the functional organization of their internal world, and as this becomes clearer, the logic of chronic shame for protecting the other can be entertained, and the other can begin to be re-inserted in the narrative[4]. This work demonstrates the function of chronic shame to 'protect' the *self* from visceral shame feelings and protect the abusive

[3] nb., in childhood seeing the self at fault may have reduced reactive feelings towards the scaregiver in an attempt to decrease the likelihood of further harm, yet in later life, for many, such harm is no longer present, and the chronic shame narrative is partly in service of shielding the [abusive] other.

[4] Again, I am grateful to Dr Steve Arthey for sharpening my thinking and clinical observations in these areas.

internal *other* from complex feelings like love and rage (See Dorahy, 2017). The reason for, and persistence of, chronic shame is overdetermined (DeYoung, 2015).

Summary

This paper first noted two pathways to the shame affect, including how they are evident in abuse and neglect experiences. It then focused on two functions of chronic shame evident in work with adult victims of child abuse who present a range of psychiatric conditions, commonly but not exclusively posttraumatic and dissociative disorders. Chronic shame is a cognitive defence against acute affective shame and also a means to protect the relationship with the scaregiver/s, long after the abuse has ended. Adapting a flexible and relational approach to therapy allows the therapist to listen out for and explore the benefits and functions of chronic shame while remaining with the patient as they see their self as akin to the shame, then entangled by the shame and then motivated to disentangle their self from the shame and explore what is behind it. This later step brings into focus more clearly the (abusive) other, their absence from or diminished influence in the narrative of the person's life, and the feelings and memories associated with them in all their complexity. The hold of chronic shame on the self can then give way to the client having a new relationship with the emerging life inside them, obscured by self-neglect and self-abuse (e.g., derogatory self-attack) prior to this point. Their relational life and motivation to set and achieves goal are now less impeded by chronic shame and have a chance to emerge and grow.

References

Abbass, A. (2015). *Reaching Through Resistance: Advanced Psychotherapy Techniques.* Kansas City, MO: Seven Leaves Press.

Andrews, B. (1998). Shame and childhood abuse. In P. Gilbert & B. Andrews (Eds.), *Shame: interpersonal behavior, psychopathology, and culture* (pp. 176–190). New York: Oxford University Press.

Badouk Epstein, O. (2018). From Proximity Seeking to Relationship Seeking: Working Towards Separation from the "Scaregivers". *Frontiers in the Psychotherapy of Trauma and Dissociation, 1(2*), 290–306

Bateman, A. & Fonagy, P. (2009). *Psychotherapy for borderline personality disorder: Mentalization-based treatment.* Oxford: Oxford University Press.

Benau, K. (2017). Shame, attachment, and psychotherapy: Phenomenology, neurophysiology, relational trauma, and the harbingers of healing. *Attachment, 11*, 1-27.

Bromberg, P.M. (1998). *Standing in the spaces: Essays on clinical process, trauma, and dissociation*. New Jersey: Analytic Press.

Bromberg, P. M. (2017). Psychotherapy as the Growth of Wholeness: The Negotiation of Individuality and Otherness. In. M. Solomon & D. J. Siegel (eds.), *How People Change: Relationships and Neuroplasticity in Psychotherapy* (pp. 17-52). New York: Norton.

Chefetz, R. A. (2015). *Intensive psychotherapy for persistent dissociative processes: The fear of feeling real*. New York: Norton.

Dearing, R. L & Tangney, J. P. (2011). Introduction: Putting shame in context. In Dearing, R. L., & Tangney, J. P. (Eds.), *Shame in the therapy hour* (pp. 3-19). American Psychological Association, Washington, DC.

De Hooge, I. E., Zeelenberg, M., & Breugelmans, S. M. (2010) Restore and protect motivations following shame, *Cognition and Emotion, 24*, 111-127.

DePrince, A. P., Chu, A. T., & Pineda, A. S. (2011). Links between specific posttrauma appraisals and three forms of trauma-related distress. *Psychological Trauma: Theory, Research, Practice, and Policy, 3*(4), 430-441.

DeYoung, P. A. (2015). *Understanding and treating chronic shame*. New York: Routledge.

Dorahy, M. J. (2017). Shame as a compromise for humiliation and rage in the internal representation of abuse by loved ones: Processes, motivations and the role of dissociation. *Journal of Trauma and Dissociation, 18(3)*, 383-396.

Dorahy, M. J., & Clearwater, K. (2012). Shame and guilt in men exposed to childhood sexual abuse: A qualitative investigation. *Journal of Child Sexual Abuse, 21*, 155-175.

Dorahy, M. J., McKendry, H., Scott, A., Yogeeswaran, K., Martens, A., & Hanna, D. (2017). Reactive dissociative experiences in response to acute increases in shame feelings. *Behaviour Research and Therapy, 89*, 75-85.

Elison, J., & Harter, S. (2007). Humiliation: causes, correlates, and consequences. In J. L. Tracy, R. W. Robins, & J. P. Tangney (Eds.) *The self-conscious emotions: Theory and research* (pp. 310-329). New York: Guilford Press.

Elison, J., Lennon, R., & Pulos, S. (2006). Investigating the compass of shame: The development of the Compass of Shame Scale. *Social Behavior & Personality, 34*, 221-238.

Fairbairn, W. R. D. (1943). The repression and the return of bad objects (with special reference to the 'war neuroses'). In Fairbairn, W. R. D. (1952). *Psychoanalytic Studies of the Personality* (pp. 59-81). London: Routledge & Kegan Paul

Feiring, C. & Taska, L. S. (2005). The persistence of shame following sexual abuse: A

longitudinal look at risk and recovery. *Child Maltreatment, 10*, 337-349

Gilbert, P. (1997). The evolution of social attractiveness and its role in shame, humiliation, guilt and therapy. *British Journal of Medical Psychology, 70*, 113-147

Gilbert, P. (1998). Shame and humiliation in the treatment of complex case. In N. Tarrier, A. Wells & G. Haddock (Eds.), *Treating complex cases: The cognitive behavioural therapy approach* (pp. 241-271). Chichester: Wiley & Sons.

Gilbert, P. (2007). The evolution of shame as a marker for relationship security: A biopsychosocial approach. In J. L Tracy, R. W. Robins & J. P. Tangney (Eds.), *The self-conscious emotions: Theory and research* (pp. 283-309). New York: Guilford.

Herman, J. L. (2011). PTSD as a shame disorder. In R. L. Dearing, & J. P. Tangney (Eds.), *Shame in the therapy hour* (pp. 261-275). American Psychological Association, Washington, DC.

Kaufman, G. (1989). *The psychology of shame. Theory and treatment of shame-based syndromes*. New York: Springer.

Klein, D. C. (1991). The Humiliation Dynamic: an Overview. *The Journal of Primary Prevention, 12*, 93-121.

Kluft, R. P. (2007). Application of innate affect theory to the understanding and treatment of dissociative identity disorder. In E. Vermetten, M. J. Dorahy and D. Spiegel (Eds.), *Traumatic dissociation: Neurobiology and treatment* (pp. 301-316). Arlington, VA: American Psychiatric Press.

Lewis, H. B. (1971). *Shame and guilt in neurosis*. New York: International University Press.

Lewis, M. (1992). *Shame: The exposed self*. New York: the Free Press.

Lewis, M. (2014). *The rise of consciousness and the development of emotional life*. New York: Guilford.

Middleton. W., Sachs, A., & Dorahy, M. J. (Eds) (2018). *The abused and the abuser:*

Victim-perpetrator dynamics. Abingdon, Ox: Routledge.

Miller, S. B. (1988). Humiliation and shame: Comparing two affect states as indicators of narcissistic stress. *Bulletin of the Menninger Clinic, 52*, 40-51.

Morrison, A. P. (2011). The psychodynamics of shame. In R. L. Dearing, & J. P. Tangney (Eds.), *Shame in the therapy hour* (pp. 23-43). American Psychological Association, Washington, DC.

Nathanson, D. L. (1992). *Shame and Pride: Affect, Sex, and the birth of the self.* Norton: New York.

Ross, C. A., & Halpern, N. (2009). *Trauma Model therapy: A treatment approach for trauma, dissociation and complex comorbidity*. Richardson, TX: Manitou Communications, Inc.

Schimmenti, A. (2012). Unveiling the hidden self: Developmental trauma and pathological shame, *Psychodynamic Practice, 18*, 195-211.

Schore, A. N. (1998). Early shame experiences and infant brain development. In P. Gilbert & B. Andrews (Eds.), *Shame: interpersonal behavior, psychopathology, and culture* (pp. 57–77). New York: Oxford University Press.

Schore, A. N. (2019). *Right brain psychotherapy*. New York: Norton.

Steele, K. (2019). *Attachment, collaboration and dependency in chronic trauma and dissociation.* Workshop presented at the 36th annual conference of the International Society for the Study of Trauma and Dissociation (ISSTD). March 30th-April 1st, 2019, New York City.

Talbot, J. A., Talbot, N. L., & Tu, X. (2004). Shame-proneness as a diathesis for dissociation in women with histories of childhood sexual abuse. *Journal of Traumatic Stress*, *17*, 445-448.

Talbot, N. L. (1996). Women sexually abused as children: The centrality of shame issues and treatment implications. *Psychotherapy, 33*, 11-18.

Tangney, J. P. & Dearing, R. L. (2002). *Shame and guilt*. New York: Guilford.

Tomkins, S. S. (1963/2008). *Affect, imagery, consciousness, Volume II*. New York: Springer.

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CLINICAL PRACTICE ARTICLE

The influence of shame on posttrauma disorders: have we failed to see the obvious?

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Background: While fear is known to be the dominant affect associated with posttraumatic stress disorder (PTSD), the presence and possible influence of other emotions is less well explored. Recent changes to diagnostic criteria have added anger, guilt and shame alongside fear as significant emotional states associated with the disorder. This article suggests that shame is a frequent, often poorly recognised sequel to trauma, occurring as a result of the meaning the individual places on the traumatic experience and on subsequent interpersonal and environmental events.

Methods: The article reviews the literature on the socio-interpersonal aspects of the posttraumatic experience with particular emphasis on the emotion of shame as both primary and secondary emotion, in its intrapersonal and interpersonal contexts, and in adaptive and maladaptive forms.

Results: The review suggests that posttrauma shame, and maladaptive shame regulation strategies, often manifesting as anger, substance abuse, social withdrawal or depression, may play an important role in the maintenance or exacerbation of the symptoms of PTSD and the development of co-morbidities.

Conclusion: The recognition of shame and maladaptive shame regulation strategies in PTSD treatment and management is critical. However, because shame is frequently considered a painful and discomforting emotion, it may fail to be addressed in the therapeutic setting by both client and therapist. Examination of potential shame-related changes in self-concept, close interpersonal relationships and social inclusion are recommended for individuals who have experienced a range of traumas to identify and address any underlying unacknowledged shame.

Keywords: *PTSD*; *shame*; *maladaptive shame regulation*; *anger*; *substance abuse*; *depression*

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For the first time, the diagnostic criteria for posttraumatic stress disorder (PTSD) in the Diagnostic and Statistical Manual of the American Psychiatric Association, 5th Edition (DSM-5) (American Psychiatric Association [APA], 2013), have included persistent negative emotional states of fear, horror, anger, guilt, or shame. Whether, and how, these emotional states might influence the course of the disorder has received limited coverage in the existing literature.

This article explores theories of shame and maladaptive shame regulation, and the role these might play in the exacerbation and perpetuation of posttrauma disorders. It examines the literature on trauma-related shame. It discusses its role as a primary affect occurring in the peritraumatic period, and as a secondary emotion following appraisal. It further defines its intrapersonal and interpersonal manifestations and their interactions, its connection with neurobiological processes and the importance of its recognition in treatment and management.

Shame in everyday life

Shame in Western culture is considered a virtually invisible, ubiquitous part of everyday life by Scheff (2014); associated with feelings of weakness, vulnerability, and the likelihood of rejection (Lansky, 2003); and hidden, because it is shameful in itself (Kaufman, 1989). Because the experience of shame is often considered to be painful and disempowering, and because recognition of shame in itself can be felt as shameful, it has been suggested that it may evoke any one, or a combination of, maladaptive shame regulation strategies or defences (Elison, 2005; Elison, Garofolo, & Velotti, 2014; Nathanson, 1987, 1992; Velotti, Elison, & Garofolo, 2014; Webb, 2003, 2010). These reactions are consistent with many of the symptoms and

co-morbidities of PTSD. They include anger and violence, substance addiction and isolation (Van der Kolk, 2013), and the often-accompanying feelings of hopelessness and helplessness that can progress to depression, and ultimately to suicide (Violanti, Andrew, Mnatsakanova, Hartley, Fekedulegn, & Burchfiel, 2015).

Shame and guilt: distinguishing between the two emotions

There are differing contemporary theoretical accounts of the nature of shame and guilt. One group of authors represented by M. Lewis (2003), Tangney and Dearing (2002), and Tracy and Robins (2004), consider shame a destructive emotion with little or no adaptive value, and guilt the adaptive and mature emotion. These authors, some of whom have received prominence as a result of their authorship of the Test of Self Conscious Affect (Tangney, Wagner, & Gramzow, 1989), consider both guilt and shame to be "self-conscious emotions"—a product of evaluation of one's behaviour or one's "self" with reference to a particular standard. This is said to require a cognitive capacity that is not achieved before the age of 2 or 3 years (M. Lewis, 2000), implying that shame cannot exist as an affect before that age. However considerable evidence exists for the observation of shame in much younger children than this (Izard, 1971; Nathanson, 1992; Tomkins, 1962, 1963) suggesting that the affect of shame is not contingent on level of cognitive development.

A different view of shame is held by these affect theorists. First described by Charles Darwin in the late 19th century, primary or basic affects are considered to be universal, found from infancy onwards in cultures worldwide, with common facial expressions and postural characteristics (Darwin, 1872/1965; Ekman, 1972, 1973; Tomkins, 1962). The spectra of primary affects (with some minor variations across theories) include embarrassment–shame–humiliation; irritability–anger–rage; sadness–distress–grief; interest–excitement–awe; surprise–startle–shock; anxiety–fear–terror; happiness–joy–rapture; and disgust/dissmell (Ekman, 1972; Nathanson, 1987, 1989; Tomkins, 1962, 1963, 1991, 1992; Webb, 2003). In the terminology of affect theory, *feelings* occur as a result of awareness of the *affects* (Basch, 1976) and *emotions* are composed of the feelings, together with cognitive associations with, and behavioural reactions to, previous experience of them—the autobiographical memory (Nathanson, 1992).

Within affect theory, shame has an observable characteristic set of facial and postural signs. They include the breaking of eye contact, the lowering and turning away of the face, upper body slump, and dilation of blood vessels of the face and neck (Darwin, 1872/1965; Nathanson, 1992; Webb, 2003). There are parallels to the physiological characteristics of shame in the animal world in the dominance/submission behaviours of primates, thought to serve an evolutionary purpose in averting intra-species attack (Keltner & Harker, 1998). There are recognisable cross-cultural and historical variations in the function of shame. In parts of Asia, Africa, and South and Central America, and in collectivist cultures generally, it is often valued as serving an adaptive function regulating social behaviour; here the display of shame is considered positive (Sheikh, 2014).

Peri-traumatic shame

When viewed as a sequel to trauma, shame may potentially manifest as a *primary* emotion, occurring as a peri-traumatic reaction at the time of the traumatic exposure or as a *secondary* emotion via the process of subsequent cognitive appraisal of the meaning and its future implications, or as both.

Ozer, Best, Lipsey, and Weiss (2003) in a meta-analysis of associated empirical research, found that the intensity of the peri-traumatic emotions (in which they included fear, helplessness, horror, guilt, and shame) was among the strongest correlates of PTSD, and that higher distress in the peri-traumatic period was related to higher level of symptoms. In an analysis of trauma clinic patients, Holmes, Grey, and Young (2005) examined the intrusive memories and emotionally charged "hotspots" of trauma memories. They found that these memories, which were considered to reflect peri-traumatic processing, more often related to a severe negative view of the self than to fear, helplessness, or horror, and emphasised that this needed to be considered in the treatment of PTSD. This severe negative view of the self corresponds to shame, suggesting that shame could be strongly implicated in the peri-traumatic response.

Shame as a secondary emotion

Secondary emotions were considered by Brewin, Andrews, and Rose (2000) to be fundamentally different from primary emotions as they are based on cognitive appraisals following the trauma and may have an important impact on the later development of PTSD. Ehlers and Clark's (2000) cognitive theory of PTSD proposed that symptoms persist only if individuals process the trauma in a way that results in a sense of on-going threat. They suggested that this threat might be the product of other emotions as well as fear, including shame, identified as damaged self-concept. Lee, Scragg, and Turner (2001) proposed a clinical model of shame and guilt-based PTSD, suggesting that shame can be seen as a current threat in that it attacks the person's psychological integrity, resulting in feelings of inferiority, social unattractiveness and powerlessness. In a summary of recent research on the psychological processes implicated in PTSD, Brewin and Holmes (2003) found that posttrauma appraisal frequently resulted in increased negative emotions, including shame, and associated these with slower recovery from PTSD.

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Intrapersonal and interpersonal shame

Shame can operate at the level of the individual, the interpersonal relationship, the group, and even the culture (Gilbert & Andrews, 1998) and can be generated in a number of ways. At the level of the individual, intrapersonal shame can have an internal or an external origin (Gilbert, 2001), or be a combination of both (Cook, 1996). Internal shame may be associated with a belief that one has not lived up to one's personal value system in the context of one's thoughts, behaviour, or appearance. It results in a devaluation of one's self-concept—a belief that one is less worthy, less capable, weak, or inadequate. External shame involves the judgements of others which, if accepted and internalised, become internal shame as well (Gilbert & Andrews, 1998). An example of how internal shame might occur, but be difficult to identify, might be the soldier or police officer who kills in the line of duty. Their behaviour might be considered entirely appropriate and justified in their terms of engagement or training, but completely antithetical to their personal underlying values, and hence destructive to their self-concept. Also at the intrapersonal level, Janoff-Bulman (1992) and Edmondson et al. (2011) proposed that trauma can shatter deeply held core beliefs or assumptions about personal identity and the nature of the world, resulting in a sense of powerlessness and resultant shame and fear. These shattered beliefs and assumptions have in turn been linked to changes in self-identity or self-concept, thought to represent an important, largely unexamined factor in the pathogenesis of PTSD (Berntsen & Rubin, 2006; Ehlers & Clark, 2000).

At a close interpersonal level, shame is considered a signal of risk to the social bond—a sign that the other might be disapproving of one's actions or self, and that this might culminate in rejection (Scheff, 2000). In a study linking partner emotional support, negative interaction and trauma, Cox, Buhr, Owen, and Davidson (2015) found that emotional support was linked to reduced distress, while negative interaction was strongly linked to increased distress. A similar result was found by Robinaugh et al. (2011), who found that negative dyadic interaction was associated with the maintenance of PTSD symptom severity because of its association with negative posttrauma cognitions.

At the more distant interpersonal level, shame can be evoked by loss of status, as in losing one's standing in a social group or one's job, or letting one's family or team down (Gilbert, McEwan, Bellew, Mills, & Gale, 2009). Loss of social rank was found to be predictive of a diagnosis of PTSD in a study investigating "mental defeat" (Troop & Hiskey, 2013). In the culture of the military or emergency services being responsible for, or having been unable to prevent, injury or loss of life can be a source of shame (Lifton, 1993), as can simply having survived when others did not (Wilson, Drozdek, & Turkovic, 2006). In a larger societal sense, veterans returning home from the unpopular war in Vietnam were frequently subjected to public shaming and stigma (Herman, 1992). At a cultural level, Scheff (1994, 1997) has related the upsurge of world terrorism to the shame and humiliation experienced by disenfranchised and disempowered honour cultures and religious groups.

As an example of how shame might operate at multiple levels, a police officer who vomited at an incident involving scattered body parts and suffered shame at the time as a result of perceiving himself or herself unable to cope adequately, would experience primary, internal shame. Secondary internal shame might then occur as the police officer reflected on this event and increasingly doubted their ability to cope adequately with future similar incidents. Secondary external shame might also be present if they lose status in the eyes of their peers and become objects of criticism or ridicule. The primary internal shame might form the content for intrusions related to the incident, and this and the secondary—internal and external—shame might then intensify and culminate in increased symptoms or a co-morbid disorder.

Shame: adaptive and maladaptive presentations

In common with all primary affects, shame has the potential to function adaptively, playing a constructive role in social interaction. Through ordinary experiences of shame, which include self-consciousness, embarrassment, or feeling foolish, individuals are thought to learn boundaries for socially acceptable behaviour (Retzinger, 1995). Because they do not consider it a "negative" affect *per se*, Elison (2005) and Webb (2003, 2010) suggest subsequent psychopathology results from maladaptive shame regulation strategies. Shame then remains unacknowledged, and is expressed as another affect or combination of affects, or as avoidant behaviour.

A number of different theorists relate shame to the emergence of other symptoms. From a background of psychoanalytic theory, Lansky (2000) described how shame remains hidden from awareness following trauma. He identified an altered ego state, disorganised and at risk of fragmentation, that he called the "posttraumatic state." He proposed that this state gives rise to shame as a result of the person believing they no longer meet their ego ideal or belief in their prior identity. In addition, because this state is disempowering and frightening, he suggested it results in defences that keep shame-arousing awareness from consciousness, and replace it with a variety of pathological phenomena which may include impulsive self-destructive behaviours, withdrawal, or anger. He saw this as a defence against the sense of fragility, neediness, and resultant shame that invariably accompanies the posttrauma state. H. B. Lewis (1971) described shame as a "sleeper" in psychopathology because of its many disguised presentations,

where shame can be "unacknowledged" or "bypassed," resulting in the emergence of other affects or behaviours.

Theorists who have connected shame with anger include Scheff (2011) and Gilligan (1997, 2001) who maintained that *all* violence has some form of bypassed shame at its core. They consider that disrespect from others is experienced as shame/humiliation and retributive aggression results from this. Elison et al. (2014) conceptualised shame as social pain—the pain of feeling unvalued or excluded—with the response of anger and violence as a maladaptive defence. Tangney and Dearing (2002) related the shame response to the emergence of anger and aggression and used this as confirmation of their belief that shame is a destructive emotion. Scheff (2014) described the phenomenon of the recursive "feeling trap" to explain how the emotions might persist over time. Applied to shame, he proposed that one can become ashamed because one is ashamed, or angry because one is ashamed, then ashamed because one is angry, and so on, gathering increasing force with time, and potentially leading to depression or self-harm. It is possible also that shame diverted into anger, combined with the hyperarousal features of the disorder, could account for the frequency of anger reactions in PTSD, as described by McHugh, Forbes, Bates, Hopwood, and Creamer (2012). If this is so, anger management techniques as they are employed in the presence of PTSD (and perhaps in a more general sense) might require an examination of the possible presence of underlying shame as the driver of the anger, as proposed by Velotti et al. (2014).

Scheff (1994) described shame as the "master emotion" with a central role in evoking a range of other emotions. Nathanson (1987, 1992) similarly conceptualised shame as a key emotion, proposing a "Compass of Shame," with shame in a central position and shame-related behaviours summarised as: "attack other," "attack self," "withdrawal," and "avoidance." The theory behind the Compass of Shame suggested that individuals develop scripts or schemas in order to ignore, reduce, or displace shame, without directly addressing its origin. Webb (2003, 2010) proposed developments to this concept, suggesting that the behaviours map a compass of shame-avoidance rather than shame itself. He adopted the language used by participants in a qualitative study to rename Nathanson's (1987) "withdrawal" and "avoidance" poles as "hide from other" and "hide from self," thereby more clearly identifying the bi-polar dimensions of aggression and alienation of the basic shame-avoidant responses. The four poles thus correspond to the social behaviours of "aggression," "depression," "isolation," and "addiction," together with their associated avoidant emotions of fear, anger, distress, and disgust (see Fig. 1).

This theory was lent empirical support by Elison, Lennon, and Poulos (2006) and Elison, Poulos, and Lennon (2006), who developed a Compass of Shame Scale. This found supportive evidence for the four distinctive shame-related behaviours. The authors concluded that

Fig. 1. Compass of shame-avoidant behaviours and masking emotions (Webb, 2010, developed from Nathanson, 1992).

each approach could be adaptive or maladaptive, depending on the context. The four types of shame-avoidant behaviours bear a strong resemblance to the prominent symptoms and behaviours associated with PTSD.

Shame and fear: neurobiological aspects

In the sense that shame may signal a threat to sense of self, perception of the world as a safe and predictable place, close relationships and/or standing in a group, it is understandable that it would serve to activate neural mechanisms associated with fear. In the case of the individual exposed to fear evoking trauma, this would have the effect of feeding in to an already activated fear response. A mechanism whereby this might occur is described by Lanius, Frewen, Vermetten, and Yehuda (2010), who proposed two pathways to PTSD following trauma: fear conditioning and early life vulnerabilities. In the fear conditioning model, progressive augmentation of the fear response is thought to occur through repeated exposure to stimuli evoking the emotion, resulting in increasing strengthening of the response and its expansion into neighbouring neural circuits. These include the ventromedial prefrontal cortex, amygdala, and hippocampus. Because this progressive augmentation occurs over time, it provides a model for the frequency of delayed presentation of PTSD. Diagnosis of the disorder more than 6 months after exposure to trauma following exacerbation or reactivation of previous symptoms was found to represent over one third of military and over 15% of civilian cases in studies reviewed by Andrews, Brewin, Philpott, and Stewart (2007).

The second pathway to PTSD included the effects of early childhood environment. Lanius et al. (2010) suggested that disorders of attachment, which may, but do not necessarily include maltreatment or abuse, could play a part in a reduced ability to regulate emotions through dysfunctional development of the emotional and arousal

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regulating systems. This leads to impaired ability to regulate physiological arousal to threat and vulnerability to trauma-related disorders. The process of emotion and arousal regulation has been defined by Frewen and Lanius (2006) as a medial–frontal/paralimbic modulation of lower level systems of emotional responses to incoming stimuli. This is considered to involve a range of affects clinically prominent in PTSD including shame, in addition to fear. Arousal may be undermodulated, resulting in re-experiencing and hyperarousal, or overmodulated, leading to dissociative symptoms.

An association between attachment disorders and PTSD was supported in a longitudinal study of the relationship between mothers with a diagnosis of PTSD and their infants by Enlow, Egeland, Carlson, Blood, and Wright (2014), who found that an insecure mother–infant attachment relationship increased the risk of developing PTSD following trauma exposure at age 17.5 years. Because shame signals a threat to the social bond, which is manifest in its primary form in mother–infant attachment, it is likely that early disruption in this relationship could provide later increased vulnerability to shame associated with perceived loss of support and/or damaged self-concept following trauma.

Lowered cortisol leading to a prolonged stress response has been consistently found in many individuals with a diagnosis of PTSD and is considered to have its origins in childhood adversity and present a vulnerability to PTSD following later exposure to trauma (Yehuda & Seckl, 2011). In an investigation of the psychosocial factors associated with low cortisol, Mason et al. (2001) found the most prominent factors to be disengagement and shame laden depression, which they related to inconspicuous but potentially overwhelming shame resulting from both primary and secondary traumatisations.

The importance of shame in treatment and management

Because the perception of shame in others can also evoke a discomforting emotion in the observer, it may fail to be addressed in therapy (Lansky, 2003; H. B. Lewis, 1971). Shame may remain unidentified in an unconscious collusion with the patient to fail to recognise the distressing emotions (Wilson et al., 2006).

The aspect of shame that involves stigma associated with seeking treatment is well documented, particularly in the case of military or police, whose training and subculture emphasise stoicism (Hoge, 2010). Less well recognised is the shame that may be present in the therapeutic situation itself when the patient is required to display his or her vulnerability to the therapist, who might be perceived as impatient, judgemental, or disinterested (Lazare, 1987).

Most theoretical accounts of PTSD have emphasised fear as the primary emotion associated with this disorder. However, other affects, including shame, may also form part of the response, but may not be readily volunteered. Shame associated with a traumatic event was found to impede emotional processing (Brewin, Dalgleish, & Joseph, 1996), impact negatively on the therapeutic alliance (Black, Curran, & Dyer, 2013), and potentially serve to worsen the posttrauma reactions in the context of treatment because it has the potential to contribute to later psychopathology and affect help-seeking (Lee et al., 2001). In light of these findings, the recommendation that issues of shame associated with changes in self-concept be addressed in as an integral part of treatment (Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005) might usefully be adopted. Changes in close relationships, occupation or social standing, and associated shame are also suggested as important areas for initial investigation.

Unacknowledged shame and its diversion into shame-avoidant behaviours is a further significant area for examination, not only because it masks awareness of the underlying emotion and hence affects treatment, but also because it may further exacerbate symptoms. Shame-avoidant anger may, for example, evoke further shame as the individual reflects on its effect on others, and the changes to their own self-image. It is likely that the military and police, in particular, are prone to this aspect of shame-avoidant emotion and related behaviour, since their training emphasises defensiveness in the face of threat (Hoge, 2010).

Conclusions and implications for treatment

DSM-5 has given us a diagnosis of PTSD based on its phenomenological presentation, which includes the persistent emotional state of shame. This article addresses the underlying dynamics of this emotion and its complex interactions with other emotions and behaviours and proposes that it might function as a unifying and core component in the exacerbation, maintenance and delayed presentation of PTSD, and the development of co-morbidities.

However, because recognition of shame in itself is often considered shaming, identifying the extent of its presence in the initial stages of therapy may be problematic. It might best be accomplished through examination of three potential domains: *intrapersonal shame,* the examination of any changes in self-concept; *interpersonal shame at the intimate level*, which might include any changes in personal relationships; and *interpersonal shame at an occupational and societal level*, which could include issues of loss, isolation, and exclusion.

Treatment might then usefully explore these changes in terms of the "sleeper" of unacknowledged shame—how initial shame signals might have been diverted into maladaptive shame regulation strategies; how these have contributed to the manifestation of symptoms of the posttraumatic state; and how they might be addressed by more shame-adaptive responses that reconstruct and

reinforce positive self-identity and significant personal and social relationships.

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References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Andrews, B., Brewin, C. R., Philpott, R., & Stewart, L. (2007). Delayed-onset posttraumatic stress disorder: A systematic review of the evidence. *American Journal of Psychiatry*, *164*(9), 1319–1326.

Basch, M. F. (1976). The concept of affect: A re-examination. *Journal of the American Psychoanalytic Association*, *24*(4), 759–777. doi: http://dx.doi.org/10.1177/000306517602400401

Berntsen, D., & Rubin, D. C. (2006). The centrality of event scale: A measure of integrating the trauma into one's identity and its relation to post-traumatic stress symptoms. *Behaviour Research and Therapy*, *44*, 219–231.

Black, R. S. A., Curran, D., & Dyer, K. F. W. (2013). The impact of shame on the therapeutic alliance and intimate relationships. *Journal of Clinical Psychology*, *69*(6), 646–654.

Brewin, C. R., Andrews, B., & Rose, S. (2000). Fear, helplessness and horror in posttraumatic stress disorder: Investigating DSM-IV criterion A2 in victims of violent crime. *Journal of Traumatic Stress*, *13*(3), 499–509.

Brewin, C. R., Dalgleish, T., & Joseph, S. (1996). A dual representation theory of posttraumatic stress disorder. *Psychological Review*, *103*(4), 670–686.

Brewin, C. R., & Holmes, E. A. (2003). Psychological theories of posttraumatic stress disorder. *Clinical Psychology Review*, *23*, 339–376.

Cook, D. R. (1996). Empirical studies in shame and guilt: The Internalized Shame Scale. In D. L. Nathanson (Ed.), *Knowing feeling: Affect, script and psychotherapy* (pp. 132–165). New York: Norton.

Cox, D. W., Buhr, E. E., Owen, J. J., & Davidson, E. (2015). Linking partner emotional support, partner negative interaction and trauma with psychological distress: Direct and moderating effects. *Journal of Social and Personal Relationships*. Advance online publication. doi: http://dx.doi.org/10.1177/0265407515574467

Darwin, C. R. (1872/1965). *The expression of emotions in man and animals*. Chicago, IL: University of Chicago Press.

Edmondson, D., Chaudoir, S. R., Mills, M. A., Park, C. L., Holub, J., & Bartkowiak, J. M. (2011). From shattered assumptions to weakened worldviews: Trauma symptoms signal anxiety buffer disruption. *Journal of Loss and Trauma*, *16*(4), 358–385. doi: http://dx.doi.org/10.1080/15325024.2011.572030

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, *38*, 319–345.

Ekman, P. (1972). Universal and cultural differences in facial expression of emotion. *Nebraska Symposium on Motivation*, *19*, 207–283.

Ekman, P. (1973). *Darwin and facial expression: A century of research in review*. New York: Academic Press.

Elison, J. (2005). Shame and guilt: A hundred years of apples and oranges. *New Ideas in Psychology*, *23*(1), 5–32. doi: http://dx.doi.org/10.1016/j.newideapsych.2005.07.001

Elison, J., Garofalo, C., & Velotti, P. (2014). Shame and aggression: Theoretical considerations. *Aggression and Violent Behavior*, *19*(4), 447–453. doi: http://dx.doi.org/10.1016/j.avb.2014.05.002

Elison, J., Lennon, R., & Poulos, S. (2006). Investigating the compass of shame: The development of the Compass of Shame Scale. *Social Behaviour and Personality*, *34*(3), 221–238.

Elison, J., Pulos, S., & Lennon, R. (2006). Shame focused coping: An empirical study of the compass of shame. *Social Behaviour and Personality*, *34*(3), 161–168.

Enlow, M. B., Egeland, B., Carlson, E., Blood, E., & Wright, R. J. (2014). Mother–infant attachment and the intergenerational transmission of posttraumatic stress disorder. *Developmental Psychopathology*, *26*(1), 41–65. doi: http://dx.doi.org/10.1017/S0954579413000515

Ford, J. D., Courtois, C. A., Steele, K., van der Hart, O., & Nijenhuis, E. R. (2005). Treatment of complex posttraumatic self-regulation. *Journal of Traumatic Stress*, *18*(5), 437–447. doi: http://dx.doi.org/10.1002/jts.20051

Frewen, P. A., & Lanius, R. A. (2006). Toward a psychobiology of posttraumatic self-dysregulation: Reexperiencing, hyperarousal, dissociation and emotional numbing. *Annals of the New York Academy of Science*, *1071*, 110–124. doi: http://dx.doi.org/10.1196/annals.1364.010

Gilbert, P. (2001). Evolution and social anxiety: The role of attraction, social competition, and social hierarchies. *The Psychiatric Clinics of North America*, *24*(4), 723–751.

Gilbert, P., & Andrews, B. (1998). *Shame: Interpersonal behavior, psychopathology, and culture*. Cary, NC: Oxford University Press.

Gilbert, P., McEwan, K., Bellew, R., Mills, A., & Gale, C. (2009). The dark side of competition: How competitive behaviour and striving to avoid inferiority are linked to depression, anxiety, stress and self-harm. *Psychological Psychotherapy*, *82*(Pt 2), 123–136. doi: http://dx.doi.org/10.1348/147608308x379806

Gilligan, J. (1997). *Violence—Reflections on a national epidemic*. New York: Vintage Books.

Gilligan, J. (2001). *Preventing violence*. London: Thames & Hudson.

Herman, J. L. (1992). *Trauma and recovery: From domestic abuse to political terror*. New York: Basic Books.

Hoge, C. W. (2010). *Once a warrior, always a warrior*. Guilford, CT: Globe Pequot Press.

Holmes, E. A., Grey, N., & Young, K. A. (2005). Intrusive images and "hotspots" of trauma memories in posttraumatic stress disorder: An exploratory investigation of emotions and cognitive themes. *Journal of Behaviour Therapy and Experimental Psychiatry*, *36*, 3–17.

Izard, C. E. (1971). *The face of emotion*. New York: Appleton-Century-Crofts.

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: Free Press.

Kaufman, G. (1989). *The psychology of shame*. New York: Springer.

Keltner, D. H., & Harker, L. A. (1998). The forms and functions of the nonverbal signal of shame. In B. Gilbert & P. Andrews (Eds.), *Shame: Interpersonal behaviour, psychopathology, and culture* (pp. 78–98). Cary, NC: Oxford University Press.

Lanius, R. A., Frewen, P. A., Vermetten, E., & Yehuda, R. (2010). Fear conditioning and early life vulnerabilities: Two distinct pathways to emotional dysregulation and brain dysfunction in PTSD. *European Journal of Psychotraumatology*, *1*, 5467. doi: http://dx.doi.org/10.3402/ejpt.v1i0.5467

Lansky, M. R. (2000). Shame dynamics in the psychotherapy of the patient with PTSD: A viewpoint. *Journal of American Academic Psychoanalysis*, *28*(1), 133–146.

Lansky, M. R. (2003). The "Incompatible Idea" revisited: The oft-invisible ego-ideal and shame dynamics. *The American Journal of Psychoanalysis*, *63*(4), 365–376. doi: http://dx.doi.org/10.1023/B:TAJP.0000004741.67949.3f

Lazare, A. (1987). Shame and humiliation in the medical encounter. *Archives of Internal Medicine*, *147*(9), 1653–1658.

Lee, D. A., Scragg, P., & Turner, S. (2001). The role of shame and guilt in traumatic events: A clinical model of shame-based and guilt-based PTSD. *British Journal of Medical Psychology*, *74*(Pt 4), 451–466.

Lewis, H. B. (1971). *Shame and guilt in neurosis*. New York: International Universities Press.

Lewis, M. (2000). Self-conscious emotions: Embarrassment, pride, shame, and guilt. In M. Lewis & J. M. Haviland-Jones (Eds.), *Handbook of emotions* (2nd ed., pp. 623–636). New York: Guilford Press.

Lewis, M. (2003). The role of the self in shame. [Article]. *Social Research*, *70*(4), 1181–1204.

Lifton, R. J. (1993). *The protean self: Human resilience in the age of fragmentation*. New York: Basic Books.

Mason, J. W., Wang, S., Yehuda, R., Riney, S., Charney, D. S., & Southwick, S. M. (2001). Psychogenic lowering of urinary cortisol levels linked to increased emotional numbing and a shame-depressive syndrome in combat-related posttraumatic stress disorder. *Psychosomatic Medicine*, *63*(3), 387–401.

McHugh, T., Forbes, D., Bates, G., Hopwood, M., & Creamer, M. (2012). Is there a need for a concept of PTSD-related posttraumatic anger? *Clinical Psychology Review*, *32*, 93–104. doi: http://dx.doi.org/10.1016/j.cpr.2011.07.013

Nathanson, D. (1987). *The many faces of shame*. New York: Guilford Press.

Nathanson, D. L. (1992). *Shame and pride: Affect, sex and the birth of self*. New York: W. W. Norton.

Ozer, E. J., Best, S. R., Lipsey, T. L., & Weiss, D. W. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. *Psychological Bulletin*, *129*, 52–73. doi: http://dx.doi.org/10.137/0033-2909.129.1.52

Retzinger, S. M. (1995). Identifying shame and anger in discourse. *American Behavioral Scientist*, *38*(8), 1104.

Robinaugh, D. J., Marques, L., Traeger, L. N., Marks, E. H., Sung, S. C., Beck, G., et al. (2011). Understanding the relationship of perceived social support to post-trauma cognitions and post-traumatic stress disorder. *Journal of Anxiety Disorders*, *25*(8), 1072–1078.

Scheff, T. (1994). *Bloody revenge: Emotions, nationalism and war*. Boulder, CO: Westview Press. (online publication).

Scheff, T. (1997). *Emotions, the social bond, and human reality: Part/whole analysis*. Cambridge: Cambridge University Press.

Scheff, T. (2000). Shame and the social bond: A sociological theory. *Sociological Theory*, *18*(1), 84–99. Retrieved September 17, 2015, from http://www/jstor.org/stable/223283

Scheff, T. (2011). The catastrophe of scientism in social/behavioural sciences. *Contemporary sociology—A Journal of Reviews*, *40*(3), 264–268.

Scheff, T. (2014). The ubiquity of hidden shame in modernity. *Cultural Sociology*, *8*(2), 129–141. doi: http://dx.doi.org/10.1177/1749975513

Sheikh, S. (2014). Cultural variations in shame's responses: A dynamic perspective. *Personality and Social Psychology Review*, *18*(4), 387–403. doi: http://dx.doi.org/10.1177/1088868314540810

Tangney, J. P., & Dearing, R. (2002). *Shame and guilt*. New York: Guilford.

Tangney, J. P., Wagner, P., & Gramzow, R. (1989). *The Test of Self-Conscious Affect (TOSCA)*. Fairfax, VA: George Mason University.

Tomkins, S. S. (1962). *Affect, imagery, consciousness: Volume I, the positive affects*. New York: Springer.

Tomkins, S. S. (1963). *Affect, imagery, consciousness: Volume II, the negative affects*. New York: Springer.

Tomkins, S. S. (1991). *Affect imagery consciousness: Volume III, the negative affects: Anger and fear*. New York: Springer.

Tomkins, S. S. (1992). *Affect imagery consciousness: Volume IV, cognition: Duplication and transformation of information*. New York: Springer.

Tracy, J. L., & Robins, R. W. (2004). Putting the self into self-conscious emotions: A theoretical model. *Psychological Enquiry*, *15*, 103–125.

Troop, N. A., & Hiskey, S. (2013). Social defeat and PTSD symptoms following trauma. *British Journal of Clinical Psychology*, *52*, 365–379. doi: http://dx.doi.org/10.1111/bjc.12022

Van der Kolk, B. A. (2013). What is PTSD really? Surprises, twists of history, and the politics of diagnosis and treatment. *Journal of Clinical Psychology: In session*, *69*(5), 516–522.

Velotti, P., Elison, J., & Garofolo, C. (2014). Shame and aggression: Different trajectories and implications. *Aggression and Violent Behaviour*, *19*, 454–461.

Violanti, J. M., Andrew, M. E., Mnatsakanova, A., Hartley, T. A., Fekedulegn, D., & Burchfiel, C. M. (2015). Correlates of hopelessness in high suicide risk police occupation. *Police Practice and Research*. Advance online publication. doi: http://dx.doi.org/10.180/15614263.2015.1015125

Webb, T. (2003). *Towards a mature shame culture: Theoretical and practical tools for personal and social growth*. PhD Thesis, University of Western Sydney. Retrieved September 7, 2015, from http://handle.uws.edu.au:8081/1959.7/676

Webb, T. (2010). On love, shame and other strong emotions. *NTV Journal*, *5*(1), 46–73.

Wilson, J. P., Drozdek, B., & Turkovic, S. (2006). Posttraumatic shame and guilt. *Trauma Violence Abuse*, *7*(2), 122–141. doi: http://dx.doi.org/10.1177/1524838005285914

Yehuda, R., & Seckl, J. (2011). Mini review: Stress-related psychiatric disorders with low cortisol levels: A metabolic hypothesis, *Endocrinology*, *152*(12), 4496–4453. doi: http://dx.doi.org/10.1210/en.2011-1218

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Shame and Guilt, Misconceptions and Controversies: A Critical Review of the Literature

Alon Blum

The literature on shame and guilt is very heterogeneous. Researchers and theorists in the field have used a number of definitions, approaches, and measurement methods, rendering futile any attempt at a comparative analysis. The article reviews the relevant literature and summarizes the different approaches to shame and guilt while highlighting relevant conceptual issues. The literature review is followed by a thorough delineation of the two constructs. Affective, cognitive, and phenomenological definitions are discussed for a fuller understanding of the phenomena. The cognitive attributional theory is discussed and is also used to explain the process of elicitation. The delineation of shame and guilt is followed by a comprehensive discussion of parsimony. In addition to drawing attention to the current multiplicity of definitions in the literature, the article intends to serve as a more unified framework for future studies of shame and guilt.

Keywords: shame; guilt; literature review; definitions; parsimony

In a postmodern world, it seems as if there is no place for irrational emotions such as shame and guilt. However, they have a profound impact on the human psyche and can be observed as early as in the socialization processes of children (Lewis & Feiring, 1989). They have the potential to govern individual behavior and influence collective decisions such as law making and international economical support. One of the only facts in the field that all researchers agree on is that it requires further study.

A review of the shame and guilt literature finds it full of contradicting empirical findings, criticism, and controversies. The controversies are so extreme that some researchers can present results that suggest that guilt is associated with various psychopathologies (Jones & Kugler, 1993) whereas others dismiss guilt as just a factor in the development of psychopathology (Tangney, Wagner, & Gramzow, 1992) and perceive guilt to be an adaptive emotion. Those differences influence subsequent theories about processes that involve shame and guilt, their role in symptom formation, and consequently, therapy methods.

One of the major problems with empirical studies of shame and guilt is concerned with instrument design. Researchers with conflicting views on shame and guilt designed measurement instruments that reflect their different approaches. Currently, there are no methods of measuring shame and guilt that are free from serious methodological flaws: low validity and reliability, high intercorrelations between supposedly different subscales, measuring constructs that are not represented in reality, and so on (see, for example, the reviews by Ferguson & Crowley, 1997; Ferguson, Stegge, Eyre, Vollmer, & Ashbaker, 2000; Tangney, 1996). Most of those problems can be ultimately traced to differences in definitions, misconceptions, and reliance on previous biased studies and their conclusions. The article offers a comprehensive delineation of shame and guilt, the differences between them, and the differences from similar constructs. The following discussion, by means of a

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meticulous examination of the constructs, will hopefully both encourage and enable the reader to be critical when reviewing the literature, especially when designing future studies.

Historically, the understanding of shame and guilt has had a reciprocal relationship with a variety of fields: from classical literature through science to criminal law. Simple dictionary definitions explain shame to be a painful emotion resulting from an awareness of inadequacy, which is associated with dishonor and has hyponyms such as self-disgust and self-hatred. Guilt on the other hand is a sense of remorse caused by feeling responsible for some offense (Longman Dictionary of Contemporary English, 2006; Oxford English Dictionary, 2004).

Until the 20th century, it was shame that was in focus. The word *guilt*, for example, does not appear in the *New Testament* (Drumbl, 2000). The same is true in other classical works which deal with self-conscious emotions but focus exclusively on shame—such as the works of Shakespeare and Tolstoy. Shame, and not guilt, was also in the core of old days' criminal law. The idea behind "reintegrative shaming" was that when the shamed criminal is returned to the victimized community, his shame will deter potential criminals, educate children, and trigger atonement. Atonement, however, was later agreed to be associated more with guilt than with shame (Street & Arias, 2001; Tangney, Wagner, & Gramzow, 1992).

It was mainly the work of Freud who brought guilt under the spotlight of scientific attention. Helen Block Lewis (1987), arguably the single most important contributor to the field of shame, mentioned that Freud was actually close to discovering the truth (as Lewis understands it) about shame when he studied hysterical/borderline women. Freud discovered that the vast majority of his subjects reported some form of childhood sexual abuse. Initially, he started developing his theory of seduction which was then neglected in favor of infant sexuality. Most of Freud's patients came from respectable families, and consequently Freud concentrated on sexual fantasies and guilt that they experienced, instead of seriously considering reports of abuse. Later, Freud (1933/1961, p. 132) dismissed shame altogether as " . . . a feminine characteristic par excellence, which has as its purpose, we believe, concealment of genital deficiency." The source of shame was recognized as reaction formation against sexually exhibitionistic impulses, and it was not associated with any psychopathology. Instead, Freud extenuated the role of guilt which results from self-punitive processes (the ego accepting punishment from the superego for unacceptable impulses) and is connected to a childhood fear of withdrawal of love by the parents (Freud, 1923/1959). According to Freud, psychopathology stems from an overly developed superego and the excess guilt it creates. Melancholia, for example, was explained by his theory as the ego submitting to punishment from the superego. Masochism and obsessional neuroses were associated with guilt as well. Freud received some criticism that was somewhat influenced by the feminist movement. His theories were seen as typical to the men-dominated field of psychology at that period (M. Lewis, 1992; H. B. Lewis, 1971). Consequently, in recent years science has shown a growing interest in shame.

It was mostly due to Lewis' work from 1971 that shame came back to the focus of study as a construct, which is at least equal in importance to guilt. In her book *The Role of Shame in Symptom Formation*, H. B. Lewis wrote that shame, like other intense emotions, will lead to symptom formation when it is repressed, denied, or not dealt with in any other way. She added the repression of shame to the traditional psychoanalytical notion of repressed libidinal drive, as a cause of illness.

Lewis (1971) suggested that people have different affective styles (shame-proneness vs. guilt-proneness) that cause individuals to experience different degrees of shame or guilt across situations. Those differences result in different formations of psychological symptoms: Shame-proneness causes a vulnerability to affective disorders (especially depression) and guilt-proneness leads to a vulnerability to thought-related disorders (paranoia, obsessive–compulsive syndromes). Interestingly, approximately 20 years earlier, Erikson (1950) suggested more or less the opposite. Erikson differentiated between shame and guilt in his theory of ego challenges. However, the theory's second challenge (autonomy vs. shame and doubt) was related to problems such as paranoid ideation, compulsive behaviors, defiant shamelessness, and rage towards the self. The third challenge (initiative vs. guilt) was related to anxiety, denial, psychosomatic symptoms, jealousy, grandiosity, and self-righteous anger towards others. This illustrates how similar the two constructs are and how easily they can be (and are) interchanged in theory. The same process which Freud (1917/1957) discussed as an explanation of melancholia in "Mourning and Melancholia" was later used by writers (H. B. Lewis, 1971; M. Lewis, 1992; Lewis,

Sullivan, Stanger, & Weiss, 1989) to connect between shame and depression. Whereas Freud argued that guilt causes hostility to turn inwards and cause melancholia, H. B. Lewis discussed shame turning to anger which is retroflexed and leads to depression. Clearly, with such confusion in the relevant literature, two fundamental steps are crucial at this moment: a clarification of the definitions of shame and guilt, followed by a delineation of the difference between them.

Shame and guilt are complex phenomena. Initially, they are simply affects—a physiological response to an event that does not involve any cognition. Yet they quickly develop in scope and complexity and include awareness, cognitions, recollections from past experiences, and the mechanisms through which they intertwine. It is mainly the emotional aspect of shame and guilt which can cause psychological symptoms. Emotions are affects combined with the reactions they trigger. They influence information processing, self-evaluation, and self-regulatory behavior (Ferguson & Crowley, 1997; Ferguson, Stegge, Miller, & Olsen, 1999). Therefore, they can become maladaptive when expressed intensely, frequently, or inappropriately, relative to the demands of the situation, personal needs, or the cost to interpersonal relationships.

Shame, Guilt, and Trauma

Posttraumatic shame and guilt is an understudied and often ignored area of research. This is unfortunate because shame and guilt have implications for all stages of working with trauma: from help seeking and diagnosis through treatment to recovery and relapse (Kubany & Watson, 2003). Considering that the vast majority of traumatized persons are innocent victims, shame and guilt may appear to be irrelevant and even inappropriate study variables in certain trauma groups. Looking for signs of shame among parents who just found out their child has cancer is less intuitive than studying guilt among reckless drivers. However, failing to recognize shame and guilt in a patient can be very disruptive to treatment. Part of the experience of shame is an urge to hide it from others and avoid any thoughts or reminders of the shaming event. Consequently, help seeking, in general, and professional treatment, in particular, are affected (Andrews, 1995). Patients who are in treatment for months and even years can refrain from mentioning the single most important aspect of their experience because of the shame it involves and the fear of being exposed and rejected. When specifically treating posttraumatic stress disorder (PTSD), the emotion that is usually in focus is fear, and an important part of a typical treatment is imaginary exposure (Yovell, 2001). The theory behind imaginary exposure is that controlled exposure to traumatic memories, in a safe environment, will ultimately lead to the patient resolving his/her conflicts. Shame and guilt (especially dormant shame) are especially important for this process because they can disrupt the effect of imaginary exposure (Lee, Scragg, & Turner, 2001).

Besides the indirect effect of shame and guilt through the interference with treatment, it is further agreed that shame, for example, is associated with negativity biases when judging others' evaluations of the self, anxiety, low self-esteem, eating disorders, narcissism, alcoholism, low empathy, lower role-taking ability, and anger directed at the self (Andrews, Brewin, Rose, & Kirk, 2000; Ferguson et al., 1999; Lowinger & Solomon, 2004; Tangney, Wagner, Fletcher, & Gramzow, 1992). The relation between shame and depression is also well-established. According to Beck (1967), depression is the end result of the lowering of self-esteem due to failure to meet (primary narcissistic) standards. The end result of prolonged shaming according to Beck is, therefore, likely to be depression. Guilt is better acknowledged in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision; American Psychiatric Association [APA], 2000) and is mentioned together with major depression, binge eating, antisocial personality disorder, and PTSD, which has been confirmed in various empirical studies (Demaria & Kassinove, 1991; Harder, 1995; Jarrett & Weissenburger, 1990; Jones & Kugler, 1993). Ultimately, posttraumatic shame and guilt have implications for assessing suicidality (Wilson, Drozdek, & Turkovic, 2006, p. 123). Wilson et al. do not elaborate on this important issue but the rational behind it is clear: Self-annihilation is the ultimate defense against the pain from a faulty (shamed) self.

Definitional Issues

The remainder of the article offers comprehensive definitions first of shame and then of guilt. Both affective and cognitive aspects are discussed for a fuller understanding of the constructs, and to support the subsequent discussion of parsimony. The process through which shame and guilt are triggered is explained by the cognitive attributional theory (M. Lewis, 1992). Furthermore, phenomenological definitions are offered to portray what shame and guilt feel like.

Shame

Shame is a complex phenomenon involving affect, emotion, and feeling. Some writers take a more deterministic approach and do not see shame as a self-conscious emotion (Martens, 2005). Martens portrays shame simply as a primitive, initially physiological, response to rejection, and the threat of isolation. The idea of shame originating from a fear of withdrawal of love is not new and was first discussed by Freud (1923/1959). However, concentrating the definition of shame exclusively on the affective reaction is counterproductive, and ignoring the role of self-evaluation in shame fails to explain why an individual can react differently to similar stimuli. Most theorists agree that shame has a cognitive part as well. The affective part is nonetheless important. It can be observed directly and has implications for the development of psychopathology. Charles Darwin (1872/1998) was probably the first writer to discuss physical reactions associated with shame, and in a similar but more current publication, Lazare (1987) mentioned blushing, fainting, sweating, burning, freezing, and a sense of weakness as physical reactions associated with shame. Breaking eye contact, lowering of the gaze, and hunching of the shoulders are mentioned by Darwin as well. However, Lazare saw the physical reactions as associated with shame and not as composing shame. Accordingly, Lazare continued to discuss cognitive aspects of shame.

Most theorists agree that shame is an intense, negative emotion (Andrews, Qian, & Valentine, 2002; Tangney, Miller, Flicker, & Barlow, 1996). Shame involves feelings of helplessness, incompetence, inferiority, and powerlessness (Andrews et al., 2002; Ferguson et al., 1999) and generates a desire to escape or avoid contact with others (Ferguson et al., 1999) as well as conceal deficiencies (Andrews et al., 2002).

Several writers added the exposure of the self (publicly) as defective to the definition (Severino, McNutt, & Feder, 1987; Tangney, Wagner, & Gramzow, 1992). This is a deviation from the psychodynamic view of shame: a completely internal process in which defense mechanisms of the self protect it against violating personal values. However, the dispute about the role of others in shame can be easily reconciled. The "others," who are required for being exposed, do not have to exist in reality. They can be imaginary or simply symbolic (e.g., an image of the parents). Gilbert (1998) extended the role of "others" in shame and suggested the differentiation between internal and external shame: External shame is associated with social anxiety; internal shame is concerned with the person being devalued in his/her own eyes. Truly, an individual can perceive shame to be public and at its core shame can be traced to early experiences of being shamed by others (the parents in infancy or early childhood). However, ultimately shame originates from one's self-judgment.

A Phenomenological Definition of Shame

H. B. Lewis was probably the first to compose a comprehensible definition of shame. This was later refined and expanded upon by Michael Lewis (1992) and is offered here with slight changes as a working definition for the discussion of shame. A phenomenological definition is beneficial in its ability to detail the way how shame is experienced. It explains what shame feels like. Phenomenologically, shame is experienced as composed of the following:

1. Intense pain, discomfort, and anger. Although all writers agree on pain or at least discomfort accompanying shame, anger is not that intuitive. However, shame can motivate a type of anger described as a hostile, humiliated fury that is originally directed at the self but can easily be redirected against the rejecting other (Lewis, 1971; Tangney, Wagner, Fletcher, et al., 1992). This fury, in turn, can be perceived by the individual as inappropriate and magnify the shame, a process Kohut (1972) termed it "narcissistic rage."
2. A desire to hide (Ferguson et al., 1999). At the core of the shame experience is an urge to minimize any further painful exposure of the self and end the discomfort.
3. A feeling of being no good, inadequate, and unworthy. The crucial issue here is the *globality* of the statements about the self. The experience is of the self, as a whole, being deficient in certain ways. In shame, there is a fusion of subject and object (the self) which is a point that will help clear the difference from guilt in which the object is not the self.

Wilson et al. (2006) saw shame as a continuum of reactions from mild embarrassment to severe humiliation. For purposes of simplicity and clarity, shame can be defined as the extreme of the spectrum. This is not only more interesting in the context of psychopathology but also serves to protect the

parsimony of the construct. It is assumed here that the layman intuitively knows the semantic and phenomenological difference between being shamed, embarrassed, and for that matter, guilt-ridden. This assumption, however, is controversial (see, for example, the critique by Tangney, 1996, of global adjective lists). For now, the point is explained through the following examples: Abusing children when intoxicated is considered by most to be shameful and not just embarrassing; however, getting involved in a bar fight can be perceived as embarrassing but not necessarily shameful. This example raises an important issue: Although abusing children when drunk is (hopefully) considered shameful in most societies and cultures, failing a test, getting laid off from work, or being involved in a bar fight are more ambivalent situations. It seems as if shame is not solely dependant on contingency factors. The same situation can trigger shame in one person but not in another, and shame experience varies across time or culture. Clearly, to understand shame, it is necessary to examine the process through which shame is triggered. The cognitive attributional theory (M. Lewis, 1992) explains elicitation, focusing on cognitive processes (as opposed to situational aspects).

Elicitation of Cognitive Feelings

Shame at its core can be argued to be a part of human nature and, therefore, similar in all humans. Developmentally, shame, which is a self-evaluative feeling, can only appear after the child has a cognitive capacity for objective self-awareness and abstract knowledge. According to Fischer (1980), these skills develop around the age of 18 months. They allow the child to create representations of representations and think of past and future events. They also help in understanding discrepant events. (The child can be both bad and good.) Consequently, the first appearance of shame is dependent on physiological developments and, therefore, similar in all children. Furthermore, Freudian ideas trace core shame to a perception of a defective body. This is based on the idea that the ego is first and foremost a "body ego" (Severino et al., 1987). However, the similarities which characterize all humans stop shortly after the first appearance of shame. The socialization of shame and the development of shame-proneness are very individual. As all researchers of shame report, they find variability in shame responses of different individuals to similar events. The aftermath of catastrophes is an exceptionally well-suited situation for studying this phenomenon. This suggests that the shame response, though triggered by situational factors, also depends on other personal, internal variables.

Based on the cognitive attributional theory (M. Lewis, 1992), three factors intertwine in the elicitation of shame and guilt:

1. Super ego demands. These are different rules, goals, and values which may appear personal, but are prescribed by the individual's parents, other social groups, or the culture at large. Lewis, Sullivan, Stanger, and Weiss (1989) showed that children as young as 3 years of age already have a set of their own standards, and they show distress when they violate them.
2. Evaluation of actions, thoughts, and feelings—in terms of the standards from the previous point. There are two types of evaluations that are especially important for the elicitation of shame (and guilt): evaluation of failure versus success, and the perception of the source of blame (internal or external).
3. The focus of blame attribution: H. B. Lewis (1971) distinguished between global and specific attributions. Janoff-Bulman (1979) termed those attributions as *characterological self-blame* (parallel to "global") and as *behavioral self-blame* (parallel to "specific"). The former focuses on one's character, is esteem related, and is concerned more with the past (deservingness). The latter is control oriented, focuses on behavior, and is concerned more with the future (avoidance of reoccurrence, repentance).

According to M. Lewis (1992), shame is the consequence of an evaluation of failure, in relation to the person's standards when the person makes a global evaluation of the self. Note that situational factors can still play an indirect role; but ultimately, the elicitation of shame is determined by internal processes. In a setting of a terror attack, for example, an (objectively) innocent victim can still find reasons to blame himself and feel shame and guilt ("It is my fault, I should have been more observant of the other passengers . . .") whereas the suicide bomber may feel no shame because he did not violate any "personal" standards. The cognitive attributional theory offers a specific method of differentiating between shame and guilt—in guilt, the attribution of blame is instead focused on a specific behavior—and is not global about the self in its entirety.

A discussion of shame cannot be complete without mentioning *bypassed shame*, a term first used by Lewis (1971). Shame, once triggered, is a rather

homogenous phenomenon. The discussion so far accommodates divergence in the elicitation of shame but once shame is triggered, it does not appear to vary phenomenologically. Although technically this is true, shame can take two distinct forms. It can be experienced as described so far, and it can be "bypassed" (Lewis, 1971). Bypassed shame is not simply the absence or dismissal of shame but closer in nature to a repressed feeling in a psychodynamic context. Accordingly, bypassed shame has the potential to be more incapacitating than felt shame.

Felt Shame and Bypassed Shame

Shame per se is not a destructive state. Similar to all other emotions, it serves a purpose. Most scholars would agree that shame actually serves a constructive role, which is necessary for human development and function. Erikson (1950) suggested that, in childhood, developing a capacity for experiencing and dealing with shame is necessary for healthy psychological development. Shame serves a social function as well, both in socialization and by providing a mechanism for (a relatively) peaceful method of enforcing a consensus.

Despite being part of normal human nature, and possibly playing certain positive roles, shame has been shown to have the potential of causing psychopathology. Experiencing shame is normal, and usually shame is dealt with in a manner that does not result in psychopathology. Normal, or felt shame refers to a state in which the shamed person is indeed in an emotional state of shame and is also aware of it—and feels it. H. B. Lewis (1971) suggested the term *bypassed shame* to describe a state in which the self is defended from fully experiencing shame. *Unfelt shame* and *unacknowledged shame* are parallel terms used interchangeably by other writers. These terms refer to a situation where there is recognition of the shame event but no consequent development of shame feeling. The self reflects on the shame event from the position of the others, thus distancing itself from the shame event. The person is actually in an emotional state of shame but is not aware of it (H. B. Lewis, 1971). Normal shame, when triggered properly, following a conventionally shaming event can be easily dealt with through natural dissipation over time, forgetting, laughter, and confession (H. B. Lewis, 1971; M. Lewis, 1992). Bypassed shame is more debilitating due to the unconscious aspect of it and has a higher risk of resulting in psychopathology.

Similar to other intense emotions, shame will also result in psychopathology when it is repressed, denied, or not dealt with in any other way. Therefore, to be resolved, emotions have to be brought up to consciousness. When a strong painful feeling is repressed, it does not simply disappear. The repression acts as an irritant and the repressed feeling is converted into various symptoms. Lewis (1971) suggested that repressed shame can manifest in serious conditions such as depression, rage, narcissism, and multiple personality disorder (now termed *dissociative identity disorder*). Kohut (1971) discussed the role of unacknowledged shame in rage and narcissistic personality disorder. Other problems associated with bypassed shame have to do with the fact that feelings are not only an inner state within the individual but also serve as communicative signals. Unacknowledged shame is, therefore, disruptive of interpersonal relationships or at least social interactions. It can also obstruct the attempts by others to offer help and comfort.

Parsimony of Shame

The scientific principle of parsimony states that if the studied phenomena (shame and guilt) can be explained by another construct (e.g., differences in attributional style), the studied phenomenon becomes effectively redundant to the further understanding of psychopathology (Tangney, Wagner, & Gramzow, 1992). This is especially true for shame and guilt, which are very close emotions and not easy to measure separately. If the variability they contribute to psychopathology can be explained by more established, easily measured variables, it would be unpractical to continue their study. Therefore, it is necessary to delineate the differences between shame/guilt and similar constructs. In the following, shame is differentiated from low self-esteem, attributional style, humiliation, embarrassment, and shyness. Aside from arguing for the importance of shame as a distinct construct, discussing parsimony helps further refine the definition of shame by differentiating it from all similar constructs.

Shame versus low self-esteem. Andrews (1995) and Tangney (1996) based the distinction on the fact that shame involves a "desire to conceal," which does not necessarily exist in low self-esteem. According to Wong and Cook (1992), who developed the internalized shame scale (ISS), internalized shame is an extremely painful affect experienced

around a basic sense of inferiority, whereas low self-esteem is a less dynamic concept that is focused on self-description of self-rating. Indeed, the ISS correlates substantially with measures of self-esteem, maybe due to this problematic theoretical distinction used by Cook. Tangney (1996) clarified the distinction: Shame-proneness probably plays a role in problems of self-esteem. However, self-esteem is a stable trait involving one's general evaluation of the self, largely independent of specific situations. Moreover, it is mainly a self-evaluative construct (and thus mostly cognitive in nature). Shame, as has been illustrated earlier, is an affective state as well.

Shame versus attributional style. The difference between shame and attributional style was illustrated in a study by Tangney, Wagner, and Gramzow (1992). They found that attributional styles (and more precisely, the depressogenic attributional style) as measured by the Attributional Style Questionnaire (ASQ; Seligman, Abramson, Semmel, & von Baeyer, 1979) correlated with shame-proneness. Indeed, the two constructs share many factors. Shame-proneness positively correlated with making internal, stable, and global attributions for negative events and negatively correlated with making internal, stable (and somewhat global) attributions for positive events (which is the essence of the depressogenic attributional style). In their study, Tangney et al. showed that attributional style explains a significant portion of the variance in depression measured by the Beck Depression Inventory (BDI; Beck, 1972) and the Symptom Checklist 90 (SCL-90; Derogatis, Lipman, & Covi, 1973). In the two samples, results were between 7% and 14% of the variance (p. 475). However, when shame-proneness was forced into the equation it was found that shame-proneness generally doubled the proportion of variance predicted in depression. Therefore, the link between shame and depression is not solely due to attributional style, and the difference between the two is evident. Proneness to shame is nonetheless very close to the depressogenic attributional style. However, the depressogenic attributional style is more general and is not framed by the individual's standards. It can be applied to a wider range of events and is similar to general negativity and pessimism.

Shame versus humiliation. Unlike with shame, the humiliated person does not feel that he/she is to blame (The evaluation is external and not internal as with shame) so there are feelings of injustice and possibly fantasies of revenge. There is no (initial) negative self-evaluation (Lee et al., 2001). According to this distinction, Wilson et al. (2006), who discussed shame that is free of blaming the self, that is, "One may *not* blame oneself for what has happened but experiences a profound loss of dignity and power," (p. 124) were actually discussing humiliation and not shame. Wilson et al. preferred understanding shame as a continuum of reactions from mild embarrassment to severe humiliation; but, as mentioned earlier, a more focused definition is both more interesting and more productive, especially regarding psychopathology and treatment. Moreover, attributing blame internally or externally has severe consequences for how anger is directed and how the negative feelings can be dealt with.

Shame versus embarrassment. For some, embarrassment is closely linked to shame. However, from a biological perspective, it is much less intense and associated with different body postures and facial expressions. Embarrassment is expressed by gaze aversion and smiling which is not associated with shame (M. Lewis, 1992). An example can clarify the difference: When receiving a compliment, a person may experience embarrassment but not shame: This situation does not involve a negative evaluation, only exposure that causes self-consciousness.

Shame versus shyness. The easiest method of distinguishing shyness from shame/guilt is that the discomfort with shyness lies with the actual observation, or being seen. Hence, the difference is the evaluation part of shame. Moreover, based on observations of infants in social interactions with their mothers, Lewis and Feiring (1989) noted that shyness can be observed early in infanthood (unlike shame which appears around the age of 18 months, at the earliest) and is more likely to be physiological in nature. Emerging so early in life makes it clear that shyness does not involve an evaluation of the self because the infant lacks the cognitive skills necessary for self-evaluation.

Guilt

Phenomenologically, *guilt* is described as an aversive conscious emotion that involves criticism of and remorse for one's thoughts, feelings, or actions. This emotion is accompanied by a sense of wrongdoing as if one has committed a transgression (Klass, 1987). Kugler and Jones (1992) described a dysphoric feeling associated with the recognition that one has violated a personally relevant moral or social standard. Slightly

more detailed are Ferguson et al. (1999) who defined guilt as an agitation-based emotion in which the person experiences fear, worry, anxiety, tension, and the desire to make amends for behaviors perceived as violating internal moral standards. Most writers agree that guilt has a feeling or affective component and an interpretive or cognitive component. When compared to shame in intensity, guilt is the less debilitating. With the cognitive attributional model in mind, guilt can be defined in the following manner: It is the consequence of an evaluation of failure in relation to the person's standards when the person makes a specific evaluation of the self (M. Lewis, 1992). It is not the self which is in focus but a specific behavior, usually the behavior that caused the guilt (H. B. Lewis, 1971).

This definition is based on psychodynamic ideas and understands guilt ultimately as an intrapsychic process. Some modern writers disagree and concentrate instead on situational factors. Baumeister, Stillwell, and Heatherton (1994) maintained that guilt is fundamentally derived from concerns about breaches in interpersonal relationships—and involve a concern about losing a relationship. They further claim that the intrapsychic factors of guilt are exaggerated (intentionality, blame, responsibility, choice, or mitigating circumstances). Indeed, they note that people feel guilty for accidental transgressions as well as for voluntary ones (p. 264). However, it is the subjective perception of responsibility and blame that matters and not an objective observation. Baumeister et al. fail to mention that people can assume responsibility for an accident even when it is quite clear that in reality they are innocent. When there is absolutely no attribution of blame, the person will not make a specific negative evaluation of his/her action and might, for example, feel sadness instead of guilt.

Kubany and Watson (2003) suggest a multidimensional approach to guilt, meaning that it is composed (as a construct) from different variables that interact. According to them, guilt magnitude is a function of distress and four interrelated beliefs about one's role in the event: responsibility, lack of justification, violation of values, and foreseeability or preventability. Any situational variables that affect those factors are, therefore, assumed to increase the magnitude of guilt. Kubany and Watson specified such contextual variables as *infliction of damage or harm*, *physical proximity*, or *direct involvement in a negative event*, *causing harm to a close-relationship partner*, *being blamed by others*, *causing irreparable damage*, and so on. Interestingly, Lowinger and Solomon (2004) studied reckless drivers who caused death in an accident. They found that seeing the corpse, knowing the victim, and having positive feelings towards it made no significant difference for severity of guilt. Those results are better understood through a psychodynamic approach in which guilt is an internal process and depends more on the person's superego, or standards, than on contextual factors.

Although situational parameters are not crucial for the development or severity of guilt, they are very interesting in another respect. Because in guilt the focus of attention is on a specific transgression, guilt can effectively take as many forms as there are types of transgressions. Kubany, in an earlier work (1994), developed a taxonomy of (combat-related) guilt. This is a good example of the possible complexity of the guilt phenomena. Besides theoretical importance, different types of guilt require different therapeutic approaches, as can be seen in the following example: In "incompetence guilt" the patient feels guilty for an action (or lack of) which stemmed from fear, an honest mistake, an accident, inexperience, and so on. The underlying assumptions are that the individual could have done something he/she was not trained to do and that his/her behavior under stress could and should have been perfect. Clearly, the therapeutic strategies (especially when taking a cognitive approach) are different from a case of "perpetuator guilt" or "atrocity guilt" in which the patient feels guilt for actions that he/she believes to be beyond his/her moral standards or beyond any justification.

Parsimony of Guilt

Most of the effort of theoretically distinguishing guilt from other constructs revolves around shame. Two other established constructs are similar enough to guilt to threaten the construct's parsimony:

Guilt versus humiliation. In guilt, the person assumes responsibility for his/her action and the harm done. Therefore, it results in a desire to make amends, confess, or repent. In humiliation, there is no perception of responsibility in the sense that the person does not assign blame internally. Humiliation may, therefore, result in a desire for or fantasies of revenge and retribution (M. Lewis, 1992).

Guilt versus moral standards. Moral standards are a set of beliefs guiding one's evaluation of behaviors. Guilt is an affective disposition. However, guilt is

often triggered by a failure of some moral standard. Therefore, moral standards could determine (a) when and (b) to what degree guilt will be experienced (Tangney, 1996). Theoretically, though, people can have high moral standards and yet consistently rationalize their misbehavior and avoid guilt in a situation where others with lower moral standards will feel guilt. Indeed, Kugler and Jones (1992) found no relationship between these two factors.

Guilt Versus Shame. So far, shame has been theoretically differentiated from guilt but as will become clear shortly, translating those differences into valid instruments is at the least complex, if not impossible. The appropriateness of measuring the two constructs separately is questionable.

Tangney is one of the most devoted adherents of separating shame and guilt in research. She has also developed two of the most popular measurement instruments for shame and guilt. First, the Self-Conscious Affect and Attribution Inventory (SCAAI—Tangney, Burggraf, Hamme, & Domingos, 1988) and a year later the Test of Self-Conscious Affect (TOSCA—Tangney, Wagner, & Gramzow, 1989). In an article from 1992, Tangney, Wagner and Gramzow showed the possible danger of ignoring the difference between shame and guilt in research. When testing for bivariate correlations between shame, guilt, and "externalization of blame," they received results that were affected by the correlation between guilt and shame (which was approximately $r = .5$). This correlation was especially problematic because guilt proneness correlated positively with externalization and shame-proneness correlated negatively with externalization. Studying guilt mixed with shame in this case can result in nonsignificant results. By conducting partial correlations, and factoring shame out of guilt and vice versa, Tangney et al. received different results. This is obviously a very strong argument for the importance of separating shame and guilt in research. Not separating between shame and guilt under certain circumstances may lead to a risk of not measuring an effect when actually there is one in reality.

Several theorists have questioned whether this statistical manipulation of separating guilt from shame has a counterpart in reality or whether it creates a purely hypothetical construct (Ferguson & Crowley, 1997). The results yielded from Tangney's part correlations are doubtful in that the exact nature of the common variance that is being statistically removed is unknown. It is impossible to tell whether the common variance is really "clean" and only reflects the relation between guilt and shame, or whether it is due to method variance or a third, unconsidered construct (Ferguson & Crowley, 1997). Statistically, it is more interesting to observe "pure" shame, cleansed of guilt. However, this statistically created construct is artificial and probably does not correspond to shame in the real world which consequently limits any further discussion.

It is important to remember the difference between shame and guilt and consider it when interpreting results. It is further accepted here that under some (specific and mild) conditions guilt may be theoretically observed separately from shame. However, those conditions are not very relevant for triggering events of higher magnitude—such as most traumatic events. Moreover, shame motivates a desire to hide and can be dormant, only rising to the surface of consciousness occasionally (Lewis, 1971; Ferguson et al., 2000; Tangney, Wagner, Fletcher, et al., 1992), and guilt can also serve as a defense mechanism against shame, which contributes to the difficulty of measuring and interpreting shame-free guilt.

Attempts to measure the two constructs separately have so far been unsuccessful. The problem is illustrated further by Janoff-Bulman (1979). Her initial differentiation between behavioral and characterological self-blame is theoretically important for understanding the difference between shame and guilt. Simultaneously, her research illustrates the methodological problems of measuring them separately. In her study, Janoff-Bulman used hypothetical situations followed by questions designed to measure either behavioral or characterological self-blame. In one of those hypothetical situations, a student writes down a telephone message wrong for his roommate. The question that measures behavioral self blame is, "How much do you blame yourself for what you did—when taking down the telephone number" and the characterological self-blame is measured by the question, "How much do you blame yourself for the kind of person you are—the kind of person who causes inconveniences for others." Those two questions, designed to measure two distinct phenomena, show how close guilt and shame are in reality. Human behavior depends on character traits. Blaming a specific behavior without any spillover to the whole self, even in a trivial situation, as given in the foregoing example of failing to convey a telephone message to a roommate, is problematic. Observing shame and guilt truly separately

from each other in the real world is very doubtful. In psychodynamic terms, shame can be associated with an experience of the self being bad in relationship to superego expectations; in this case, there is an interface with guilt. Therefore, there is often a simultaneous feeling of shame and guilt (Severino et al., 1987).

Despite being theoretically different, numerous studies show a significant positive correlation between shame and guilt, even when measured on the SCAAI and TOSCA which were specifically designed to measure them separately. For example, shame and guilt correlated at .43 and .63 in two groups when measured by SCAAI, and .45 when measured by TOSCA (Tangney, Wagner, & Gramzow, 1992). Shame and guilt (measured by TOSCA) correlated ($r = .43$, $p < .001$) in a sample of war veterans (Leskela, Dieperink, & Thuras, 2002) as well.

Tangney, Stuewig, and Mashek (2007) have taken the differentiation between shame and guilt a step further. Their work is built upon the theory of H. B. Lewis, and they understand the difference between shame and guilt as lying in the shamed individual's focus on either the entire self or a specific behavior (Street & Arias, 2001). Shame, in which the individual focuses on his/her entire self, is therefore seen as the more incapacitating of the two. Tangney does not only perceive guilt to be less incapacitating than shame but sees it as a positive, constructive emotion. Any psychopathology that is observed in relation to guilt is explained by Tangney through shared variance with shame. As mentioned earlier, guilt, similar to all other emotions, serves a purpose and, in that regard, may be considered constructive. However, concluding that guilt is only an adaptive emotion, fostering socially adaptive behaviors, is problematic (Ferguson & Crowley, 1997). Excessive guilt, as any excessive feeling, is maladaptive. Moreover, guilt (and not shame) is considered by the APA to be a criterion for diagnosing a major depression: "feelings of worthlessness or excessive or inappropriate guilt . . . nearly every day" (APA, 2000, p. 327) and "feelings of worthlessness or guilt" as one of the symptoms of a major depressive episode, as discussed in *DSM-IV-TR* (APA, 2000). There is also ample empirical evidence that guilt is positively correlated to psychopathology, even when measured separately from shame (Harder, 1995; Jones & Kugler, 1993).

Tangney's constructive approach to guilt is not the only attempt to differentiate shame from guilt. Stone (1992), for example, has defined guilt as a coassembly of shame and fear. However, fear (of exposure) is usually seen as an integral part of shame and is, therefore, not a good base for differentiation. Slightly more refined is the attention to degree of public exposure and the claim that shame is more public than guilt (Severino et al., 1987). However, Tangney, Marschall, Rosenberg, Barlow, and Wagner, 1994; and Tangney et al., 1996, showed that even though guilt and shame are more likely to be experienced in company, solitary shame is just as prevalent as solitary guilt.

Tangney has explored the possibility of differentiating shame and guilt based on the characteristics of the eliciting event but found very few classic shame- or guilt-inducing experiences, based on content analyses of data provided for open questions (Tangney, Wagner, & Gramzow, 1992; Tangney et al., 1994). This reinforces Lewis' (1971) idea that the difference does not lie within the objective nature of the transgression but rather the subjective evaluation of it.

Kubany and Watson (2003, p. 67) summed up the existing knowledge in the literature: "Authorities have not agreed on the fundamental meaning of shame or on how shame and guilt can be readily differentiated." They continued and wrote that there is no operational definition of shame today, and thus it is hard to judge when shame or guilt are observed.

Conclusion

It is advisable to be critical when reviewing studies that examine guilt and shame, especially when they report results which are specific to only one of the constructs. Existing shame and guilt self-report questionnaires are far from perfect in differentiating between the two constructs, and future studies should consider examining the benefits of, for example, implicit or performance-based methods. The consistent reports of high correlations between shame and guilt subscales of different questionnaires are an indication that guilt and shame often occur together. Lewis (1971), in a comprehensive analysis of therapy excerpts, found shame and guilt to usually occur within a range of 500 words. Specifically, when working with victims of trauma, it is advisable to suspect the existence of shame and interpret expressions of guilt as a possible sign of dormant shame. The same is true when interpreting results from studies of shame and guilt in trauma groups. It is often beneficial to conceptualize shame and guilt as an integrative construct—"shame and guilt" and thus avoid the methodological problems of differentiating between the two. As discussed earlier, it is unlikely that they exist individually in the aftermath of a traumatic

event. Clearly, however, more research is needed about the relation between shame and guilt. A fuller discussion of treatment strategies was beyond the scope of this manuscript, but it is a subject that is covered in the existing literature. Understanding the differences and similarities between the different emotions and recognizing them in the patient is, however, the first step in offering adequate consultation.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

Andrews, B. (1995). Bodily shame as a mediator between abusive experiences and depression. *Journal of Abnormal Psychology, 104*, 277-285.

Andrews, B., Brewin, C. R., Rose, S., & Kirk, M. (2000). Predicting PTSD symptoms in victims of violent crime: The role of shame, anger, and childhood abuse. *Journal of Abnormal Psychology, 109*(1), 69-73.

Andrews, B., Qian, M., & Valentine, J. D. (2002). Predicting depressive symptoms with a new measure of shame: The Experience of Shame Scale. *British Journal of Clinical Psychology, 41*, 29-42.

Baumeister, R. F., Stillwell, A. M., & Heatherton, T. F. (1994). Guilt: An interpersonal approach. *Psychological Bulletin, 115*, 243-267.

Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects*. New York: Harper and Row.

Beck, A. T. (1972). Measuring depression: The depression inventory. In T. A. Williams, M. M. Katz, & J. A. Shields (Eds.), *Recent advances in the psychobiology of the depressive illnesses* (pp. 299-302). Washington, DC: U.S. Government Printing Office.

Darwin, C. (1998). *The expression of the emotions in man and animals*. Oxford, UK: Oxford University Press. (Original work published 1872)

Demaria, T., & Kassinove, H. (1991). Predicting guilt from irrational beliefs, religious affiliation and religiosity. *Journal of rational emotive and cognitive behavior therapy, 6*, 259-272.

Derogatis, L. R., Lipman, R. S., & Covi, L. (1973). SCL-90: An Outpatient Psychiatric Rating Scale-Preliminary Report. *Psychopharmacology Bulletin, 9*, 13-28.

Drumbl, M. A. (2000). Punishment, postgenocide: From guilt to shame to civis in Rwanda. *New York University Law Review,* 75, 1221-1326.

Erikson, E. H. (1950). *Childhood and society*. New York: W.W. Norton.

Ferguson, T. J., & Crowley, S. L. (1997). Measure for measure: A multitrait-multimethod analysis of guilt and shame. *Journal of Personality Assessment, 69*, 425-441.

Ferguson, T. J., Stegge, H., Eyre, H. L., Vollmer, R., & Ashbaker, M. (2000). Context effects and the (Mal)adaptive nature of guilt and shame in children. *Genetic, Social, and General Psychology Monographs, 126*, 319-345.

Ferguson, T. J., Stegge, H., Miller, E. R., & Olsen, M. E. (1999). Guilt, shame, and symptoms in children. *Developmental Psychology,* 35, 347-357.

Fischer, K. (1980). A theory of cognitive development: The control and construction of hierarchies of skills. *Psychological Review,* 87, 477-531.

Freud, S. (1957). Mourning and Melancholia. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 243-258). London: Hogarth Press. (Original work published 1917)

Freud, S. (1959). The Ego and the Id. In J. Strachey (Ed. & Trans.), *The complete psychological works of Sigmund Freud* (Vol. 19, pp. 3-66). London: Hogarth Press. (Original work published 1923)

Freud, S. (1961). New introductory lectures on psychoanalysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 22, pp. 5-182). New York: Norton. (Original work published 1933)

Gilbert, P. (1998). What is shame? Some core issues and controversies. In P. Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behaviour, psychopathology, and culture* (pp. 39-54). New York: Oxford University Press.

Harder, D. W. (1995). Shame and guilt assessment, and relationships of shame- and guilt-proneness to psychopathology. In J. P. Tangney & K. W. Fischer (Eds.), *Self-conscious emotions: The psychology of shame, guilt, embarrassment, and pride* (pp. 368-392). New York: Guilford.

Janoff-Bulman, R. (1979). Characterological versus Behavioral Self-blame: Inquiries into depression and rape. *Journal of Personality and Social Psychology,* 37, 1798-1809.

Jarrett, R. B., & Weissenburger, J. E. (1990). Guilt in depressed outpatients. *Journal of Consulting and Clinical Psychology,* 58, 495-498.

Jones, W. H., & Kugler, K. (1993). Interpersonal correlates of The Guilt Inventory. *Journal of Personality Assessment, 61*, 246-258.

Klass, E. T. (1987). Situational approach to assessment of guilt: Development and validation of self-report measure. *Journal of Psychopathology and Behavioral Assessment, 9*, 35-48.

Kohut, H. (1971). *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorders*. New York: International Universities Press.

Kohut, H. (1972). Thoughts on narcissism and narcissistic rage. In P. Ornstein (Ed.), *The search for the self: Selected writings of Heinz Kohut: 1950-1994* (Vol. 2, pp. 615-658). Madison, CT: International Universities press.

Kubany, E. S. (1994). A cognitive model of guilt typology in combat-related PTSD. *Journal of Traumatic Stress,* 7(1), 3-19.

Kubany, E. S., & Watson, S. B. (2003). Guilt: Elaboration of a multidimensional model. *Psychological Record,* 53, 51-90.

Kugler, K., & Jones, W. H. (1992). On conceptualizing and assessing guilt. *Journal of Personality and Social Psychology, 63*, 318-327.

Lazare, A. (1987). Shame and humiliation in the medical encounter. *Archives of Internal Medicine, 147*, 1653-1658.

Lee, D. A., Scragg, P., & Turner, S. (2001). The role of shame and guilt in traumatic events: A clinical model of shame-based and guilt-based PTSD. *British Journal of Medical Psychology*, 74, 451-466.

Leskela, J., Dieperink, M., & Thuras, P. (2002). Shame and posttraumatic stress disorder. *Journal of Traumatic Stress, 15*, 223-226.

Lewis, H. B. (1971). *Shame and guilt in neurosis*. New York: International Universities Press.

Lewis, H. B. (1987). *The role of shame in symptom formation*. Hillsdale, NJ: Lawrence Erlbaum.

Lewis, M. (1992). *Shame the exposed self*. New York: The Free Press.

Lewis, M., & Feiring, C. (1989). Infant, mother, and mother-infant interaction behavior and subsequent attachment. *Child development, 60*, 831-837.

Lewis, M., Sullivan, M. W., Stanger, C., & Weiss, M. (1989). Self-development and self-conscious emotions. *Child development, 60*, 146-156.

Longman Dictionary of Contemporary English (CD ed.). (2006, October 12). Upper Saddle River, NJ: Pearson ESL.

Lowinger, T., & Solomon, Z. (2004). PTSD, guilt, and shame among reckless drivers. *Journal of Loss and Trauma, 9*, 327-344.

Martens, W. (2005). A multiple model of shame. *Journal for the Theory of Social Behavior,* 35, 399-414.

Oxford English Dictionary (2nd CD-ROM ed.). (2004, December 10). New York: Oxford University Press.

Seligman, M. E. P., Abramson, L. Y., Semmel, A., & von Baeyer, C. (1979). Depressive attributional style. *Journal of Abnormal Psychology,* 88, 242-247.

Severino, S. K., McNutt, E. R., & Feder, S. L. (1987). Shame and the development of autonomy. *Journal of the American Academy of Psychoanalysis, 15*(1), 93-106.

Stone, A. M. (1992). The role of shame in post-traumatic stress disorder. *American Journal of Orthopsychiatry, 62*(1), 131-136.

Street, A. E., & Arias, I. (2001). Psychological abuse and posttraumatic stress disorder in battered women: Examining the roles of shame and guilt. *Violence and Victims, 16*(1), 65-78.

Tangney, J. P. (1996). Conceptual and methodological issues in the assessment of shame and guilt. *Behavioral Therapy and Research, 34*, 741-754.

Tangney, J. P., Burggraf, S. A., Hamme, H., & Domingos, B. (1988). *The self-Conscious Affect and Attribution Inventory (SCAAI)*. Bryn Mawr, PA: Bryn Mawr College.

Tangney, J. P., Marschall, D. E., Rosenberg, K., Barlow, D. H., & Wagner, P. E. (1994). *Children's and adults autobiographical accounts of shame, guilt and pride experiences: An analysis of situational determinants and interpersonal concerns*. Unpublished manuscript. George Mason University, Fairfax, VA.

Tangney, J. P., Miller, R. S., Flicker, L., & Barlow, D. H. (1996). Are shame, guilt, and embarrassment distinct emotions? *Journal of Personality and Social Psychology, 70*, 1256-1269.

Tangney, J. P., Stuewig, J., & Mashek, D. J. (2007). Moral emotions and moral behavior. *Annual Review of Psychology,* 58, 345-372.

Tangney, J. P., Wagner, P. E., Fletcher, C., & Gramzow, R. (1992). Shamed into anger? The relation of shame and guilt to anger and self-reported aggression. *Journal of Personality and Social Psychology, 62*, 669-675.

Tangney, J. P., Wagner, P. E., & Gramzow, R. (1989). *The test of self-conscious affect*. Fairfax, VA: George Mason University.

Tangney, J. P., Wagner, P. E., & Gramzow, R. (1992). Proneness to shame, proneness to guilt, and psychopathology. *Journal of Abnormal Psychology, 101*, 469-478.

Wilson, J. P., Drozdek, B., & Turkovic, S. (2006). Posttraumatic shame and guilt. *Trauma, Violence & Abuse,* 7(2), 122-141.

Wong, M. R., & Cook, D. (1992). Shame and its contribution to PTSD. *Journal of Traumatic Stress,* 5, 557-562.

Yovell, Y. (2001). *Mindstorm*. Tel Aviv, Israel: Keshet.