12 Regulating and Coping with Shame

James M. Harper

Summary. – Shame is a powerful affect which serves both positive and negative functions. One positive function of shame is its use to help socialize and teach norms important for survival and interpersonal success. However, when people experience frequent shame experiences, they develop trait shame or internalize the shame, and it becomes a part of their negative identity. In other words, they learn to expect shaming experiences, they learn to hide their flawed sense of self from others, and they interact with others in a way that increases the likelihood of receiving shaming messages. This article reviews psychometric properties of several standardized measures of shame and concludes that the Internalized Shame Scale, ISS (Cook, 2001) is not only useful for research but can be used clinically as well. Shame appears to be related to a number of personality concepts including pessimism, narcissism, dependent personality, borderline traits, external locus of control, and introversion. People cope with internalized shame in a number of ineffective ways including substance use, hypersexual behavior, eating disorders, and withdrawing in relationships and attacking others as well as the self. Anthropologists have identified the role of shame in various cultures and argue that the experience of shame is universal.

The word shame has its origins in the French Teutonic root "skam" and the pre-Teutonic root "skem"which means "covering" or "covering oneself". According to Tompkins (1963) and others (Barret, 1995; Nathanson, 1992; Nathanson, 1997), shame is one of nine affects present in humans at birth as evidenced by each affect having a unique pattern of neuron firing in the nervous system. Ekman's (1999) cross cultural studies on facial representations of emotion support the universality of shame across cultures. He argues that facial affect

systems are present in the nervous systems of all human beings, and that different affects are represented by changes in facial musculature with each emotion having specific changes in facial expression. Non-verbal signs of shame include hanging the head down, letting hair cover the eyes, and eyes downward. Defensive facial reactions to shame include the "frozen face" where the face is keep in tight control, head tilted back with chin jutted out, and contempt with the lip forming a sneer.

Shame is often described as humiliation, embarrassment, and fallen pride (Kaufman, 1996). When people experience shame, their experience acts as an inhibitor of the affect of joy and of continuing interest in something. Every person has experienced shame at some point in their life, and most have experienced shame multiple times as they felt ashamed or humiliated. With shame, people experience an accompanying desire to disappear or hide, or to "break into a thousand pieces". More frequent and intense experiences with shame eventually lead to an internalization of shame. Internalization of shame is a condition in which a person feels flawed at their very core. They experience a "badness" about themselves that does not change regardless of their actions. Some experience this as "not ever being good enough", "having a bad effect on others", and "being broken in some way but not being certain about how or why they are broken".

According to many theorists (Harper & Hoopes, 1990; Kaufman, 1996), the internalization of shame has roots in the dynamics of interpersonal relationships early in life and is subsequently influenced by interactions with peers, teachers, extended family, and in adult contexts such as romantic relationships and work. Internalization of shame, sometimes referred to as proneness to shame (Cook, 1996), is related to the absence of three processes in families which Harper & Hoopes (1990) referred to as the affirmation triangle. The three processes are accountability, intimacy, and appropriate dependency. When any one of these processes is absent in family relationships, individuals will experience and internalize shame. Accountability means that family members feel and act responsibly toward others to meet basic emotional needs. Not only are children accountable to parents to some standard including values, but parents are accountable to children in terms of identifying standards that are personal to the family. Family members are able to express why their personal standards are important to them in a very personal way. When children are young, parents express and teach their standards and values and provide a structure for children. As children grow older, they learn to express standards as important to them personally. Intimacy means family members are able to share physical touch, be nurturing to each other, and share emotional experience in what object relations theorists call a "holding environment" where the parent is able to contain the child's affect, is not threatened by emotion, and gives meaning to it". When intimacy processes are present, family members disclose personal information and feelings to each other. Dependency refers to the ability of family

members to rely on each other emotionally and for basic needs. When dependency is present in families, parents allow young children to inconvenience them while they meet these children's needs. They are not usually irritated by the needs of the child and they recognize that the child needs to be dependent on them. As children grow older, parents allow them appropriate independence but are still basic dependency or attachment figures. As children enter emerging adulthood, they become interdependent with their parents. The attachment security never disappears even though the children are becoming more independent and autonomous.

In conditions where dependency, accountability, or intimacy are absent, children internalize shame and become shame prone meaning that they begin to view the world as a place where they expect shame from others and actually do things that bring shame upon them. The received the message that they are inconvenient to their parents, that their basic feelings are inappropriate, and their interpersonal world is unpredictable. According to Panskepp (2004), while people have the inherent capacity to experience affects of different kinds, the environment they are raised in interacts with these affect programs in their brains and can increase the likelihood that an individual will use certain affect programs over others. An example would be a child who experiences a lot of fear training his affect systems to more easily and quickly go to fear. When a child feels anger, fear, or sadness, if the parent is threatened by the presence of emotion in the child, or if the parent sends a message that the emotion is inappropriate or inconvenient, the child will experience shame, and when this happens frequently, children will internalize shame and assume that something about them is flawed because the feelings emanate from them but seem to be rejected by others as something bad. Over time the internalization of shame leads to what Miller (2008) calls a presentation of a false self in which a person presents an image to others that is not congruent with their internal experience of themselves and their world.

According to Kaufman (1996), individuals proceed through several steps to finally internalizing shame. In the first stage, they exhibit self contempt, self blaming, and negative comparisons of themselves to others. As they continue to give more energy to such thoughts and behaviors, they move to stage II in which they begin to disown attachment needs, feelings, and what Kaufman calls self clusters such as the child self, the adolescent self, and the needing self. In time an individual eventually moves to the third stage in which splitting, seeing the self as all negative and others as all positive, takes over. The final step in the process is one in which the whole person bases their identity on shame. They arrive at the conclusion that it is better to receive affirmation for one's badness rather than no acknowledgement at all. In family systems without a healthy affirmation triangle (accountability, intimacy, and dependency) this development sequence for shame proceeds fairly quickly and at young ages.

COPING WITH SHAME AND INTERNALIZED SHAME

People use several defense mechanisms for protecting themselves by keeping others from discovering their shame. Compensation is frequently used where a person presents to others as perfect or at times with grandiosity. This imposter syndrome (Harper & Hoopes, 1990) has the effect calming the person as long as they perceive that others will not uncover their shame. To others the person may seem confident, sometimes overly confident, as seen in trying to impress others and in people who always need to be the center of attention. Putting down others to make one's self feel superior is often used to avoid facing feelings of inadequacy. The isolating and ill at ease feelings associated with shame are sometimes relieved with humor and laughter shared with others.

Individuals prone to shame, because they have internalized it, cope with their feelings of shame in numerous unhealthy ways. Some may experience rage as a reaction to internalized shame. Rage keeps others from discovering the shame and pushes them away creating more distance with feels safer because the shame is less likely to be discovered. Contempt and rejection are often strategies used in interpersonal relationships (Gardner & Gronfein, 2005). Fearing discovery, the shame based person reacts first by distancing in the relationship so that the anticipated discovery of shame by the other person and the feared abandonment and rejection when their shame is discovered is never realized. Becoming defensive and blaming others is also used to protect oneself from intense experience of shame. Substance use and sexual compulsivity are behaviors that are often used to avoid the more dark feelings of shame. While these activities do not resolve the internalized shame, they help individuals temporarily feel better and suspend for a time the feelings of shame. Unfortunately, the shame usually returns with more intensity as the individual deals with their feelings about their behavior or experiences the interpersonal disruptions that are often accompanied by drug and alcohol use and sexual behavior outside the relationship.

Self harm, eating disorders and rage are also ways of defending against shame. Again, they do not resolve internalized shame, and they contribute to become more shame prone, but they allow people to escape for a short time from the intense shame affect. Fee & Tangney (2000) found that procrastination was another way of avoiding the risk of being shamed.

Van Vliet (2009) found that certain types of attributions were linked to shame. In a qualitative study of 9 women and 4 men from Canada, recovery involved a movement towards specific and unstable attributions that enhanced self-concept and maximized a sense of power and control over the future. These participants learned to deal with self blame by examining external factors that are related to an

event. For example, a person who blamed themselves would identify all the other influences including other people and external forces that were also related to the event. They arrived at a position of "This was not just me".

Not all theorists and researchers view shame through the negative lens. Leeming & Boyle (2004) identified the social functions of shame indicating that shame helps keep social order and helps people maintain relationship status dynamics. Hooge, Breulgelmans, & Zeelenberg (2008) examined the use of shame as a commitment device whereby one person tries to influence another person to commit to something. As will be discussed later in this chapter, anthropologists have examined both the positive and negative role of shame in various cultures.

PSYCHOMETRIC MEASURES OF SHAME

The Internalized Shame Scale, ISS (Cook, 1987; 1994; 2001).- The ISS is based on the trait approach meaning that it is a measure of shame proneness or internalized shame rather than the affect of shame. A paper pencil measure, the ISS consists of 30 items based on the phenomenological experience of shame among men and women in alcohol recovery programs. A person answers each item using a 5-point Liker scale that describes how frequently the item is experienced (ranging from Never - 0 to Almost Always - 4). Six items comprise a self esteem subscale, and the remaining 24 items comprise the internalized shame subscale. Potential scores for internalized shame range from 0 to 96. The most recent version is the fifth version of the ISS. The original version in 1984 consisted of 90 items (Cook, 1996). In the original study, items that were not highly correlated with the total score were dropped. Using a sample of 44 graduate students, Cook (1996) determined that a 7-week test-retest coefficient was .85 for the 24-item shame scale. The internal consistency item coefficients ranged from .56 to .73 in a non-clinical sample.

Concurrent validity for the ISS has been established in several studies. Harder, Cutler, & Rockart (1992) compared the overall shame scale of the ISS with the shame subscale of PFQ and the shame subscale of the SCAAI and determined that the correlations were .63 and .52 respectively. Construct validity for ISS was established by Rybak & Brown (1996) in a study in which they showed that the scores from the ISS shame scale were highly correlated with anxiety, hostility, depression, and negatively correlated with positive affect.

Psychometric studies of the ISS have used samples from both clinical and non clinical populations. Akashi (1994) obtained a sample of 336 adult outpatients from adult clinics in Columbus, Ohio. She reported that the shame scale of the ISS was related to several scales from the Symptom Checklist - 90 (Deragotis, 1992) including Depression (.71), Somatisim (.45), Obsessive-Compulsive (.61), Inter-

personal Sensitivity (.74), Anxiety (.62), Hostility (.51), Psychoticism (.72), Phobic Anxiety (.55), and Paranoid Ideation (.61). The ISS Technical Manual (Cook, 2001) reports several samples which were taken from clinical populations.

Compass of Shame Scale, CoSS (Elison, Pulos, &, Lennon, 2006; Nathanson, 1992).- This scale measures use of the four shame coping styles, namely Attack Self, Withdrawal, Attack Other, and Avoidance. In the Withdrawal category, a person acknowledges the experience as negative, accepts shame's message as valid, and tries to hide from the situation. In the Attack Self category, the person experience is negative, shame is internalized, and anger is turned inward on the self. A person in the Avoidance category does not acknowledge the negative experience of self, denies the message of shame, and distracts from painful feeling. In the Attack Other category, a person often does not accept the negative experience of self and often denies the shame message the negative experience of self, typically does not accept shame's message, and then blames or ridicules someone else.

The development of the CoSS was founded in Nathanson's book on shame, Shame & Pride (1992). The format includes a number of scenarios that invoke shame affect which are based on Nathanson's eight classifications of situations which are shaming. Each scenario is followed by a stem with that requires a response to four possible reactions to the scenario based on the four types of coping. All four of the items are answered based on how frequently a person might react in that way on a scale ranging from 0 - Never to 4 - Almost Always. For instance, a stem might say "When I feel rejected by someone", and the responses would include "I avoid them", "I soothe myself with distractions", "I brood over my flaws", and "I get angry with them". The person is required to rate each of the four responses.

The initial version of the CoSS included 72 items which were reviewed for content validity. The scale was then given to a select group of 34 who then provided feedback on clarity in understanding the items. The inter item correlation coefficients for the initial scale ranged from .82 to .88. Based on feedback from those taking the scale, the items were reduced to 48 items in the second version. Elison, Pulos, & Lennon (2006) administered the 48 item CoSS to 90 undergraduate students in a reliability and validity study of version 2. Three week test-retest reliability coefficients for each of the four types of coding ranged from .81 to .92.

Confirmatory factor analysis showed that each item factor loaded on the scale it was theoretically expected to represent. The authors did not report individual factor loadings in their article, but the goodness of fit indices were all acceptable (Elison *et al.*, 2006). Convergent validity was determined by comparing scores from CoSS with scores from the Internalized Shame Scale (Cook, 2001), Symptom Checklist-90 (Deragotis, 1992), The Attack Other Scale (Cook, 1996), and The Ways of Coping Questionnaire (Folkman & Lazarus, 1988). Results showed that Withdrawal and Attack Self subscales were moderately correlated with the to-

tal score from the ISS shame scale (.71 and .72) but not with the Attack Other and Avoidance subscales. The Withdrawal, Attack Self, Attack Other subscale scores were also moderately correlated with the Global Severity Index and the Positive Symptom Distress scores from the SCL-90 as well as with interpersonal sensitivity and depression scores from the SCL-90. The Avoidance subscale of the CoSS was not significantly correlated with any of these other scales.

In terms of construct validity, Campbell & Elison (2005) found that Attack Other was associated with greater hostility and anger as would be predicted by the theory. Yelsma, Brown & Elison (2002) found that Withdrawal, Attack Self, and Attack Other subscale scores were significantly correlated with Coopersmith's (1967) 58-item Self-esteem Inventory, but Avoidance was not significantly correlated. Elison *et al.* (2006) also reported construct validity for this measure.

Adapted Shame and Guilt Scale, ASGS (Hoblitzelle, 1987; 1990).- The ASGS consists of series of adjectives that are considered shame words and guilt words. Filler words are also added to the list. Hoblitzelle (1987) use factor analysis to obtain 10 shame words (bashful, mortified, shy, humiliated, abashed, embarrassed, depressed, chided, reproaches, and ashamed) and 11 guilt words. The respondent rates each adjective on a 7-point Likert scale ranging from 1 (Not at all like me) to 7 (Very much like me). The ratings are then summed yielding a score that ranges from 7 to 70 for the shame subscale.

In a study of 137 Vanderbuilt University students, test-retest reliability was .87 for the shame subscale. Factor loadings for the 10 shame words ranged from .52 to .66 in one study (Hoblitzelle, 1987) and from .56 to .73 in another study (Hoblitzelle, 1990). The convergent validity coefficient for the AGSG with the Beal Shame test was .46. Correlations between the AGSG and several scales were .64 for Social Avoidance and Distress, .62 for Fear of Appearing Incompetent, .34 for Self-Criticism. Construct validity was determined by using the total shame score to predict depression scores. Findings showed that the SGSG score was positively correlated with characterological blame and .54 with a self-rating of depression.

Self-Conscious Affect and Attribution Inventory, SCAAI (Tangney, 1990).- This inventory presents a series of scenarios some of which are negative and some are positive. The difference between the SCAAI and the ASGS is that the scenarios for the SCAAI were generated by participants in research studies. In the SCAAI the scenario is presented, and the test taker is asked to rate a number of different possible responses, one of which is shame proneness related and one of which is guilt related. An example would be, "You raise your hand and are called upon by the teacher, and then you give the wrong answer". The shame prone response would be, "You have the feeling that everyone is looking at you". The guilt response would be "You are annoyed with yourself for raising your hand and vow to

study harder for the next class". The resulting shame score is obtained by summing the ratings for shame prone responses.

Harder, Rockart, & Cutler (1993) compared the ASGS and SCAAI , and the correlation between the two shame subscales was .54. Construct validity for the ASGS was determined by examining correlations between the SCAAI and the depression score from the Beck Depression Inventory (Beck, 1987) (.44), Self-Derogation (.64), Narcissism (-.37), Social Anxiety (.49), and Shyness (.55). In a second study, Harder *et al.* (1993) compared the shame score of the ASGS with the SCL-90 Symptom Checklist (Derogatis, 1992) and found shame to be significantly correlated with Global Severity (.44), Positive Symptom Distress (.47), Depression (.38), Obsessive-compulsive (.50), Interpersonal Sensitivity (.47), Anxiety (.31), and Psychoticism (.37).

Test of Self Conscious Affect, TOSCA-3 (Tangney, Dearing, Wagner & Gramzow, 2000).- TOSCA is a modification of the SCAAI so it is another scenario based test that yields scores for Shame, Guilt, Externalization, Detachment/ Unconcern, Alpha Pride, and Beta Pride subscales. TOSCA-3 presents 10 negative and 5 positive scenarios to which a person rates multiple responses using a guilt. The scenarios were drawn from written, personal experiences with shame of hundreds of college and non-college adults.

In a cross sectional developmental study of 1245 university students, Tangney, Dearing, Wagner, & Gramzow (2000) reported Cronbach alpha coefficients of .74 for the shame subscale. Three and one half week test-retest reliability was reported to be .74 for shame.

Construct validity comparisons showed that the shame scale score was significantly related to Interpersonal Sensitivity (.46), Depression (.43), Beck Depression Inventory (.51), Obsessive-compulsive (.38), Anxiety (.34), Psychoticism (.39), and Trait Anxiety (.53).

State Shame and Guilt Scale, SSGS (Marschall, Sanftner, & Tangney, 1994).- The SSGS consists of 15 items which yield three subscales. Examples of shame items include: "I want to sink into the floor and disappear," and "I feel small." This measure was developed to provide a validity check for a shame induction experience (Marschall *et al.*, 1994). Respondents rate how present the target emotion is using a 5-point Likert scale which ranges from 1 (not feeling this way at all) to 5 (feeling this way very strongly). The score of the Shame subscale ranges from 5 to 25 with a higher score indicating greater amounts of shame. Reliability data were based on a study of undergraduate college students (Tangney & Dearing, 2002). Alpha coefficients for items on the Shame subscale ranged from .82 to.89.

Differential Emotions Scale (DES-IV) state version (Izard, 1993).- The DES-III is used to rate participants' emotional state in the moment by having them respond to 36 items that represent 12 discrete emotional states including shame. Each of these subscales consists of 3 items. Respondents rate how present the item is on

a 5-point Likert scale ranging from 1 (not at all) to 5 (extremely present). Youngstrom & Green (2001) reported internal consistency reliability for the Shame scale as .52d and test-retest reliability coefficient of .82. Validity studies were not found which focused on just the Shame scale alone. This instrument has been used in clinical studies (Carey, Finch, & Carey, 1991; Kashani, Suarez, Allan, & Reid, 1997) and non-clinical populations (Boyle, 1984; Izard, 1993; 2001).

Personal Feelings Questionnaire-2, PFQ-2 (Harder & Zalma, 1990).- The PFQ-2 asks respondents to indicate how much they are experiencing the feeling (0=not experiencing to 3=experiencing the feeling continuously). Ten of the items load on the Shame subscale so it is possible to obtain a score between 0 and 30. Shame-based adjectives include feeling ridiculous, self-consciousness, feeling humiliated, feeling stupid, feeling childish, feeling helpless/paralyzed, feelings of blushing, feeling disgusting, and feeling laughable.

Internal reliability coefficients for the shame scales was .72, and test-retest reliability was .91. In terms of construct validity, Harder, *et al.* (1993) found that the PFQ-2 shame score was a significant predictor of Depression (.43), Self-Derogation (.39), Public Self-Consciousness (.30), and Private Self-Conscious (.29), Social Anxiety (.23) and Shyness (.25).

OTHER METHODS OF MEASURING SHAME

Emogram Shame Scale (Mudge, 2003).- Emogram is computer based presentation of five sets of 33 images. It measures changing emotions. It takes 6-10 minutes to view the entire set of images that represent varying degrees of 11 emotions including shame. Emogram produces an initial baseline report and then produces progress reports. According to Priesmeyer, Knickerbocker, Comstock, & Mudge, 2001, the initial report presents a valid snapshot of an individual's emotional functioning. They argue that a visual representations of emotion are more reliably recognized than words for emotions. This work is related to Ekman's photos of facial representations of emotion. A team of academics and social service provides selected five set of photos that represented three intensities of each emotion. The images are presented on a computer screen, and the respondent uses a 6-point Likert scale to answer how much the image is like them. Emogram reports are different from most assessment because nonlinear systems theory is used to analyze each emotion, and the system can show change in emotion over time. McGinnis (2007) found that the Emogram Shame score was correlated .28 with the Shame scale from the PFQ-2.

Emotional Stroop Task (Stroop, 1935).- The Emotional Stroop Task has been widely used in research to assess the processing of emotion (Cohen, Usher, & Mc-

Clelland, 1998; McLeod, 1991; McKenna & Sharma, 1995; McKenna & Sharma, 2004). It is considered a measure of implicit shame. The task presents emotionally charged words that are color coded, and respondents are asked to recall the colors for different words. Time in processing the color represents the degree of selective processing of the meaning of the word (McLeod, 1991). Studies (Rocca *et al.*, 2008; McKenna & Sharma, 1995) have shown that the emotional words interfere more with processing than the neutral words. Shame words include "hide," "exposed," "unloved", "rejection," "abandonment," "isolation," and "failing".

Early Memories Test (Mayman, 1968) and other *quasi-projective tests* (Gottschalk & Gleser, 1969).- In the Early Memories Test, respondents were asked to talk about several of their memories from their early childhood. The content was then scored of references to ridicule, inadequacy, shame, embarrassment, humiliation, and threat of being overly exposed. In the Gottschalk task, respondents were asked to speak for 5 minutes about a dramatic event in their life. The content of their talk was then theme coded for shame content. Five week test-retest reliabilities for the Gottschalk report were very low (.14). The five week test-retest for the Binder approach was .69. Ursu (1984) found no construct validity for these methods so they have been mostly discarded.

Thurston-Cradock Test of Shame, TCT (Thurston & Cradock, 1997).- This is a projective test in which a person is given a series of 10 pictures and is asked to use the pictures create a story with a beginning, middle, and end. Respondents are asked to tell what characters in the story are thinking and feeling. Meier (2003) scored the content of the TCT for aggression and showed that shame was related to stories where characters were bullies or victims.

Observational Coding of Shame.- Because nonverbal cues to shame are easily observable, some researchers have coded transcripts of interviews in which individuals discuss an experience. For example, Rahm, Renck, & Ringsberg (2006) identified verbal and nonverbal cues related to shame as sexual abuse survivors described their traumatic experiences. Theorists (Harper & Hoopes, 1990; Kaufman, 1996) have listed several types of verbal and nonverbal behaviors that are indications of shame. While the application of these indicators has occurred mostly in clinical interviews as psychotherapists assessed the problems of their clients, this same method could be applied to interviews of research subjects.

EVALUATION OF MEASURES OF SHAME

Most of the measures discussed above have been developed for and used primarily in research. The one exception is the Internalized Shame Scale (Cook, 2001) which has been used in both research and with clinical populations. One of

the dilemmas in measures of shame is whether an investigator desires to measure state shame (transitory affect of shame) or trait shame (internalized shame). If an individual is interested in trait shame, then the ISS is probably the most developed inventory for measuring shame. The measures that use adjectives lend themselves more readily to measuring state shame.

The scenario based approaches to measuring shame have been criticized because they do not directly measure a person's shame but instead measure their reported responses to the scenario rather than how much they respond similarly in their daily life. Of the scenario based measures Tangney (1990) reported that it appears that the TOSCA may be more psychometrically sound than the SCAAI.

Cook (1996) argued that the ISS is more sensitive to peoples' experience of shame emotions than the adjective based scales or the scenario based measures. Because of clinical cut off scores, the ISS will be the most useful in clinical settings and in research with clinical populations. As a clinical measure, the ISS is short, inexpensive, and easy to administer. Yet, there is some debate on whether the ISS Shame scale is one coherent scale or whether it is made of three subscales. Future research needs to further investigate the factor structure of ISS, especially if headway is made in examining how different aspects of shame impact other important variables.

Much of the development of these measures have been with sample of college age people who are mostly Caucasian. All of the discussed measures need to be tested with more age groups to determine if they hold their validity. These shame measures also need to be tested with different racial and cultural groups to determine if they operate the same way in a multi-cultural context.

SHAME AND PERSONALITY

Friedman (1999) found that internalized shame was related to several clinical personality styles. He involved psychotherapists in administering the PQF-2 (Harder *et al.*, 1993) and the MCMI-III to their clients. Ninety-one people completed the questionnaires. Results showed that shame was significantly related to Narcissistic Personality (-.52), Histrionic Personality (-.61), Avoidant Personality (.57), Schizoid Personality (.53) and Self-Defeating Personality (.53).

Miner-Rubino, Twenge, & Fredrickson (2002) had a sample of 98 college females to complete a self objectification and body-shame questionnaire along with measures of the Big Five personality traits. Results showed that Self-Objectification (a type of shame) and Body-Shame were both highly correlated with Neuroticism, Agreeableness, and Intellect, but neither was significantly correlated with Extraversion or Conscientiousness. Harder *et al.* (1992) also found that shame as

measured by the PFQ was significantly related to Neuroticism (.70), and negatively related to Agreeableness (-.37), and Extraversion (-.25). They also found that shame was positively related to external locus of control meaning that as shame increases the tendency to feel controlled by external people or factors also increases.

Schoenleber & Berenbaum (2010) hypothesized that shame plays an important role in Cluster C personality disorders in a sample of 237 undergraduate students. Their results showed that Shame-Proneness and Shame-Aversion were both significant predictors of Cluster C personality disorders. Parks (2002) also found that Internalized-Shame was associated with increased anger and rage.

According to Harper & Hoopes (1990), individuals who are prone to shame will express more pessimism. They believe that things will go wrong for them. They are insecure in their relationships because they have to be hyper-vigilant about people uncovering their shame, and if people appear to be getting too close to uncovering their shame, they will reject the other person or withdraw to avoid the anticipated rejection they believe they will receive when the other person finds out how bad or flawed they are. Lundberg, Kristenson, & Starrin (2009) studied 14,854 adults between 18 and 79 years old and found that Proneness to Shame was related to Pessimism.

CONSEQUENCES OF INEFFECTIVE REGULATION OF INTERNALIZED SHAME

Frequent shaming experiences eventually turn into internalized shame which has been shown to be linked to a number of different psychopathologies. Claesson & Sohlberg (2002) discovered that individuals with high trait shame were most likely to be rejected and abandoned in their significant adult relationships. It seems that shame prone individuals spend so much time worrying about whether their shame will be discovered and the "other" will reject them, that they set up relationship dynamics that lead to that outcome.

Several researchers (Cook, 1991; Fischer, 1987; Wells, Bruss, & Katrin, 1998) found that internalized shame is high in populations of alcohol and substance users. Harper & Hoopes (1990) postulated that the relationship between shame and addictions could be bidirectional meaning that sometimes individuals use drugs or alcohol to get relief from the shame and other times shame is the result of substance use. Numerous researchers (Grabhorn, Stenner, Stangier, & Kaulfhold, 2006; Keith, Gillanders, & Simpson, 2009; Skaderud, 2007; Swan & Andrews, 2003; Troop, Allan, Serpell, & Treasure, 2008) have shown that individuals who suffer from eating disorders exhibit high levels of trait or internalized shame.

Shame also seems to be higher in people who have suffered sexual abuse (Feinauer, Hilton, & Callahan, 2003; Murray & Waller, 2002; Rahm, Renck, & Ringsberg, 2006) or physical abuse as children (Kim, Talbot, & Cicchetti, 2009) and in other traumas (Lee, Scragg, & Turner, 2001). As shown in the discussion of measures of shame, numerous psychopathologies seem to be related to elevated levels of shame including depression, anxiety, and problems with anger (Grosch, 1994; Wright, Gudjonsson & Young, 2008). Mills, Imm, Walling, & Weiler (2008) found that higher shame responses in children were associated with greater cortisol activity and slower regulation of the cortisol response indicating that shame is related to stress and poor coping with stress.

A major consequence of not regulating internalized shame is disruption in adult romantic relationships. Shame is related to insecure attachment styles (Karos, 2006; Wells & Hansen, 2003) and distressed couple relationships (Greenberg, 2008), and sexual satisfaction and function is negatively related to shame (Harper, in press). Communication in relationships is also affected because of the guardedness of a shame-prone person and the strategies to defend against shame being discovered (Gratch, 2010). Lombardi (2007) discussed the negative influence of shame on sexual expression and experience.

ANTHROPOLOGICAL PERSPECTIVES ON SHAME

Anthropologists distinguish guilt cultures and shame cultures, and there has been much controversy over the use of these stereotypes (Creighton, 1990). Boellstorff & Lindquist (2004) argues that emotion as a concept should be viewed in the context of culture and that some cultures elicit more shame response. Fessler (2004) interviewed numerous individuals in Benkulu, Indonesia and in California and did qualitative analysis looking for themes of shame. He concluded that Benkulu exhibited more shame than California. Fung (1999) argues the importance of shame in helping individuals conform to standards of society and in her qualitative study of 9 families in Taiwan, she observed that shaming practices in parenting were used with children as young as 2 years old. Li, Wang, & Fischer (2004) interviewed native Chinese about terms for shame and identified 113 terms for shame. They concluded that these terms fall into two categories, state shame and other focused shame reactions. State shame took a focus on the self related to losing face and guilt. Other focused reactions included embarrassment and humiliation. Scherer & Wallbut (1994) compared data from a series of cross-cultural studies and found that physiological processes accompanying shame and how shame is expressed differed across many of the countries. Yang & Rosenblatt

(2000) claimed that since shame is so universal across cultures, an understanding of shame within a culture might offer a sense of that culture. They studied shame in Korean families and its positive role in keep society organized and building identity in the Korean family. Anoli & Pascusi (2005) analyzed the role of shame in Italian and Indian cultures.

CONCLUSIONS

Shame is a powerful affect which serves both positive and negative functions. However, when people experience frequent shame experiences, they develop trait shame or internalize the shame, and it becomes a part of their identity. In other words, they learn to expect shaming experiences, and they learn to hide their flawed sense of self from others. Shame appears to be related to a number of personality concepts including pessimism, narcissism, dependent personality, borderline traits, external locus of control, and introversion to name a few. People cope with internalized shame in a number of ineffective ways including substance use, hypersexual behavior, eating disorders, and withdrawing in relationships and attacking others as well as the self. Anthropologists have identified the role of shame in various cultures and argue that the experience of shame is universal.

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