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SHAME AND PSYCHOPATHOLOGY: FROM RESEARCH TO CLINICAL PRACTICE

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Abstract

Shame is a self-conscious emotion that was recently acknowledged as having a unique contribution to psychopathology, different from that of guilt. Several investigations have pointed out the roles that this emotion may play in the development and/or the maintenance of psychological problems. This article discusses the implications of shame for psychopathology research by focusing on four directions: shame as a predictor, shame as a diagnostic criterion, shame as a mechanism of change, and shame as outcome. We also argue for the relevance of shame in therapeutic practice, and we highlight some particular features which may have a significant impact on successful interventions, by discussing shame assessment and conceptualization, shame and disclosure in therapeutic alliance and ways of tackling shame. Starting from the existing evidence, we point out the gaps in the literature, and offer some future directions and recommendations in order to clarify the role of shame and improve treatment outcome.

***Keywords**:* shame, self-conscious emotions, shame regulation, guilt.

Introduction

It is now known that besides having a well-established set of basic emotions such as fear, joy, sadness (Campos, 1995), the human being is characterized by a larger emotional spectrum including the so-called self-conscious emotions. Despite their importance to psychological functioning (Tracy & Robins, 2004), self-conscious emotions, such as shame, guilt, pride and embarrassment, have received much less attention in the clinical research literature. This may be at least partially due to the fact that until the seminal work of H.B. Lewis (1971), the field of self-conscious emotions lacked a clear integration and conceptualization, thus not allowing the differentiation between the several self-conscious emotions. After Lewis (1971) introduced the distinction between shame and guilt, stating that in shame the focus is on the global self, whereas in guilt the focus is on a specific behavior, other models which define

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self-conscious emotions have emerged. One of the most influential is the appraisal-based model proposed by Tracy and Robbins (2004). According to this model, self-conscious emotions are generated by cognitive appraisals about an event's implications for self-identity and the causal attributions for that event. These appraisals and attributions determine whether a basic or a self-conscious emotion will be elicited, as well as the type of self-conscious emotion. The differentiation among several self-conscious emotions allowed researchers to investigate the role of each of these emotions in psychopathology, thus leading to a flourishing of this field in the last two decades.

The aim of this article is to discuss the implications for psychopathology research and practice of one of these self-conscious emotions, namely shame. The experience of shame is characterized by a sense of the self being flawed, thus the focus of the negative evaluation is the entire self which is impaired by a global devaluation (Lewis, 1971). Based on Tracy and Robbins' (2004) model, shame requires internal attributions about stable, global aspects of the self. A distinction must be made between shame as an emotional state, and shame-proneness which refers to an emotional trait or disposition to experience shame (Tangney, 1996). Also, some authors argue that shame can be best conceptualized in terms of two dimensions: internal shame (being focused on negative self-evaluation) and external shame (being focused on fear of others' judgments; Gilbert, 1998).

For a long time, researchers did not make a clear distinction between shame and guilt. Although, many empirical studies (e.g., Lindsay-Hartz, 1984; Tangney, 1992) showed that shame and guilt differ substantially along affective, cognitive and motivational dimensions. The term guilt is being used indiscriminately to refer to characteristics of both shame and guilt (Tangney, 1996). The main difference between the two is that shame is centered on the entire self, which is devaluated, whereas in guilt the focus is on a specific behavior negatively evaluated, but the global self is left intact. At a behavioral level, shame is associated with a desire to hide, whereas guilt results in a desire to repair, to apologize (Tangney, Burggraf, & Wagner, 1995; Tangney, Stuewig, & Mashek, 2007). Moreover, even though both shame and guilt are negative emotions, the experience of shame is considered to be more painful and damaging (Tangney, Wagner, & Gramzow, 1992).

Despite the fact that clinical literature emphasizes guilt as an important feature of psychopathology, several studies show that shame is associated with psychopathology to the same or even greater extent than guilt (Fergus, Valentiner, McGrath, & Jencius, 2010; Kim, Thibodeau, & Jorgensen, 2011; Pineles, Street, & Koenen, 2006; Tangney et al., 1992). Several studies have shown that shame and shame-proneness are associated with social phobia and generalized anxiety disorder (Fergus et al., 2010; Matos, Pinto-Gouveia, & Gilbert, in press), bipolar disorder (Highfield, Markham, Skinner, & Neal, 2010), eating disorders (Grabhorn, Stenner, Stangier, & Kaufhold, 2006; Hayaki, Friedman, & Brownell, 2002), personality disorders (Brown, Linehan, Comtois, Murray, & Chapman,

2009; Rusch et al., 2007), and, perhaps the most investigated association, with depression (De Rubeis & Hollenstein, 2009; Kim et al., 2011; Orth, Berking, & Burkhardt, 2006; Tangney et al., 1992).

Shame in psychopathology research

Shame as a predictor of psychopathology

A first line of research investigates shame as a predictor of the development and course of emotional disorders. Andrews, Qian, and Valentine (2002) showed that shame was associated with depressive symptoms, and that it predicted additional significant variance in a future evaluation, even when initial symptoms were controlled, thus suggesting that shame may play a significant role in the onset and course of depression. These results are supported by De Rubeis and Hollestein (2009) who showed that shame-proneness was a significant predictor of depressive symptoms, both concurrently and over the course of 12 months.

Other studies indicate that shame influences the course of other mental disorders as well. Shame in eating contexts and body shame were related to the severity of eating disturbance in a community sample (Burney & Irwin, 2000). In one undergraduate sample, shame-proneness was associated with higher levels of bulimic symptoms when controlling both for guilt and depressed mood (Hayaki et al., 2002). Also, in a clinical sample, higher levels of shame were associated with higher levels of bulimic symptoms, but this relation was not sustained when controlling for guilt and depressed mood, which might be due to the high correlation between shame and depression (Hayaki et al., 2002). Shame-proneness was found to correlate positively with the severity of post-traumatic stress disorder (PTSD; Leskela, Dieperink, & Thuras, 2002). Moreover, shame and anger towards others were the only independent predictors of PTSD symptoms at 1 month after a violent crime, and shame was the only independent predictor of symptoms at 6 months when controlling for 1-month PTSD symptoms (Andrews, Brewin, Rose, & Kirk, 2000). A study on patients with borderline personality disorder showed that higher levels of nonverbal shame expression (e.g., head movements downward, eye contact) were associated with an increased risk of self-injury even after controlling for other relevant emotions or past self-injury acts, but self-reported shame and others-evaluated shame were not after controlling for fear (Brown et al., 2009). A possible explanation of these results is that negative affectivity in general, not necessarily shame is associated with future self-injury (Brown et al., 2009).

The results of these investigations suggest that shame is a predictor of psychological symptoms and their severity. Yet, we must be cautions as some of these studies are cross-sectional in nature and do not allow conclusions about the direction of these relationships. Even though there are some promising longitudinal studies, more research is needed in this area. If future studies confirm

these results, shame may be considered a relevant factor that should be approached in prevention programs but also addressed and monitored in therapeutic environments.

Shame as a diagnostic component

A major drawback in the study of self-conscious emotions has been the lack of a clear and unequivocal distinction among these emotions, including shame and guilt. In order to understand their independent contribution to psychopathology we should first make a distinction between adaptive and maladaptive guilt. Even though guilt, characterized at a cognitive level by internal, specific, and unstable attributions, is a negative emotion, several authors point out its adaptive functions, like motivating reparative action (Tangney et al., 2007) or prosocial behavior (Kim et al., 2011). However, it is important to acknowledge that, under certain circumstances, guilt can be a maladaptive emotion. We talk about maladaptive guilt when it is generated by inappropriate attributions of responsibility, called *contextual maladaptive guilt,* or when it is free floating, not related to specific contexts, also called *generalized guilt* (Kim et al., 2011). Some authors suggest that guilt becomes maladaptive when it becomes fused with shame (see Tangney et al., 1995).

Tangney et al. (1992) found that shame-proneness is more strongly associated with psychopathology than guilt-proneness, and that the relations between guilt-proneness and psychopathology are due to shared variance between shame and guilt-proneness. Other studies looking at the effects of shame and guilt simultaneously confirm these results indicating that the association of guilt with depression is substantially smaller or even disappears when controlling for shame (Fontaine, Luyten, De Boeck, & Corveleyn, 2001; Harder, Cutler, & Rockart, 1992; Pineles et al., 2006). The fact that shame-proneness is stronger associated with depression then guilt-proneness is supported by a recent meta-analysis which included 108 studies (Kim et al., 2011). Yet, when splitting the analysis between adaptive and maladaptive guilt, a similar association as in the case of shame was found between maladaptive guilt (both contextual-maladaptive and generalized) and depression. Also, the association between external shame and depressive symptoms was significantly higher than for internal shame. As mentioned above, Tangney et al. (1995) suggest that maladaptive guilt is guilt fused with shame, but future studies should clearly identify if there is a difference between these two constructs and whether the maladaptive effects of guilt are due to its association with shame.

These results have potentially important implications for diagnostic in depression. Although DSM-IV (American Psychiatric Association, 2000) considers only inappropriate guilt as a diagnostic criterion of a major depressive episode, we support the suggestion of Kim et al. (2011) that these criteria should be revised considering the large body of evidence in favor of including shame as a criterion. Even though one might argued that shame and guilt are similar

emotions, and that inappropriate guilt, which is present in depression, also involves shame, the theoretical and empirical findings presented above demonstrate that shame and guilt differ along many dimensions and can be considered distinct emotions.

Shame-proneness and shame regulation as a mechanism of change

A third area in which shame might be considered is in understanding the process of change during psychotherapy, specifically whether changes in shame-proneness and shame-regulatory strategies can determine changes in the outcomes of psychotherapy. In this case, the question is whether shame-proneness and shame regulation can be considered as mechanisms of change in the treatment of different mental disorders.

Several studies demonstrate that the way shame is regulated may impact depressive symptoms. De Rubeis and Hollenstein (2009) showed that avoidant coping was a full mediator of the longitudinal relationship between shame-proneness and depressive symptoms in adolescents. This might indicate that an effective approach for preventing or reducing depressive symptoms is to teach shame-prone persons how to use more active coping strategies (Mills, 2005). Also, one study showed that rumination substantially mediated the effects of event-related shame on depression (Orth et al., 2006). Cheung, Gilbert, and Irons (2004) found that rumination partially mediates the relationship between shame and depression. Another study showed that self-rumination was a mediator of the relationship between shame-proneness and personal distress but shame-proneness also mediated the relationship between self-rumination and personal distress, the authors suggesting a cyclic relation between these phenomena (Joireman, 2004).

In relation to eating disorders, one study showed that, in a nonclinical group, perceived parental control was associated with bulimic attitudes and shame-proneness moderated this link (Murray, Waller, & Legg, 2000). Moreover, internalized shame was shown to be a mediator between family dysfunction and bulimic psychopathology (Murray et al., 2000). In another investigation, shame-proneness predicted eating disorders symptomatology over and above general negative affectivity but the relationship was fully mediated by difficulties in emotion regulation (Gupta, Rosenthal, Mancini, Cheavens, & Lynch, 2008). A study by Fergus et al. (2010) showed that changes in shame-proneness during treatment were associated with reductions in several anxiety disorders symptoms, specifically obsessive-compulsive, social phobia and generalized anxiety disorder. Some authors suggest that shame regulation may also be relevant for personality disorders (Schoenleber & Berenbaum, 2012), but this hypothesis needs further investigation.

Thus, there is evidence suggesting that shame regulation and shame proneness may affect the development and maintenance of psychopathology. However, existing investigations are only the first step in determining whether shame-proneness and shame regulation can be considered mechanisms of change.

To prove this, future studies need to: (1) show strong associations between the intervention and the mediators of change and between mediators and therapeutic change; (2) demonstrate the specificity of the association between intervention, outcome and mediators; (3) use experimental manipulation in order to prove changes in mediators that further determine changes in outcomes; (4) show consistency by replications of findings in different investigations, samples and conditions; (5) investigate temporal interposition (i.e., mediators temporally precede outcomes); (6) indicate gradient (i.e., greater activation or levels of mediators is associated with greater effects in outcomes); (7) indicate plausible or coherent explanation of the actual process through which one variable influences another (Kazdin, 2007).

While there are some studies showing that shame regulation strategies can be considered statistical mediators, to our knowledge, there are no studies demonstrating causality and temporal sequentially of treatment, mediator and symptoms. Furthermore, while existing studies fulfill the plausibility and coherence criteria, there is no data on the other required conditions.

Shame as an outcome

Finally, shame may be studied in psychopathology as an outcome. At this point, depending on one's focus, shame-proneness can be regarded and studied both as possible outcome or possible mechanism of change. A firm conclusion in this sense needs considerable future research. Studies investigating shame-proneness as a mechanism of change should take into consideration the requirements presented above. If changes in the shame-proneness prove to be concomitants with changes in symptomatology, then it will be plausible to consider shame-proneness as an outcome rather than mechanism of change.

Shame in clinical practice

Shame assessment and conceptualization

Based on studies showing that shame can be a relevant predictor for psychopathology, we argue that practitioners should address shame-proneness and shame experiences in the intervention. In order to do this efficiently there are two aspects that should be considered: (1) patients may often use the terms shame and guilt interchangeably (even highly-educated individuals; Tangney et al., 2007) and (2) practitioners should pay attention when choosing the measures to evaluate shame and guilt.

It is important to investigate what the client means by feeling guilty. The best way to do that is to look at the attributions and appraisals he/she makes in specific situations. This allows the therapist to differentiate between guilt and shame. Equally important is choosing the right measure in order to evaluate these constructs as there are scales which evaluate only one dimension of shame. Also, when measuring guilt, it is important to use scales that capture maladaptive guilt.

Moreover, if we choose a measure that evaluates both shame-proneness and guilt-proneness it may be beneficial to talk with the patient about the distinction between shame and guilt (for more information on the assessment of shame and guilt see Robins, Noftle, & Tracy, 2007).

Assessing shame can have implications for the clinical conceptualization as well. The conceptualization we offer to the patient about his/her tendency to feel shame should accurately reflect underlying beliefs and their role in the development and/or maintenance of his/her problems.

Underlying beliefs and tackling shame in psychotherapy

Although in the last two decades plenty of studies confirmed the distinction between shame and guilt introduced by Lewis (1971), little is known about "how to best recognize, manage, treat or capitalize on shame in the therapy hour" (Dearing & Tangney, 2011, p. 375). Based on the existing literature, we discuss the ways in which shame can be tackled in psychotherapy, integrating the findings into a cognitive-behavioral therapy (CBT) approach.

Although clinical guidelines focusing on the way shame should be approached in a therapeutic setting are available (e.g., Dryden, 1997), some argue that most clinical texts only briefly discuss the maladaptive nature of this emotion (Teyber, McClure, & Weathers, 2011). Moreover, even more problematic is the fact that shame is easily overlooked in the therapeutic encounter (Dearing & Tangney, 2011). Looking at the existing evidence on the implications of shame for mental disorders, and at current practice, we argue that clinicians should pay more attention and approach shame in a much more explicit manner in the therapeutic process. Below we describe some of the cognitive and behavioral techniques which could be used to tackle shame. One core CBT technique is cognitive restructuring. As shame-proneness is characterized by internal, global and stable evaluations, cognitive restructuring could be used to tackle these evaluations and reduce the shame experienced by shame prone-individuals. Fear of others' judgments should be approached in the same way.

Beyond directly addressing shame and shame-proneness, processes that mediate the relationship between shame and psychological symptoms could also serve as a target of therapeutic intervention (Joireman, 2004). To do so, clinicians could try to change maladaptive shame regulation strategies. For example, in a given context the experience of shame may be elicited rather quickly, and the ruminative process that follows shame, may be more susceptible to intervention (Orth et al., 2006). By providing strategies to overcome rumination and teaching patients more adaptive emotion regulation strategies in different contexts (e.g., distraction, cognitive reappraisal) the therapist may reduce the occurrence of shame and other psychological symptoms. Behavioral techniques, such as opposite action, could also be used to challenge avoidance which is also a maladaptive shame regulation strategy (De Rubeis & Hollenstein, 2009). This technique encourages the clients to behave "as if" they were not ashamed, to

approach and disclose rather than hide and conceal, to make eye contact rather than shrink, to acknowledge their worth rather than recognizing their shortcomings (Dearing & Tangney, 2011). Another well-known technique which can be used to tackle shame is the shame attacking exercise in which clients are encouraged to do certain "shameful" things in order to overcome their shame by disputing the underlying dysfunctional/irrational beliefs.

Besides these traditional cognitive-behavioral strategies, there are a few explicitly shame-focused therapies: compassionate mind training (Gilbert & Procter, 2006) and shame-enhanced dialectic-behavioral therapy (DBT) for borderline personality disorder (Rizvi & Linehan, 2005), both built on a cognitive-behavioral framework, which describe other techniques in addressing shame. While shame-enhanced DBT is based on the technique of opposite action already presented above, using this technique as the main tool for reducing shame, the central element of compassionate mind training is teaching self-compassion as an effective method for regulating shame (e.g., imagining comforting a friend who has a similar shame-inducing problem; Furukawa & Hunt, 2011) with the aim of making clients more attentive to their needs and feelings and accepting them (Dearing & Tangney, 2011).

These are several ways in which shame can be addressed in therapy. Hopefully, future studies using randomized experimental designs will clarify the efficacy and effectiveness of these shame-focused interventions (Dearing & Tangney, 2011). Moreover, it is important to identify which are the active ingredients of these interventions, thus allowing the choice of optimal strategies and techniques for tackling shame.

Shame and disclosure in therapeutic alliance

A central feature of shame is the desire to conceal the presumed deficiencies, and this aspect has important implication for psychotherapy. Based on a diary keeping procedure MacDonald and Morley (2001) found that in a psychotherapy outpatient sample 68% of the emotional incidents recorded (participants were required to record feelings of shame, guilt, hatred, and disgust) in the diaries were not disclosed to other persons. In comparison, in similar studies with non-clinical samples (Rimé, Mesquita, Boca, & Philippot, 1991) only 4-10% of the emotional incidents were not disclosed. The main themes associated with non-disclosure were negative self-evaluations and the anticipation of negative interpersonal responses to disclosure (e.g., others will blame or judge them), which are cognitive elements of shame.

Also, studies investigating the extent of non-disclosure in therapy indicate rates between 41 and 46% (Hill, Thompson, Cogar, & Denman, 1993; Kelly, 1998; Swan & Andrews, 2003). Additionally, it was found that an important reason for non-disclosure was shame and that shame-proneness made non-disclosure more likely. Swan and Andrews (2003) showed that non-disclosure in the treatment of eating disorders was associated with significantly higher levels of

characterological shame and shame around eating. Although some studies did not found this relation (e.g., Farber & Hall, 2002), Swan and Andrews (2003) and Hook and Andrews (2005) showed that the link between shame and non-disclosure in therapy is more likely to involve symptom-related problems rather than total degree of disclosure.

Some studies indicate that disclosure has a significant impact on symptomatology, even though, not all investigated the direct role of shame in this relationship. Sloan and Kahn (2005) showed that, on the short run, clients' self-reported disclosing tendencies were related to a decrease in symptom-related distress. Even more interesting are the results of Hook and Andrews (2005) which indicate that non-disclosure of symptoms in participants who were no longer in therapy was significantly associated with current depression symptoms even when controlling for shame-proneness, depression severity and demographic variables. However, no such relationship was found in participants who were still in therapy. The authors argue that therapy is an ongoing process, with client variations related to time necessary for disclosing symptoms and suggest that it may be more reasonable to determine the impact of non-disclosure only at the end of therapy.

Given that shame can have a negative impact on disclosing information in therapy and that it is possible that non-disclosure of symptom-related feelings and behaviors could contribute to current symptomatology we argue that therapists should explicitly address the issue of shame and non-disclosure in order to overcome these problems.

Conclusions

Shame is an emotion with important implications for psychopathology research and practice. This paper has described four possible implications of shame for psychopathology and therapy: shame as a predictor, shame as a diagnostic criterion, shame as a mechanism of change and shame as an outcome. The existing studies support the potential role of shame in psychopathology. However, future research which can prove causality and temporal mediation is needed. These findings also have relevant implications for psychotherapy practice. We argue that the mental health practitioners should explicitly address shame in therapy. By tackling shame-proneness and maladaptive shame regulation strategies we may reduce the negative impact of this emotion on therapeutic alliance and symptomatology. Well controlled efficacy studies that distillate the most efficacious techniques to tackle these issues could have a benefic impact on practitioners' effectiveness in clinical practice.

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