The Significance of Shame: An Adlerian Perspective

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Abstract

Shame is a universal affect and emotion which has application within cultures and to individuals throughout the world. It can be considered an aid to learning, teaching, or punishing, and it can also be imposed to control or defeat others. Shame refers to a reaction experience of having violated cultural, community, familial, or individual norms in an unacceptable way and having the hidden, vulnerable self exposed to others against our will. For some individuals, shame can represent a minor impact to their lives and well-being. For others, it can be an all-encompassing, life-threatening problem. Shame can appear as an affect during the course of a child’s normally healthy learning. Problematic shame can originate from a number of sources resulting in unmediated mistaken beliefs from dysfunctional infant/caregiving which are never adequately resolved. Traumatic shame can result from multiple sources including family or peer relationships with repetitive abuse. Any repetitive shaming can unconsciously become an internalized secret. An understanding of pathological shame is indeed critical for evaluating client functioning. Either shame or shame proneness within any societal, familial, or occupational relationship or manifesting within an individual can have far reaching implications and long-term consequences. A clinical scenario of a patient who suffered emotional neglect and/or intense role reversal during his childhood will help clarify how developmental trauma may dramatically affect the patient’s personality and behaviors, and ultimately lead to negative expectations toward interpersonal relationships, disturbing feelings of shame, and a sense of a defective self. Shame experiences derived from the abuse during developmental stages of life - whether intentional or not – wrought by bad or unworthy parents are subsequently linked to some psychopathological manifestations, such as anger/rage/conduct disorders, anxiety, withdrawal/isolation, eating disorders, and various addictive or perversion disorders.
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Finally, I am grateful for my Spiritual journey as it continues to offer opportunities to share gratitude and wonder during every day of life.
Dedication

To my wife, Sally (Beck) Nord

Throughout her life,

*even as the youngest of seven,*

she has been an inspiration
to a multitude of all ages and backgrounds
touched and blessed through her

selfless kindness,

gracious exuberance,

and God-credited wisdom.

As a DMFT/LMFT,
she has provided encouragement

beyond words and deeds…
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The Significance of Shame: An Adlerian Perspective

Shame garnered little attention in psychoanalysis until 1971, when *Shame and Guilt in Neurosis* (Lewis, 1971) and *Analysis of the Self* (Kohut, 1971) were published. Shame is a universal emotion/affect as essential to the human existence as anxiety or suffering, but is much more elusive by nature; it is often unrecognized and unacknowledged (Crowe, 2004).

Shame is a prevalent emotion that arises frequently in everyday life and can contribute to the psychological difficulties that cause people to seek treatment, and for some, can cause additional shame (Dearing & Tangney, 2011). Although everyone experiences shame from time to time, some people may have a greater tendency to experience shame than others. Shame may occur from a specific in-the-moment situation when one unintentionally commits an offense or violates a standard that is commonly held to be important. Additionally, one may experience shame proneness which is a dispositional tendency to experience shame across multiple situations (Dearing & Tangney, 2011). Shame proneness may result in a self-attribute of being fundamentally flawed when one negatively assesses differences between self and others causing a diminished self-worth to the point of being considered bad, worthless, or contemptible. The diminished self-worth renders feelings of powerlessness and hopelessness (Dearing & Tangney, 2011).

In line with Adler (1932) and his life-task principle, there are multiple life-task situations which may be hotbeds for experienced or possible individual shame revolving around various family relationship acceptance or rejection, peer interaction acceptance or rejection, community acceptance or rejection, occupational/avocational acceptance or rejection, and spiritual/cultural/political acceptance or rejection. These shame experiences may be conveyed as
an involuntary physical or affect reaction or internalized without a visible reaction (Chilton, 2012).

Dearing and Tangney (2011) suggested shame can also be categorized as a moral emotion on the premise that it limits or averts socially undesirable acts. Unfortunately, although shame may influence one’s actions, the influence may not be in the direction of a higher level of moral behavior. The immediate action tendency when facing shame is to hide or escape from the trigger of the painful emotion by denying responsibility for an event, aggression toward, or blaming others (Dearing & Tangney, 2011). Additionally, shame may interfere with establishing and maintaining healthy relationships for several reasons, but among these are problems with anger and lack of empathy for others.

Greenberg and Iwakabe (2011) noted although shame can lead individuals into therapy, it is notoriously difficult for the client take on more shame by acknowledging that life is too confusing or difficult as they also lay bare deepest secrets to a relative stranger.

**Cultural Aspects of Shame**

In examining the general significance of shame for gender, culture, and society, three expansive complemental phenomena emanate: identity, culture, and ideology (Kaufman, 1992). In explaining the impact of culture, Kaufman (1992) referred to culture as shaping personality in ways similar to the family and peer group. Along with work and school, these settings transmit cultural values, meanings, and taboos. These settings become the principal arenas in which the fear of shame motivates striving toward honored values; shameful actions are discouraged, and honor-rendering actions are encouraged. Additionally, culture is the framework, the interpersonal bridge that binds people together. Further, participants experience a sense of common purpose through publicly celebrating heroes, holidays, and rituals, through retelling
stories of heritage and history, participating in hopes and dreams, practice cultural methods, and understand cultural taboos. A bond is forged as people come to feel a shared identity; they belong as one part of a whole (Kaufman, 1992).

Izard (1991) stated the experience of shame is a multi-dimensional alienation process. The adversity of eroding one’s positive self-concept, pain from loss of connection with others, and resulting avoidance behaviors associated with shame, can motivate individuals to avoid shame by increasing intellectual, physical, and social competencies (Izard, 1991). Thus, shame plays a vital role in learning and in the advancement of the various cultural societies (Van Vliet, 2008).

Being universal in nature, at least at some time in most everyone’s life, shame can have inherently adaptive, and therefore distinctly positive, features (Kaufman, 1992). For example, world-wide, shame has been crucial to the development of history’s varied cultures’ (e.g., Asian, European aristocracies, Mid-Eastern, East Indian, Native American, and Inuit cultures) maintenance of a unique identity, conscience, and sense of unified dignity.

According to Inque and Armitage (2006) and Velayutham and Perera (2004), shame promotes socially responsible behaviors within various cultures and societies. For instance, Anglo-Saxon Nordic cultural values are based on the belief that there is one, absolute God to whom individuals will account for their actions. Monotheistic cultures emphasize individual responsibility, which sets the standard for specific action-consequence reactions. Inque and Armitage (2006) and Velayutham and Perera (2004) stated cultures that worship multiple Gods do not have this collective standard, and individuals remain accountable to each other. For example, shame is the driving motivator in countries like Japan. Individuals and families do not
want to look different from peers. The Japanese referred to this moral driver as “losing face” (Inque & Armitage, 2006; Velayutham & Perera, 2004).

Chilton (2012) stated shame experiences manifest differently depending on culture. As an example, in Western societies over the last 200 years the norm has been to ignore shame. Additionally, there has been a general consensus that American culture is better off without shame; thus the idea and reality of shame was suppressed; a preference for individuals, as well. Further, shame is considered a precursor, not morally equivalent, to guilt. Guilt responds to an inner conscience whereas shame generates from real or feared external judgment by unidentified others (Guy, 2003).

In spite of attempts to suppress shame, Kaufman (1992) described American society as a shame-based culture, but shame is hidden from view. Japanese and Mediterranean cultures are much more openly organized around shame and its counterpart, honor; however, the American public-school system has been somewhat based on the ritual humiliation of its pupils. Due to indifferent dependence in teaching one way of learning, untactful partitioning of a class into different ability groups, ridiculing or shaming by teachers, and enabling student bullying of peers because of lack of talent or other abilities. According to Kaufman (1992), this kind of shaming humiliation can be observed when a child’s early excitement for school quickly dissipates.

**Shame as a Self-Conscious Emotion**

Muris and Meesters (2014) stated self-conscious emotions are essentially functional. That is, self-conscious emotions can be regarded as an important lubricant in social interactions; however, the dysregulation of guilt, shame, and pride seem to be counterproductive and associated with various types of maladaptive behavior. There is growing knowledge that many mental health problems originate in childhood (Tangney & Tracy, 2012). The effect of shame in
situations such as embarrassment, humiliation, disgrace, inadequacy, or intense disappointment can influence cognition (Yard, 2014). The word shame is derived from the Indo-European root *skam* or *skem*, which is also the derivational source of the English words *skin* and *hide*. Both skin and hide naturally cover and hide that within (Nathanson, 1987). Carl Jung suggested that affect occurs when forces of the conscious and the unconscious meet and explode with a force or energy (as cited in Yard, 2014). Once one is aware that an affect has been triggered, it is called a feeling. Further, the term emotion is reserved for any combination of affect within memory such as similar previous affect memory experiences (as cited in Yard, 2014).

Tangney and Tracy (2012) suggested self-conscious emotions, such as shame, are a grouping of emotions that involve an individual’s feedback to his or her characteristic traits or behavior. For example, when good things happen, people may experience a range of positive emotions including happiness, joy, or satisfaction, perhaps described as contentment. When the occurrence of these good things can be attributed to positive attributes or actions, a person often feels pride. Correspondingly, when bad things happen, people may experience negative emotions such as sadness, disappointment, frustration, or anger. Feelings of shame and guilt typically arise when an individual recognizes this adversity is the result of one’s own negative traits (attributes) and behaviors (Tangney & Tracy, 2012).

When a person does not feel valued, or is seen negatively through contempt or criticism, this might create what Gilbert (2003) referred to as extreme shame. In external shame, the shamed individual’s thoughts and emotions are focused outward on others who are perceived to have found the shamed individual unattractive or defective. The shamed individual perceives others as a threat to self-identify and this may trigger externalizing (e.g., aggression) or internalizing (e.g., submissive withdrawing) defensive strategies in order to stay safe. When a
person is prone to shame, internalized shame is caused by identification with the perception of another’s negative opinion causing self-devaluation and self-blame (as cited in Matos et al., 2012).

Shame is based on a negative sense of self and feels very threatening if one feels unattractive or has a perceived lack of value to others (Gilbert, 2007, Tangney & Dearing, 2002, Tracy & Robins, 2004). Early shame experiences of viewing oneself through a negative lens become a central component in autobiographical memory. Shame memoirs form the global view of self includes all life experience which develops an individual’s life narrative (Bernsten & Rubin, 2007; Bluck, Alea, Habermas, & Rubin, 2005; Pillemer, 1998; Pinto-Gouveia & Matos, 2011; Rassmussen & Berntsen, 2009).

Lewis and Sullivan (2005) posited self-conscious emotions typically entail self-evaluation and self-reflection. Self-conscious emotions require higher cognitive operation and self-conscious emotions of shame, guilt, and pride slowly emerge during maturation. Children learn to progressively deal with social interactions and intimate relationships in a more favorable way to avoid feelings of shame. On the other hand, if not well managed, these emotions lose adaptive qualities, can result in varying psychological defects, and can occur at a relatively young age (Lewis & Sullivan, 2005).

The distinctive characteristic of self-conscious emotion is that it requires the person to form stable self-representations, to be able to reflect on those representations, and, through this process, generate a self-evaluation (Tracy & Robins, 2005). Leary (2004) agreed that self-conscious emotions arise from the self-evaluation process, but also noted that this “stable self-evaluation is not the central feature of self-conscious emotions, but rather reflected representations and reflected appraisals how people believe they are being perceived and
evaluated by others” (p. 130). In other words, self-conscious emotions arise when a person perceives and evaluates the “self” through the eyes of other people (Leary, 2004). Further, when an individual thinks other people hold a positive opinion of his/her personal characteristics or behaviors, it is expressed through feelings of pride. On the other hand, when a person believes that other people are negative about his or her characteristics or actions, it is expressed through feelings of shame or guilt.

Nothing can enter the dynamic unconscious unless it first triggers one of the affects. When something unacceptable to our way of being or within our rules for living is shunted away from consciousness, it is accomplished through shame (Kaufman, 1992). According to the affect system developed by Tomkins (1979), shame is one of nine innate affects and is related primarily to a feeling of inferiority in individuals, families, and groups. The judging behavior of other people, established standards, and cultural mores, whether implicit or explicit, provide the context for shameful experiences. Other words used to describe this same feeling include humiliation, embarrassment, discouragement, and sometimes shyness (Harper & Hoopes, 1990).

Tomkins’ (1979) affect system theory consisted of nine innate affects, indicating nine ways of observing a person’s focus of attention. Each affect is distinguished by low and high intensity or experience, and described in terms of typical, respective facial responses:

Positive affect:

1. Interest-Excitement: eyebrows down, track, look, listen

2. Enjoyment-Joy: smile, lips widened up and out

Resetting affect:

3. Surprise-Startle: eyebrows up, eye blink
Negative affect:

4. Distress-Anguish: cry, arched eyebrow, mouth down, tears, rhythmic sobbing
5. Fear-Terror: eyes frozen open, pale, cold, sweaty, facial trembling, with hair erect
6. Anger-Rage: frown, clenched jaw, red face
7. Shame-Humiliation: eyes down, head down
8. Dissmell: upper lip raised (term coined by Tomkins)

Kaufman (1992) stated:

The critical distinction is between shame as an innate affect that functions simply to amplify awareness, and shame that has become internalized and magnified to the point that it now progressively captures and dominates the self.

The significance of shame lies in its profound impact on personality, psychopathology, and interpersonal relations, as well as in its role in minority group relations, minority identity development, national identity development and international relations. (pp. xii-xiii)

While shame and guilt are considered self-conscious emotions, guilt along with pride, can have a counterbalancing role to shame. That is, guilt and pride can embody a special class of emotions that can actually help people successfully navigate in the social environment. Further, these emotions keep exchanges with others in check including assisting with appropriate moral decision-making when interacting with others (Tangney & Tracy, 2012).

Most scientists agree emotions serve the important function of prioritizing and organizing ongoing behavior for the purpose of enhanced adjustment to the stresses of social and physical surroundings (Keltner & Gross, 1999). Pride can encourage future behavior that agrees with an
individual’s personal and social standards. As a result, pride can enhance one’s self-worth and maintain or improve the individual’s position on the social hierarchy. There are two categories of pride: *authentic pride* which is prosocial with high self-esteem, high agreeableness, and high conscientiousness, and *hubristic pride* which is antisocial with low self-esteem, high agreeableness, and high conscientiousness (Muris & Meesters, 2014).

Guilt is a self-conscious emotion focused around an individual or series of actions or deeds which can be remedied. Shame is a result of self-evaluation in which one is engaged in appraising one’s worth. When the result of that appraisal decreases one’s sense of self-worth, or self-esteem, shame most typically ensues (Berkovski, 2015). Further, *worth*, a self-conscious emotion, includes a focus on significance, belonging, and feeling wanted or loved.

Self-conscious emotions typically involve self-reflection, self-evaluation, and require some advanced level of cognitive functioning (Lewis & Sullivan, 2005). These findings mean that, ideally, feelings of guilt, shame, and pride gradually evolve during childhood development and help children manage social interactions and intimate relationships in a more favorable way; however, if not well regulated, these emotions can lose adaptive value and display a psychological downside, which may already have happened at a relatively young age (Muris & Meesters, 2014).

**Shame and Guilt**

Frank, Kerns, and Giacolone (1995) believed feedback is a significant part of being human. People must learn to function in a world that constantly provides feedback. Guilt may be experienced as more empowering than shame because it confers a sense of responsibility and required action. In contrast, shame is experienced earlier, beginning with the bonding and weaning process, and is, by nature, destabilizing (Franke et al., 1995).
Following initial work of Lewis (1971) and subsequent work by Tangney (1992), there is increasing evidence indicating that shame and guilt are definitely different types of self-conscious emotions. The primary difference between the two is that shame is centered on the entire self, which is devalued. On the other hand, the focus of guilt is on a specific, negatively evaluated behavior, but the global self is left intact. Behaviorally, shame is associated with a desire to hide; guilt results in a desire to repair and apologize (Tangney, Burggraf, & Wagner, 1995; Tangney, Stuewig, & Mashek, 2007).

According to Tangney, Wagner, Hill-Barlow, Marschall, and Gramzow (1996), shame and guilt are both considered negative emotions. Shame, guilt, or both, are experienced when a person behaves in a manner that is viewed as morally or socially unacceptable. Shame and guilt differ, however, in the ways in which the individual constructs meaning (Niedenthal, Tangney, & Gavanski, 1994; Tangney, 1990, 1995). Further, Tangney et al. (1996) stated,

It appears that such differences in the ‘framing’ of events are related to very distinct patterns of affect, cognition, and motivations. This interruption is supported by qualitative case study analyses (Lewis, 1971; Lindsay-Hartz, 1984; Lindsay-Hartz, deRivera, & Mascolo, 1995) and several systematic empirical studies of the phenomenology of shame and guilt (Tangney 1989, 1993; Tangney, Miller, & Flicker, 1992; Wicker, Payne, & Morgan, 1983). (p. 797)

Tangney et al. (1996) believed shame required internal attributions about the stable, global aspects of self. For instance, there is a distinction between shame as an emotional state, and shame proneness, which refers to an emotional trait or disposition to experience shame. Further, Gilbert stated shame can best be conceptualized in terms of two dimensions: internal
shame, focused on negative self-evaluation, and external shame, focused on fear of another’s judgement (as cited in Cândea & Szentágotai, 2013).

According to Tangney and Tracy (2012) and Tracy and Robbins (2004), when a person experiences guilt, the person is empathetic, feels regret and remorse, wishes the behavior had been different, and contemplates how the harm could be rectified. In contrast, shame is usually characterized by feeling inferior and worthless, and leads to a desire to escape, disappear, or seek indiscriminate retaliation. In addition, when an individual is operating out of shame, he or she may demonstrate a distinct absence of empathy.

Muris (2015) found guilt and shame are primarily functional and adaptive in nature; however, it has become clear that some people display an excessive proneness to experience self-conscious emotions that strongly dominate the person’s affective, cognitive, and behavioral responses. In other individuals, guilt and shame are so minimally present that the socially adaptive function of behavioral-discomfort is inoperable. As a result, the motivation to notice and correct morally unacceptable behaviors is absent. Muris suggested such a dysfunctional balance of self-conscious emotions has been associated with various types of psychopathology. Muris reported shame is positively related to a wide range of psychological problems including aggression, which can include narcissistic rage, depression, anxiety disorders, eating disorders, and personality pathology.

Muris stated guilt refers to a specific behavior that results in negative evaluation. Thus, when a person feels guilt, the person feels regret and remorse over the perceived offense and desires to remediate the action or behavior by taking responsibility and steps to amend the wrongdoing. These differences make a clear delineation of these two emotions: guilt motivates reparative behavior by making apologies and engaging in attempts to make amends and repair
the situation, while shame motivates defensive and avoidance behavior, thus, reverting to inaction instead of repair (Muris, 2015).

The negative self-conscious emotions of guilt and shame are typically experienced in situations in which some behavioral standard is violated, and this transgression is visible to other people (Muris & Meesters, 2014). In this situation, the person has done something that is inconsistent with current norms and values and/or with his or her own expectations, and believe that others will disapprove of this action. The result of this disapproval is rejection and disgrace. Guilt and shame are evoked by similar types of situations and, for this reason, are often used interchangeably (Muris & Meesters, 2014).

Additionally, Muris and Meesters (2014) identified 22 studies that examined the relationship between guilt and shame and psychological problems in children and adolescents. Overall, this research revealed a highly similar pattern of results as documented in the adult literature. Specifically, shame was positively related to internalizing as well as externalizing symptoms, which confirmed the premise that dysregulation of this self-conscious emotion should be viewed as a vulnerability factor for various types of psychopathology such as: aggression, depression, post-traumatic stress disorder (PTSD) symptoms, anger, anxiety, and eating disorders. In contrast, guilt was found to be negatively linked to externalizing symptoms and self-conscious emotion protected against the development of such problems.

Tangney (1991) found that shame-prone individuals were less empathetic than non-shame prone people. Conversely, guilt proneness was positively correlated with empathetic responsiveness. Positive correlations have also been reported between shame-proneness, anger arousal, and other variables of indirect hostility. Proneness to guilt, on the other hand, showed
an inverse relationship to externalization of blame and some variances of anger and hostility (Tangney, Wagner, Fletcher, & Gramzow, 1992).

According to Tangney et al. (1996) and Tangney, Wagner, Burggraf, Gramzow, and Fletcher (1991), guilt-prone individuals have a higher degree of interpersonal empathy which influenced anger responses. When a guilt-prone individual reflected from the perspective of the offender, feelings of empathy diminished anger during stressful events. The ability to take on another’s perspective decreased revenge or aggressive behavior toward the offender.

Measures from middle childhood through adulthood showed that individuals of all ages with proneness to shame were associated with maladaptive and destructive responses to anger (Muris and Meesters, 2014). Proneness to shame-free guilt was associated with constructive anger-management strategies and outcomes. These differences had an impact on the functionality of both emotions: guilt (allowing for self-esteem to survive) motivated reparative behavior by making apologies and engaging in attempts to fix the situation, while shame motivated defensive, avoidance, withdrawal behavior. The experience of shame (degraded self-esteem) was often accompanied by a sense of shrinking, of being small, of worthlessness and powerlessness, and of being exposed. To the shamed person, an attempt to correct a specific event would not improve how others and one’s self regards the offender; it would just invite more shame (Muris & Meesters, 2014).

Guilt proneness assessed in childhood predicted fewer sexual partners, less use of illegal drugs and alcohol, and less involvement with the criminal justice system (Stuewig et al., 2015). In contrast, shame proneness was a risk factor for later deviant behavior. For example, shame-prone children were more likely to have unprotected sex and use illegal drugs in young
adulthood. Children’s moral emotional styles appear to be well established by at least middle childhood, with future implications for risky behavior in early adulthood (Stuewig et al., 2015).

In a study presented by Tangney et al. (1996), proneness to shame was substantially correlated with anger arousal. In contrast, proneness to guilt uncomplicated by shame showed a modest negative correlation with anger among children and virtually no relation to anger among adolescents, college students, and adults. Shame-prone individuals appear to adopt one of two strategies when faced with situations involving interpersonal conflict: active aggression or passive withdrawal. Neither active aggression nor passive withdrawal are likely to foster a positive change in the situation or relationship at hand. In fact, shame-prone individuals reported that the likely long-term consequences of these everyday episodes of anger would be more harmful and less beneficial than those of less shame-prone counterparts.

Tangney, et al. (1992) also examined the relationship between guilt, shame, and psychopathology. Shame was strongly related to all variant measures to indicate psychopathology, and guilt was only moderately related to psychopathology. These studies supported the concept that shame and guilt are indeed different emotions with different correlates and effects. In addition, excessive shame is much more related to psychopathology than is excessive guilt.

Hosser, Windzio, and Greve (2008) constructed a longitudinal study of 1,243 male prisoners between the ages of 14-24 serving time for a first incarceration in Germany. Shame and guilt were assessed at the beginning of incarceration, and the results predicted recidivism following release. Official records of convictions were assessed using log-logistic hazard models. Results indicated that shame positively predicted recidivism, and guilt negatively predicted recidivism. These effects remained significant even after controlling for the influence
of psychological treatment. In general, guilt proneness appeared to be the more adaptive or constructive emotional style, whereas shame proneness carried more negative effects on the individual (Stuewig et al., 2015). According to Mollon (2002), shame has begun to take its rightful place in the psychodynamic understanding of the individual.

**Early Shame Development**

Abe and Izard (1999) noted emotions are functional in that they serve a purpose, and basic emotions seem to be elicited in events that are relevant to survival. Further, these positive or negative emotions appear to be helpful in promoting and optimizing the chances of personal endurance and longevity. Tracy and Robins (2004) noted self-conscious emotions typically arise when one is exposed to identity-relevant events. Additionally, identity has been defined as the total sum of traits and characteristics, social relations, roles, and social group memberships that define who a person is, and which can be focused on the past (what used to be true of the person), the present (what is true of the person now), or the future (the person one expects or wishes to become when looking ahead).

According to Tangney and Dearing (2002), shame is a self-conscious emotion that develops very early because of interactions with significant others, and the primary emotions of fear and joy precede the appearance of shame. The attributes that affect development include early language development, individualization and increased independence, control over one’s thoughts, and higher-order thinking that conceptualizes understanding and analysis. Additionally, included in these mental attributes are some defiant behaviors and temporary separation anxiety all of which mature around the age of two (Pinto-Gouveia & Matos, 2011).

According to Beebe and Lachman (2013), psychoanalytically and physiologically, shame is created through early mother/child or caretaker/child interactions. It begins as a separation
response triggered by the mother/caretaker who may unconsciously and spontaneously block the child’s attempt to reconnect with a positive affective state. Specifically, the perception of a facial display, not of joy or interest, but of indifference or disgust, causes the unanticipated break in attachment. The shame is representative of a mis-attunement in what Winnicott (1965) called a “disconnect” of “going on being.” Powles (1992) described this distress state experienced innately as spiraling downward, a shift to a low-keyed inhibitory state of parasympathetic conservation-withdrawal that occurs in hopeless and helpless stress. Additionally, at these times, the infant, as with any person, becomes inhibited and will strive to avoid attention in order to become unseen.

Yard (2014) wrote:

Metabolically, corticosteroids are produced in a shame induced stress response. The increase of corticosteroids in the brain reduces the manufacture of endorphins and corticotrophin-release in the brain causing distress in the child. A child does not have the needed coping skills to self soothe, so due to the chemical imbalance, the child is trapped in the negative affect state for a prolonged period of time. Since the child does not receive the needed visual cues, no repair can occur in the attachment break; healthy emotional development is then disrupted. The importance of the development of shame in the child is it will directly impact adult coping and shame behaviors. (p. 47)

This embodies an important part of a sense of belonging during the process of socialization. According to Kaufman (1992), learning how to become a person originates through identification, as one first identifies a beginning base from which to navigate the human world. This idea is pivotal to all that follows.
According to Kaufman (1992), a person learned how to “become” through the concept of identification (with the whole) and differentiation (with their developing life role). These two processes, identification and differentiation, alternate with one another as a person develops into a fully separate person. It is the beginning of the human journey to discover and evolve one’s place in a changing world. Without a securely established identification (to one’s satisfaction) and evolving differentiation, individuals may continue to fail in the struggle to answer: “Who am I, really? What is the core of life for the me inside? Where do I belong?” These core questions may reoccur periodically as one’s life and worldly travel evolve (Kaufman, 1992, p. xix).

Believing in something enough to invest time and effort creates a connection, and a series of connections results in rootedness to one’s place(s) of belonging. Through belonging, an individual establishes identification or the process of what it means to be human (Kaufman, 1992). During one’s life, attention can be variably focused on family-related values, social group causes or affinities, religious/spiritual belief groups, the many varied paths of knowledge, and acquisition of sports, hobby, or career skills. Individuals typically grow experientially and psychologically through the maturing process, and every connection represents the ability to further differentiate (Loader, 1998). Individuals bring a unique combination of interests, skills, and experience to these groups, and ultimately, create further differentiation. An individual’s exposure to unhealthy or abusive shaming can stunt this flourishing process of self-differentiation (Loader, 1998).

The life identification and differentiation process typically begins within the family, usually with the parent(s)/child relationship (Kaufman, 1992). Communication and modeling permeate through the family between parent and child, child and siblings, and then, through the extended family. These communication and modeling components can variably appear or exist
within each family. Because the child is too young to cognitively create connection, the connection is strictly visual (Kaufman, 1992). If positive, the child may choose to experientially join either parent to further create a visual image of connection and identification to begin that child’s life journey. If this process of identification and differentiation is never securely established, individuals may continue to struggle to find a sense of belonging and a place in the world (Kaufman, 1992).

Parenting styles have a direct impact on the development of shame. Braithwaite (1989) noted a reintegrative style of parenting where the positive parent/child relationship, included the use of warm and supportive affect, increased the development of positive self-esteem and feelings of worth. Reintegrative parenting included positive involvement in the child’s activities and correction techniques of education and guidance rather than punishment. This positive involvement made the child feel accepted, loved, and good.

**Parental Stigmatization**

*Parental stigmatization* is the opposite of reintegrative parenting and can be described as neglectful, abusive, and/or hostile parenting (Pontzer, 2010). The parent in stigmatization regards the child as defective and, over time, convinces the child he or she is defective, as well (Pontzer, 2010). The child may take on the characteristics of a stigmatizing parent and lack empathy and become hostile and aggressive with others (e.g., bullying). Additionally, according to Randall (1997), parental stigmatization breaks emotional bonds with the child and lessens the likelihood of parental compliance.

Shame can be considered an attachment emotion (Lewis, 1971). It is an emotional response to the unexpected reaction of a parent or caretaker to refuse to bond or connect. The parent is a child’s primary social bond and is very important for healthy early emotional
development. Due to the dependence of a small child, the child may resort to extreme solutions
to diminish extreme shame when attachment bonds are not met. Three of these extreme
solutions are described by Kaufman (1992) as self-attack, disowning of self, and splitting of the
self.

The antecedents of shame are self-awareness, social context, and cultural identity (Pinto-Gouveia & Matos, 2011). For shame to be experienced, an individual must exhibit enough
awareness to distinguish self from others. Shame is a crucial element in self-identity. Through
genetics, environment, or a combination of the two, shame can go beyond the surface of
interpersonal reactions in social settings to a deep internalized realm of private feelings. These
feelings form a dark shadow of negative self-judgement about one’s personal attitudes and
characteristics and have an impact on one’s desire or ability to constructively connect.
Therefore, shame can guide our behavior in social contexts, influence our feelings about
ourselves, and shape our sense of self-identity and feelings about our acceptability and
desirability (Pinto-Gouveia & Matos, 2011).

Susceptibility to shaming and its effects is part of the human experience, and typically
shame identification is introduced within the family (Loader, 1998). Starting at a very young
age, a child may often struggle to maintain a secure place or identity in an evolving world.
Shame originates in relationship to others and most often by how parents and other family
members view children. Because of the deeply personal and dependent relationships between
family members, there is extensive opportunity to abuse the shaming process. The susceptibility
to the effects of shaming are exaggerated for the child because of the normal trusting dependence
on parents and the power difference typical in a parent/child relationship (Loader, 1998). In
addition, some degree of exploitive shaming is inevitable in any parent/child relationship. There
are different variables that can make the difference in the severity of the effect of shame on the child. These considerations that effect the well-being of the child include the degree of exploitation, its consistency, the degree of parental awareness, and the presence or absence of alternative sources of genuine support (Loader, 1998). Loader suggested parents may shame in a variety of forms to serve different functions.

**Shame and Parenting**

Toxic shaming of the child takes place when it is implemented for the benefit of the parent, not the child (Loader, 1998). While this difference is important, it may not always be easy to spot, especially by the child, who may be unwittingly told the parent’s shaming behavior is for that child’s own good. Shaming the child may serve several purposes which have nothing to do with the welfare of the child (Loader, 1998). For example, Loader outlined several reasons or forms of parental shaming:

1. To improve the parent’s self-esteem deficiency.
2. To transfer revenge against one’s own parent(s) onto one’s child(ren).
3. To use rigid, conditional acceptance as a means of controlling the child.

Loader (1998) posited that sometimes the parent/child system operated as if there was a limited supply of self-esteem to be divided between the parent and child. For example, the parent sustains self-esteem by belittling (shaming) the child in the parental effort to stand tall. That is, the parent will repeatedly talk about the child’s shortcomings in comparison to the parent’s qualities. Loader suggested parental disappointment is a powerful source of shame, and the child may believe he or she cannot please the parent. As a result, the child may act out this disappointment through direct rebellion or though continued failures in an attempt to meet these unrealistic expectations. Loader stated parents often find it is difficult to deal with a child’s
failures because they are reflection of the parent’s failures. The child’s lack of success may trigger a reactivation of shame associated with a similar, unacknowledged problem or situation.

Loader (1988) believed that after suffering shame as a child, a parent may attempt to quell anger by shaming the child as a form of revenge (i.e., an inter-generational legacy of shame). For instance, when a parent shames a child, the parent is no longer the helpless victim of shaming, rather, he or she becomes the perpetrator of shame. Unfortunately, shaming behavior does not achieve intended results. Loader stated without an awareness of the impact of shame, the shaming behavior will most likely continue through subsequent generations.

Loader (1988) posited that as a child, a parent may have experienced overt rejection and a total lack of affection. As a result of this rejection, as a parent, that person may complain about a child’s clingy behavior and inability to be independent. The parent may chastise the child and consider the child useless, pathetic, or repulsive. Although Loader suggested these shaming comments amount to no more than statements of rejection, it serves the parent by, perhaps, building the parent’s damaged self-esteem using the mechanism known as ‘reversal’ to manage the parent’s childhood.

Loader (1988) stated shaming involves a misuse of parental power and control. For example, parents shape the child’s personality to some extent, but when this occurs to the exclusion of the child’s unique nature, it represents a serious threat. Since children need the acceptance of parents, consistent disappointment or disapproval can create an internal dilemma. That is, if children comply with the expectations of the parent, they may have to deny their authentic self. Conversely, if children defy the parent’s expectations, they may have to deny their need for parental approval. Loader referred to this type of shame as emotional blackmail.
Emotional blackmail is usually noticeable when the primary caregiver (usually the mother) uses the child as an extension of herself (Loader, 1988). As a result, the child receives affirmation and affection as he or she meets the mother’s needs and, conversely, is rejected when these expectations are not met. Kinston described this situation as painful, horrible, and traumatic for the child:

Should a child exist as themselves, that child is subjected to rejecting and invalidating attitudes and finds that pain, depression, rage, or resentment in the parent results. Should the child comply with the parental projection, they must destroy their own experience. The former course is clearly associated with low self-esteem, identity disturbances, and problems of self-regulation. The latter course results in an artificial sense of well-being due to the receipt of (false) approval and love, and the absence or psychic destruction of personal need, frustration, or conflict. (as cited in Loader, 1998, pp. 50-51)

Kinston stated this childhood scenario is associated with shame that manifests in the development of adult narcissistic disorders (as cited in Loader, 1998).

A Shame-Based Family Culture

A shame-based family culture may occur when the parents feel inferior in some way (Kaufman, 1988). This feeling of inferiority may occur due to the parent’s position in society or due to a previous family disgrace. Shaming may be part of the family system. For instance, each member learns and uses shaming mechanisms for a position within a family hierarchy dominated by a pervasive sense of shame. Frequently, humor is used as a means to disguise true intent and appears as friendly bantering (Kaufman, 1998).

Shame is often triggered in a child when parental, or caregiver, maltreatment (i.e., physical, emotional, and relational abuse) occurs and is harmful to the child (Loader, 1988). The
child will attempt to please the caregiver and attempts are ignored or openly rejected. The abused child, regardless of the form of the parental/caregiver maltreatment, is left to conclude that the pain the child feels at the hands of this trusted entity is the child’s fault and, therefore, deserved (Loader, 1988). The parent/caregiver may support the child’s belief by stating that the abuse was for the child’s own good. The child’s overriding need for attachment and need to believe that the parents/caregivers care, could lead to the child to conclude there is something fundamentally wrong within the child. Consequently, the child experiences an unconscious, inescapable, and often life-long, sense of shame. As a result, Loader (1988) stated a constant, subconscious mistaken notion of worthlessness develops with no reason to hope for relief.

Parents who abuse children, often have a long-standing struggle, and had to defend against, a sense of shame (Loader, 1988). The parent’s behavior is an act of unfinished business perpetrated onto his or her children. Without proper awareness and support, these children may carry shaming behaviors forward into the next generation (Loader, 1998). In essence, Loader suggested intergenerational family abuse is intergenerational shame.

According to Pontzer (2010), childhood exposure to parental hostility (i.e., cold or indifferent acceptance, inconsistent affect, reactively accusatory, and/or disappointment) may tend to stigmatize a child and foster a propensity to interact with others in such a manner. Thus, the child may either externalize the shame and become a bully, or internalize the shame and become a victim of bullying.

**Attachment and Shame Regulation**

Bowlby (1969/1982) and Ainsworth, Blehar, Waters, and Wall (1978) conducted comprehensive studies on proximity-seekig behavior in securely and insecurely attached toddlers and developed attachment theory. Attachment theory contains key propositions about
the link between attachment security and a child’s response to threat. In addition, a secure or safe attachment is based on the attachment figure’s two principal roles in the life of an infant: (a) to serve as a secure base from which the child can explore; and (b) to provide a haven of safety to which the child can return in times of threat or distress.

According to Smith (2009), the attachment concept rests on the conceptualization of the interrelation between three behavioral systems: the attachment, exploration, and fear systems. Smith stated the attachment figure’s availability and responsiveness play an important role in the activation of an infant’s fear system. That is, an available and responsive attachment figure decreases the infant’s susceptibility to fear. Conversely, according to Cassidy, Ehrlich, and Sherman (2014) Meaney and Suomi stated the lack of a soothing attachment figure can lead to long-term problems from anticipated or real threats of abandonment. Further, attachment patterns tend to be stable over time and extend into adulthood.

Smith (2009) stated Feeney found insecurely attached individuals are more likely to experience relationship conflict. According to Smith, Kerns, Aspelmeier, Gentzler, and Grabill reported lower self-esteem as a result of insecure attachment, and Alexander reported increased incidents of sexual abuse. Smith stated Kennedy and Kennedy reported insecure attachment contributed to cognitive problems in the classroom, and the shame-burdened child was less likely to explore, to be emotionally flexible in times of stress, or able to form relationships. Schore (1994) found shame and contempt often resulted in violent behavior. Additionally, attachment studies illustrate the need for social contact and the consequences of the loss of social contact (Ainsworth et al., 1978).

Weber (2003) found an integration of attachment processes and Individual Psychology (IP) demonstrated a merging of both theoretical constructs regarding lifestyle and attachment and
the capacity to form goal-directed partnerships. According to Smith (2009), the conceptual similarities between attachment and lifestyle support the significance of early family atmosphere to predict safety. Attachment and lifestyle form stability and the capacity to care about others. It appears as though secure attachment leads to social interest. It may be that insecure attachment is similar to mistaken goals or fictions that have an impact on self-esteem. Further, similarities between IP and attachment theory regarding safeguarding tendencies, defensive operations, and patterns of insecure attachment follow inadequate parenting of the child’s need to belong. From the lens of Individual Psychology and attachment theory, safeguarding tendencies to protect an individual’s self-esteem is a reaction to feelings of inferiority (Smith, 2000). According to Smith, these aspects of attachment theory are consistent with Adler’s concepts of family constellation and early recollections.

Schore (1994, 2001) proposed insecure attachment styles are more likely to result in frequent and intensified shame experiences because the attachment figures are less likely to become empathically attuned to the child. Because of the caregiver’s emotional unavailability, insecurely attached individuals are unable to contain the fragmented and over-burdened self.

According to Kohut (1971), the seeds of social interest are found in the interaction with attachment-available caregivers whose empathic responses help restore the sense of self through the experience of emotional contact. Schore noted shame is one of the first non-affirming responses from a needed attachment figure, so the child is completely at the mercy of the caregiver to obtain an optimal response for recovery. Further, the psychological survival of the child depends on the ability to experience reattachment.
The Manifestation of Shame

Shame, as an emotion, puts the individual into disequilibrium and limits an individual’s ability to cope (Van Vliet, 2008). Individuals, who are prone to being shamed, feel attacked by the outside world limiting the individual’s ability to relate socially as shame undermines core resilience of power, control, and self-esteem. This attack on the self is associated with efforts to circumvent the pain by using avoidance behaviors (Van Vliet, 2008).

Beebe and Lachman (2013) stated shame is physically perceived early in life through parent/child interactions. Initially, shame begins as a response to separation from an attachment figure. For example, the parent/caretaker repeatedly prevents the child from transitioning back to a positive affective state through facial displays of disgust. The child feels hopeless and responds by withdrawal, avoidance, and a desire to remain unnoticed. According to Chilton (2012) Konstan first demonstrated the consequences of shame in adults during the 1970s and found adults described shame as feelings of utter worthlessness. Up until that point, Chilton stated shame had not been widely researched with the exception of Hall’s study that revealed a link to shame and childhood toilet training.

Gilbert (2007), Tangney, and Dearing (2002) and Tracy and Robins (2004) concluded shame strongly influences one’s sense of self in a social environment. Gilbert et al. (2007) suggested a biopsychosocial approach to shame. In this approach, shame emerged as a threatening emotion. For example, a person may not feel attractive to a significant other because he or she perceives him or herself as inadequate. According to Bernsten and Rubin (2007), this perceived negative view becomes internalized as truth, the basis of one’s autobiographical memory, and over time, becomes generalized as part of a shame-based life narrative.
According to Schoenleber and Berenbaum (2012), Beck suggested shame triggered by negative mistaken beliefs created a high level of distress as evidenced by its position in depression theories. Further, Whelton and Greenberg (2005) suggested shame, sometimes produced by a negative belief, can be more pathological than the belief itself, as individuals perceived themselves as bad. While other emotions such as guilt are more situational, shame-based individuals internalized blame and perceived it as a character defect (Schoenleber & Berenbaum, 2012). As a result of this internalized blame, much like personality pathology, shame triggers are more pervasive through the life span and cause repeated distress.

Mills et al. (2015) believed shame memories anchor conceptions of self, provide meaning to life narratives, and operate as central self-defining memories in the self-memory system. Individuals identify with these central, self-defining memories and are acutely susceptible to shame proneness. Further, shame proneness appears to contribute to vulnerability to internalizing pathways and involves a feeling of inferiority or defectiveness. That is, a person is consistently at the doorstep of further shaming.

Pinto-Gouveia and Matos (2011) stated shame, fear, sadness, and childhood traumatic memories that become integrated into one’s life narrative can be psychologically damaging as these traumatizing memories and intense feelings can carry into adulthood. According to Matos et al. (2012), shame memories with more traumatic characteristics produce more depressive symptoms. Additionally, shame-based traumatic memories along with fear-based traumatic memories predicted future anxiety. For instance, shaming events, structured as traumatic memories, intrude on an individual causing arousal symptoms that trigger strong emotional avoidance of social engagement. This on-going threat can lead one to be locked in a defeat and threat state, which may explain the strong link between shame-based traumatic memories and

La Bash and Papa (2014) described two types of shame. *Internalized shame* is contained emotion and detrimental to an individual’s emotional functioning. *Externalized shame* is expressed externally through actions such as anger, blame, or revenge, and usually detrimental to the self, relationships, and/or society. While males tend to externalize shame leading to conduct problems, females tend to internalize shame from abuse and experience higher rates of post-traumatic stress disorder (PTSD).

Over time, external and internal shame-based memories increase vulnerability and the inability to manage negative situations (Matos et al., 2012). When the individual is in a perceived state of defeat or threat, depression, anxiety, and other stress symptoms can occur. Additionally, central shame memories can create an environment of suspicion, paranoia, lack of trust, and maladaptive behaviors for shame regulation (Matos et al., 2012). According to Gilbert (2007), Matos, and Pinto-Gouveia (2010), Matos, Pinto-Gouveia and Costa (2013), unlike other negative emotional memories, shame memories are directly related to negative self-identity and should be seen as an independent contributor to the understanding of psychopathology.

Stuewig et al. (2015) found early childhood shame positively predicted risky behaviors later in life. In contrast, childhood guilt negatively predicted risky behaviors. Stuewig found the cycle of reoccurring negative behaviors in a shame-prone child could develop into a conduct disorder. This cycle of shame in a shame-prone child can further develop a pattern of failure that generalizes into various aspects of the child’s life. These repetitive shame experiences may escalate through counterproductive patterns of behavior and maladaptive shame reactions. One example might be poor academic performance.
Early shame experiences generate a primary threat to one’s social self and may function as threat-activating memories (Ferreira et al., 2014). Shame events involve self-other interactions when an individual believes the self to exist negatively in the mind of the others. That is, a person may believe others see an unattractive, defective, inferior, and flawed person because this perception mirrors the assessment of one’s self. Criticism, rejection, teasing about physical appearance, bullying, or physical or sexual abuse represent potential shame experiences. Additionally, these experiences could occur early in life and become conditioned emotional memories (Gilbert, 2007; Matos & Pinto-Gouveia, 2010, Matos, Pinto-Gouveia, & Costa, 2013).

According to Matos et al. (2013), research shows that childhood and adolescence shaming may function as traumatic memories, and as such, evoke symptoms of intrusion, hyperarousal, and avoidance. Collectively, these memories can become central to one’s personal identification and life story, define one’s sense of self, and deeply influence one’s social interactions. Further, the traumatic features of these shame memories, and centrality to identity qualities, have been associated with several psychopathological indicators such as depression, anxiety, paranoia, and dissociation.

All children must learn to manage failure and understand the distinct difference in adaptive and maladaptive responses to failure (Stuewig, 2015). Shame-prone children have difficulty discerning the difference between the two responses. An example of an adaptive response to failure may be to search for new information and strategies to increase the chance of successful task completion on the second try. The focus is on the challenge of the new task; however, for the shame-prone child, failure may be especially difficult due to the tendency toward negative self-focus and increased shame. A shame-prone child is more likely to become
“stuck” in the shameful, internalized feelings of worthlessness and powerlessness. As a result, the person may engage in drinking and drug use to ease emotional pain (Stuewig, et al. 2015).

According to Zahn-Waxler, Klimes, and Slattery (2000), internalized problems are the most common form of maladjustment in children and youth and affects 14-18% of all young people. Additionally, according to Zahn-Waxler, Crick, Shirk, and Woods (2006), these problems are social and emotional difficulties characterized by over-controlled behavior and inner-directed symptoms including anxiety, depressed mood, and negative self-beliefs. The problems emerge early in childhood, are relatively stable across the school years, and often increase and evolve into depression and/or anxiety disorders during adolescence.

Anxiety and depression frequently co-occur and this negative thinking style (depressogenic) may be an important vulnerability factor in internalizing pathways (Mills et al., 2015). According to Hankin and Abramson, (2001) problem internalization increases dramatically during adolescence, and theories suggest that the increase can be attributed to intrapersonal vulnerabilities emerging prior to adolescence.

Shame-prone children are more likely to engage in depressogenic thinking (Mills et al., 2015). In turn, depressogenic thinking predicted internalization of problems and anxious depressive symptoms. Viewing the self as flawed or deficient following negative events is a maladaptive inferential style that contributes to an increase in the internalizing symptoms such as sad mood and social withdrawal (Mills et al., 2015). Additionally, shame-proneness in middle childhood uniquely predicted depression in adolescence. That is, adolescents who had been highly shame prone in middle childhood were 30 times more likely to meet the criteria for a diagnosis of depression than those who had not been highly shame prone.
According Stuewig, et al. (2015), a child’s moral emotional style appears to be well established by middle childhood. Therefore, shame can have negative implications for risky behavior in early adulthood. The painful feeling of shame can lead to withdrawal and depression, as well as defensive externalization and irrational anger. Another unhealthy response to shame-proneness may include an increase in peer-related problems. Peer-related problems may include any of several expressions:

1. Active bullying or propensity to be a bullying victim (Pontzer, 2010);
2. Various forms of narcissistic behavior (Krizan and Johar, 2015);
3. Conduct disorders and participation in delinquent gang activity (Stuewig et al., 2015);
4. Eating disorders and social anxiety in association with pathological dissatisfaction with one’s body (Sweetinghan & Waller, 2008).

The act of bullying, often considered an expression of externalized shame, is when a physically, mentally, or psychologically advantaged individual, or advantaged in some other way (such as belonging to a group) inflicts harm on a weaker individual for no justifiable reason. Bullying includes instances of:

1. hitting, kicking, or shoving, teasing or name-calling with hurtful intent;
2. purposeful exclusion from a group;
3. spreading false rumors;
4. forcing someone to do something that he or she does not want to do;
5. taking or damaging someone’s money or possessions;
6. racial gestures or comments;
7. sexual comments, gestures, and unwanted touching (Pontzer, 2010).
An act is not considered bullying when it involves playful teasing or an argument or fight between two people of equal strength (Pontzer, 2010).

Pontzer (2010) concluded that bullying can be a characteristic product of exposure to shaming through parental stigmatization and the modeling of bullying-type behavior within the family or like-minded peer group. Pontzer stated shame proneness in middle childhood was a significant predictor of internalizing problems in late childhood. In addition, boys with early-emerging internalizing characteristics had more social difficulties and negative views of self. Also, shame appeared to increase problem internalization among boys between middle and late childhood. For girls, shame appeared to worsen social anxiety symptoms, which were more pronounced in late childhood (Mills et al., 2015).

Kaufman (1992) stated:

The principal effects of shame on the self are hiding, paralysis, and perceived transparency. The urge to hide, to disappear from view, follows quickly in the wake of shame. Reducing that often agonizing scrutiny is critical, and all hiding behavior therefore originates in the necessity of covering the self. Furthermore, exposure itself creates an experiential paralysis: speech is silenced, movement is interrupted, the self becomes frozen. Even the contents of consciousness may become experientially erased by the sense of exposure inherent to intense shame, thereby causing eventual repression of whatever has become associated with shame. Finally, we feel transparent because we feel painfully revealed in the moment of shame; others seemingly can see inside of us and know our innermost being. (pp.195-196)

If the inner experience of shame is exposure, the outer view of shame may be captured in its characteristic facial signs: eyes down, head down, eyes averted, and blushing (Kaufman,
1992). These various, though universal, facial displays and posture profiling signify the experiencing of shame. They may also serve to communicate shame both to the person who is feeling it and to any others present or watching. Often, the shame response of lowering the eyes or head is a direct consequence of heightened visibility. This physical response may reduce that painful visibility. The physical response produces the universal symbol of the head hung in shame, often causing the facial expression to be hidden from view. From this poignant image comes the historical association of shame as “loss of face” (Kaufman, 1992).

Yard (2014) posited older individuals are capable of understanding the pain of shame, and just the thought of experiencing it again may be followed by various secondary reactions. The three most frequent reactions are fear, distress, and rage. Fear of further shame experiences is a natural secondary reaction of shame. Fear, which often manifests as anxiety, frequently functions in anticipation of further shame. Distress – the crying response – is another affective reaction to shame; many children and adults will respond to their own shame by crying. The third secondary reaction is rage, which is an exaggerated inflation of anger affect. Where anger is typically toward someone or something specific, rage is against a faceless, unidentifiable threat. This rage serves a vital self-protective function: It insulates the self, creating a protective cover, actively keeping all others away to avoid further occurrences of shame (Yard, 2014).

When shamed, the entire self becomes the focus of a person’s concerns (Tangney et al., 1996). Shame can lead to catastrophizing reactions from others so that even a limited number of negative behaviors or failures are magnified and reflect the whole (internal and external) self. This entire and enduring defeat of self results in a catastrophic feeling of being small, worthless, powerless, and not belonging (Tangney et al., 1996). In a less catastrophic framing, shame involves a feeling of (either real or imagined) exposure and increases the need to hide or sink and
disappear (Tangney et al., 1996). Shame is, therefore, more global in nature and results in an impaired self.

Yard (2014) further explained:

The affect of shame typically manifests in various forms. The principal variants of shame are discouragement, embarrassment, shyness, self-consciousness, inferiority, and guilt. Embarrassment is shame before an audience, while shyness is shame in the presence of strangers. Discouragement is shame over a temporary defeat, while inferiority is shame that is permanent. Other phenomena rooted in shame include alienation, failure, worthlessness, and defectiveness. (p. 44)

In other words, an individual does not feel a part of something or have a sense of belonging. According to Shifron (2010), Adler believed every child is born with the need to belong and with the ability to connect with others. Consequently, the inability to belong or to connect with others often results in pathology. Shame-based pathology often goes unrecognized because the focus is on various manifestations of shame rather than on the shame itself (Chilton, 2012).

Many varying definitions on topics related to shame convolute the subject. Yard (2014) suggested three differences and distinctions:

1. Shame is both an affect and a defense.
2. Shame is about the self, not simply guilt about an act.
3. As Howell noted, shame can be seen as something known only by its effect on another situation or person, (e.g., states of brooding, withdrawal, self-absorption, self-silencing). (p. 44)

Kaufman (1992) noted to feel shame is to feel seen in a painfully diminished sense.

Inherent to the experience of shame is this sudden, unexpected sense of exposure where one may
feel less than. Exposure is an important characteristic of shame and is, therefore, central to understanding its dynamic impact. Developmentally, shame begins as a wordless effective experience. Only later, when a child’s vocabulary and thought process develops, does it take on qualities of cognitive self-evaluation (Kaufman, 1992).

**Defensive Tactics for Shame Regulation**

People in the midst of a shame experience often resort to any one of a number of the defensive tactics (Schoenleber & Berenbaum, 2012). According to Lindsay-Hartz, DeRivera, and Mascolo (1995), there are three forms of shame regulations once shame has been experienced. Two of the three, *preemptive avoidance* and *escape*, remove the individual from the source of shame. Lewis (1971) identified the third form of shame regulation as *aggression* which increases engagement with the source of shame. Lewis referred to shame associated with anger or aggression “shame-rage.”

Loader (1998) outlined the responses and defenses to shame:

1. *Contempt* – an attitude that others are beneath consideration as from a superior position, thus protecting the self against any possibility of shame.

2. *Power over others* – a position that protects against shame by keeping others in a weakened position possibility through threat of voidance or power stance.


4. *Striving for perfection* – a position that acting in a certain way will avoid the possibility of shame by always getting it right.

5. *Withdrawal* – through minimizing the risk of exposure, one protects against shame by withdrawing inward away from social contact.
6. **Denial** – a state in which lack of awareness of the presence of shame can create a world where shame does not exist. (p. 45-46)

Furthermore, while these defensive postures protect against the experience of shame, if they prove ineffective, or the individual becomes overcome by shame, there are more common reactions:

1. Isolation – shame is always accompanied by the urge to hide away and this may literally happen if the possibility exists.

2. Shame-rage – shame can be reacted to by indiscriminate irrational anger at the shamer, and object, or no one specifically.

3. Humor – masking shame with humor or making fun of the shamer.

4. Transfer of responsibility – the individual may (try) to shift the responsibility for their shameful dilemma onto another person (e.g. ‘you made me do it’). This transfer is often easiest when the other person is in a subordinate position, such as an employee or a child.

5. Indifference – the shamed person may profess not to care, thus denying the shame experience. This can lead to a possible demeanor of impertinence.

6. Total humiliation – a reaction of total defeat and mortification. (p. 46)

**Shame Avoidance**

According to Jones and Berglas (1978), one manifestation of shame avoidance is *achievement sabotage* where an individual undermines one’s life tasks such as work or academic performance. This self-sabotage can occur actively (e.g., deliberately performing poorly) or passively (e.g., avoiding performing in some fashion). This self-sabotaging, or self-handicapping, is when the individual creates the barriers that decrease positive outcome. Ferrari
(1991) noted these types of self-handicaps are considered performance techniques since they allow for externalized blame should the individual’s efforts be seen as failure.

**Dependency**

Another prevention strategy used to reduce shame is the development of dependency upon others (Schoenleber & Berenbaum, 2012). Dependency is used to protect exposure to potential incompetency and to avoid responsibility. To create dependency, a shame-based individual first seeks out people who are very supportive and nurturing in nature and who can be over relied upon for assistance (Schoenleber & Berenbaum, 2012). According to Bornstein (1997), shame based dependency is associated with powerlessness and fear of exposed defects or poor performance. Schoenleber and Berenbaum (2012), indicted shame is associated with pathological dependency which may result in a diagnosis of dependent personality disorder.

**Fantasy**

Schoenleber and Berenbaum (2012) stated fantasy is another shame regulation strategy. That is, wishful thinking is used to visualize a more positive outcome or self-image. Fantasy is used as a diversion from real or imagined flaws. Although when used appropriately, fantasy can be adaptive in nature, when overused, fantasy can become maladaptive and develop personality pathology (Schoenleber & Berenbaum, 2012). Tangney et al. (1992) found a relationship exists between shame and depression; however, Kohut (1971) noted fantasy, when used as a defensive strategy, could protect against depression due to the reduction of shame.

According to Sánchez-Bernardos and Avia (2006), schizotypal personality, particularly magical ideation, has been found to be associated with proneness toward fantasy. A preoccupation with fantasies (e.g., fantasies about success or ideal love) is a criterion for narcissistic personality disorder (NPD), which is likely to be highly overlapping with grandiose
narcissism (American Psychiatric Association [APA], 2013). Additionally, Raskin and Novacek (1991) found that individuals with high narcissistic tendencies and low self-sufficiency levels were more likely to use fantasy when under high levels of stress than those with low narcissistic tendencies. Further, fantasy is most likely to be used by individuals with high levels of narcissism when they feel threatened and believe they are not competent in a given situation. As a result, fantasy becomes a means of shame reduction.

**Anger**

Anger is used as a more aggressive means of reacting to shame-based triggers (Schoenleber & Berenbaum, 2012). For example, when encountering narcissistic vulnerability, shame-based individuals become irrationally angry with others, and may resort to overtly aggressive and destructive actions with no remorse. According to Muris and Meesters (2014), shame may motivate not only avoidant behavior, but also may trigger a defensive or revengeful anger with a need to project blame outward. If this type of anger does not diminish shame, it could escalate into rage.

According to Brown, Linehan, Comtois, Murray, and Chapman (2009), anger in response to perceived defects can cause self-loathing, self-directed aggression, and self-injury; however, Lewis (1971), found when self-hate turns to blame, individuals can direct hostile acts against others. Schoenleber and Berenbaum (2012) suggested aggression shame regulation is similar to escape because it occurs after shame elicitation. Unlike escape, however, aggression shame regulation reflects an attempt to actively deal with shame-eliciting situations through engagement rather than avoidance.

Stuewig et al. (2015) stated shame-prone individuals (from early childhood through late adulthood) experienced more anger than less shame-prone peers. For instance, shame-prone
individuals appeared to adopt one of two maladaptive strategies when faced with situations involving interpersonal conflict, active aggression, or passive withdrawal. Once angered, the shame-prone person’s subsequent motivations and behaviors differed considerably from those less shame-prone individuals (Stuewig, et al., 2015). Simonds et al. (2016) posited lower levels of shame broaden one’s perspective and allow for an increased capacity for self-reflection and social interest. In addition, self-reflection and social interest provide a better foundation from which to nurture and convey compassion, sorrow, and empathy with peers.

**Perfectionism**

Perfectionistic behavior, a preventive strategy, is used in the reduction of shame (Schoenleber & Berenbaum, 2012). Perfectionism is designed to either reach extremely high standards or avoid exposure of imperfections (Schoenleber & Berenbaum (2012). According to Sherry, Hewitt, Flett, Lee-Baggley, and Hall (2007), trait perfectionism is distinguished between three perfectionistic self-presentational styles: (a) Individuals may employ perfectionistic self-promotion by focusing attention on achievements; (b) individuals may employ omission of information regarding failures in achievement; and (c) individuals may employ concealment of features they deem flawed.

**The Psychopathology of Shame**

According to Trull, Jahng, Tomko, Wood, and Sher (2010), nearly one-tenth of individuals in the general population, and nearly one-third of clinical samples, had at least one personality disorder. Further, according to Piper and Joyce (2001), and Dolan-Sewell, Krueger, and Shea (2001), personality disorders are thought to be especially difficult to treat and can complicate the treatment of other disorders.
Although there is a great deal of clinical literature written about the psychopathological effects of guilt, several studies show that shame has an equal or greater impact on psychopathological manifestations (Kim, Thibodeau, & Jorgensen, 2011). Matos, Pinto-Gouveia, and Gilbert (2013) reported shame and shame-proneness are associated with social phobia and generalized anxiety disorder. Cândea and Szentágotai (2013) reported an association between shame and bipolar disorder; Grabhorn, Stenner, Stangier, and Kaufhold (2006) associated shame with eating disorders; Brown, Linehan, Comtois, Murray, and Chapman (2009) reported an association between personality disorders and shame; and Kim et al. (2011) positively correlated shame with depression.

Shame, or the absence of it, has a long-term relationship with the concept of psychopathology (Yard, 2014). Yard stated defenses against shame included narcissistic self-inflation (grandiosity), projecting and shaming of others, lying, and replacement of a gap in a person’s memory with a falsification he or she believes to be true (thus avoiding responsibility or fault). Yard suggested defensive shame can also appear in the case of pathological perfectionism. Perfectionism is an overwhelming driving tension to get everything right, to appear flawless and sinless, thus avoiding the critical scrutiny of others and not be exposed as weak, a sham, vulnerable, or fraudulent. The perfectionist tie to shame is the fear of being discovered or exposed as a person with flaws (Yard, 2014).

Yard (2014) identified moral masochism as another potent defense. Yard posited a masochist’s shame is unconscious guilt that stems from other sources such as survivor guilt, or separation guilt. Whatever the cause, if ignored and untreated, moral masochism can lead to a life-long need for punishment. Further, Yard suggested in defensive shame, the moral narcissist depletes true object relations in order to restore childish delusions of great self-sufficiency (e.g.
the erasure of passion and elimination of self with emphasis on love of humanity over love of human beings).

According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013) those with avoidant personality disorder have pervasive fears of rejection and view themselves as inferior. Fear of rejection and an internal inferior view of self is suggestive of shame (Cuming et al., 2009). Cuming et al. stated when interpersonal avoidance behaviors are frequently and inappropriately used to avoid shameful interactions with others, there is the possibility of personality pathology. For example, maladaptive behavior and/or communication styles developed by interpersonal avoidance behaviors may include such “safety behaviors” as distancing and isolating from social environments, poor eye contact, or avoid talking about themselves when engaged with others.

Current symptoms of avoidant personality disorder, such as avoidance of occupational or recreational or social activities because of fear of criticism or rejection, can be understood as attempts to down-regulate maladaptive shame (Schoenleber & Berenbaum, 2012). Further, interpersonal avoidance is a feature of other pathological personality disorders such as obsessive-compulsive personality disorder. Both avoidant personality disorder and obsessive-compulsive personality disorder are associated with shame-proneness and aversion (Schoenleber & Berenbaum, 2010). Moreover, safety behaviors, and a self-protective communication style, have previously linked to social anxiety, which is also related to experiences of shame and fears of rejection and criticism (Cuming & Rapee, 2010).

**Narcissism**

Narcissism is a “cognitive-affective preoccupation with the self” (Westen, 1990, p. 226) and various forms of narcissism can be a manifestation or contributing factor of shame. Many
social psychologists believe all individuals exist on a continuum of narcissism (Freis, Brown, Carroll, & Arkin, 2015).

Clinical descriptions of narcissism emphasize vanity, arrogance, self-absorption, and entitlement as primary personality characteristics (Cain, Pincus, & Ansell 2008). For example, narcissistic individuals are inordinately invested in self-image, obsessed about how others view them, and often dismissive of other’s needs and wants to the extent they impede with one’s own needs. There are two distinct themes regarding a narcissist’s emotional and interpersonal behavior: narcissistic grandiosity and narcissistic vulnerability (Cain et al., 2008). Narcissistic grandiosity applies to one who tends to be overconfident, self-promoting, an exhibitionist, and exploitive. By comparison, Krizan and Johar (2015) referred to narcissistic vulnerability as the tendency to be self-centered, defensive, insecure, and resentful when presented with narcissistic individuals.

Krizan and Johar (2015) believed narcissistic grandiosity and narcissistic vulnerability criteria predicted opportunistic, arrogant, and argumentative personalities; however, grandiosity predicted assertive, egotistical, and show-off behaviors while vulnerability predicted defensiveness, complaining, and bitterness. Distinctively, narcissistic grandiosity is associated with low emotional distress, high self-esteem, and dominance, and narcissistic vulnerability is connected to low self-esteem, introversion, and high emotional distress (i.e., need for others to acknowledge efforts, accomplishments, and superiority). In spite of these differences, both narcissistic vulnerability and narcissistic grandiosity share central tendencies of obvious dismissiveness (i.e., of care or concern for others with no tangible benefit to themselves) and entitlement for interest satisfaction (Krizan & Johar, 2015).
According to Ronningstam (2009), those with narcissistic vulnerability have a fragmented sense of self and desperation for external validation that leads to both shame about narcissistic needs and unrestrained anger toward those responsible for exposing flaws in a narcissistically perceived reality. As a result, “narcissistic rage” fuels aggression.

The vulnerable type of narcissism is expressed in hypersensitive, defensive, and injurious reactions to interpersonal relationships and is associated with patterns of empirical findings distinct from that of grandiose narcissism (Miller, Price, Gentile, Lynam, & Campbell, 2012). Additionally, empirical findings among outpatient mental health clients revealed a positive correlation between vulnerable narcissism and the number of attended therapy sessions, number of cancelled therapy sessions, number of suicide attempts, parasuicidal behaviors, likelihood of visiting a psychiatric emergency room, and initial symptoms of depression, sleep problems, and psychosis among outpatient clients (Ellison, Levy, Cain, Ansell, & Pincus, 2013).

Evidence linking narcissistic grandiosity (measured with the narcissistic personality inventory) to aggression does not support the central elements of the narcissistic rage of resentfulness, fragility, and victimization (Krizan & Johar, 2015). That is, grandiosity does not intensify angry rage, shame, or aggressive behavior in response to interpersonal frustration. Krizan and Johar stated this is an important distinction from narcissistic vulnerability because so much emphasis is put on grandiosity in the assessment stage of diagnosis. Krizan and Johar (2015) stated,

It should be noted that the Narcissistic Personality Inventory (NPI; Raskin and Hall, 1981), the most commonly used measure of narcissism within personality and social psychology, captures narcissistic grandiosity, not vulnerability (Krizan and Johar, 2012). This is important because the vast majority of theory and evidence in personality and
social psychology is based on the use of this measure, and thus speaks only to grandiose aspects of narcissism. Furthermore, diagnostic criteria for narcissistic personality disorder do not currently include vulnerable symptoms of narcissism despite these being key to clinical assessment of the disorder. As a result, there is a substantial concern that assessment of narcissism across both personality and clinical domains ignores important aspects of the construct (Miller, Gentile, Wilson, & Campbell, 2013). This imposes serious limitations on understanding narcissistic aggression. (p: 785)

**Bi-polar Disorder**

Fowke, Ross, and Ashcroft (2012) studied the impact of internalized shame in the development of bipolar disorder. Fowke et al. studied 35 adult participants with bipolar and 35 adult participants with no psychiatric diagnoses with reported childhood events of abuse or neglect. Fowke et al. used the Internal State Scale, Childhood Trauma Questionnaire, and Internalized Shame Scale to assess participants. Fowke et al. found those participants with bipolar had a significantly higher level of internalized shame and reported significantly higher rates of emotional, physical, and sexual abuse, and emotional and physical neglect. Fowke et al. clearly revealed a high correlation between childhood abuse and neglect and the development of bipolar in adulthood.

**Self-harm**

Pattison and Kahan (1983) defined self-harm, as intentional self-injury without an apparent intention to complete suicide. Pattison and Kahan (1983) suggested self-harm is used for many reasons including a release of hormones, emotional relief, emotional regulation, and to communicate distress. Gilbert et al. (2010) reported a higher intensity of shame based on self-criticism lowered the desire to reach out for help and increased the need to self-harm. Gilbert et
al. stated self-harm was significantly related to feelings of inadequacy, self-hatred, and character shame.

**Depression**

Matos et al. (2013), studied the relationship between childhood shame and depressive symptoms. Matos et al. revealed traumatic shaming by significant attachment figures caused depression as these shame memories related to identity. Further, Matos et al. revealed that depressive symptoms manifested in different forms such as dissociation, thought suppression, and rumination. These different manifestations of depression are used for emotion regulation to decrease the shame-based traumatic memory. Carvalho, Dinis, Pinto-Gouveia, and Estanqueiro (2015), supported these findings on depression and included the use of avoidance as a mechanism to reduce the impact of shame memories.

**Paranoia**

Pinto-Gouveia, Matos, Castilho, and Xavier (2014) studied the effects of internal and external shame on depression and paranoia. Pinto-Gouveia et al. (2014) stated,

Depression corresponds to an involuntary defeat strategy that comes about due to loss or perceived loss or ability to function in society. Paranoid individuals tend to believe others hold negative intentions towards them and want to harm them, being generally suspicious and distrusting of others, what then leads to interpersonal difficulties (pp. 49-50).

Pinto-Gouveia et al. (2015) revealed that shame had a negative impact on both depression and paranoia. For example, shame memories, threat, and submissiveness affected both depression and paranoia symptoms; however, depression increased primarily through
internalized shame vulnerability, and paranoia increased through both external and internal
shame memories.

**Eating Disorders**

According to Matos, Ferreira, Duarte, and Pinto-Gouveia (2015), early adverse experiences in childhood, particularly by peers, may be high risk factors for eating disorders. Traumatic shaming memories are related to several psychopathological conditions (Matos et al., 2013) and are significantly associated components central to personal identity in patients with eating disorders. Additionally, these central, traumatic shaming memories may compromise one’s affect regulation system as it pertains to eating disorders (Ferreira, Matos, Duarte, & Pinto-Gouveia, 2014).

When helpful compensating efforts are blocked or fail, an individual experiences a loss of positive feelings and this is perceived as a threat (Ferreira et al., 2014). As a result, threat-based emotions are activated (e.g., shame, when one’s social acceptance, status, or self-identity is at stake). Further, the threat triggers the drive for relief, which has already been socially limited by shame, so with the drive to safeness-soothing-comfort drive goal limited, the pained individual may seek relief in various forms of maladaptive eating (Kelly & Carter, 2013). Therefore, highly self-critical individuals have increased rates of eating disorders in an effort to mediate the shame-induced pain.

Frequently, women use physical appearance to obtain positive social attention and a central self-evaluative dimension (Ferreira, Pinto-Gouveia, & Duarte, 2013). Traumatic shame memories involving social experiences outside the family circle (e.g., peers) seem to be especially damaging for patients with eating disorders and influence how physical appearance is
used as a central dimension to establish social rank and consequently, may negatively affect their self-judgement (Matos et al., 2015).

Heatherton and Baumeister (1991) reported binge-eating was a means of temporarily alleviating negative affect, and is associated with shame over and above general negative affect (Gupta, Rosenthal, Mancini, Cheavens, & Lynch, 2008). Further, Gupta et al. found that the relationship between shame and binge-eating was mediated by difficulties with emotion regulation. Because of this difficulty, food can be used as a distraction from perceived flaws.

**Individual Psychology**

Individual Psychology consists of a holistic, socially embedded, and purposeful motivational theory about how humans are motivated into movement by the desire for significance, belonging, competence, and mastery or perfection (Mosak & Maniacci, 1999). In addition, Individual Psychology includes a view of the person and the situation as a whole.

Alfred Adler introduced Individual Psychology (i.e., Adlerian counseling) in 1912 as an alternative model to psychoanalysis (Ansbacher & Ansbacher, 1956/1964). Adler was an influential forerunner to the humanistic counseling movement that emphasized holism, optimism, free will, and the subjective nature of human beings (Carlson, Watts, & Maniacci, 2006). Within Individual Psychology, *psychoclarity* was a new term introduced in 1982 (Powers & Griffith, 2012). Psychoclarity referred to the quality and form of the collaborative relationship between client and clinician in psychological counseling. Powers and Griffith (1982) stated,

The client is invited to help the therapist to see more clearly what is in the client’s thought, feeling, and action, and what its effect are upon the social field…Client and therapist are united in the effort to understand what is going on, what it goes on for, and
what it costs to keep it going... As the therapist comes to see more clearly, the client does as well.

Many therapists are trained as if their task were to pursue the goal of changing the client... The therapist who wants the client to change is setting up for a fall. Only the client can decide when to change and what and how to change. The psychoclarity formula is: You cannot change your mind until you know your mind. You cannot know your mind until you speak your mind, and your speech brings the private (sense) into the commonsense world. When that occurs, your private sense of things in no longer unspeakable and therefore, no longer unthinkable.

Therapy gives the client an opportunity to break the spell of the unspeakable by clarifying for the therapist his or her private sense of what it is to be in the world. When I know my mind I can see that while the past behavior is now understandable, it is no longer necessary.

The goal is one of self-understanding, without which a consideration of whatever might be changed is impossible. Only at this point is the client free to reconsider, and in that liberation, may decide to do so. The usual treatment was to attack the symptom, to which Individual Psychology is entirely opposed...What we must always look for the purpose for which the symptom is adopted and the coherence of this purpose with the goal of superiority... With the change of the goal, the mental habits and attitudes will also change. [The client] will no longer need the old habits and attitudes, and new ones, fitted to his new goal, will take their place (pp. 19-20).
Understanding the client begins with an imaginative reconstruction of the patterns which allows each part to be considered in the mosaic of the whole (Powers & Griffith, 2012). Further, these parts roughly include:

The Initial (therapy) interview process is to review: the life situation, presenting problem, and life task satisfaction; The Lifestyle assessment to understand the patient’s patterns (of beliefs and action) by review of: guiding lines/role models, family values, ethnic, religious, and socio-economic factors, birth order, genetic (physical and mental) self-assessment, and life opportunities/obstacles; The Early Recollections: usually relates to the current presenting problem. (Powers & Griffith, 2012, pp. 31-34)

Adler’s concept of holism proved to be effective in the process of forming a relationship of concerned equals and the intervention and treatment choices (Shifron, 2010). Shifron stated the whole is a dynamic, moving, developing, growing, and creative system. The whole operates through the inner links within all parts of the system. Additionally, the movement is the consequence of the interrelations and the contributions of each part. Many practitioners apply Adlerian principles as a stand-alone theory, considering it one of the more comprehensive therapeutic approaches (Sommers-Flanagan & Sommers-Flanagan, 2012). Eva Dreikurs Ferguson (2010) noted:

A unique and significant contribution made by Adler (1931) many decades ago was the formulation that the fundamental motivation of human beings is the need to belong. When the individual from early childhood experiences a sense of belonging as an equal and contributing member of the family and later feels belonging to the wider community, the person actualizes the ‘need to belong’ with striving to contribute to the human community. The goal of contribution is strengthened when the individual feels
belonging, and that goal is diminished when the person does not feel belonging.

According to Dreikurs, Cassel, and Ferguson, when the person feels of lesser value compared to other people, the person strives for goals other than contribution. Dreikurs and Soltz described how children who do not feel belonging, strive to be special rather than strive to contribute, in the mistaken belief that being special will bring a feeling of belonging. These ‘mistaken goals’ can be readily identified in children, and they are also evident in adults. (p. 1)

By embracing Adler’s holism, Adlerians recognize the interplay between the person and the environment toward the initiation of psychopathology (Maniacci & Johnson-Migalski, 2013). Further, Adler’s concept of holism was actually a biopsychosocial perspective that included biologic, psychologic, and social factors. Adler’s equation phrase: (Person x Situation = Psychopathology) is broken down as follows: The person is made up of the personality, pattern of daily life, genetics, temperament, physical and psychological compensation or over-compensation, and nervous system. The social context is the situation. Both sides of the equation are always present, but the context is key (Carlson et al., 2006).

According to Maniacci and Johnson-Migalski (2013), in some situations, the person side of the equation deserves far more attention. In others, it is the situation side, or the social context, that merits closer scrutiny. In many instances, the person and the situation deserve equal attention. In psychopathology, emphasis is typically placed upon either the individual or the environment, but it is the combination of the two that must be considered. For instance, in the details of fit, one will observe complexity (Maniacci & Johnson-Migalski, 2013).

Lifestyle development involves early environmental experiences and both innate and conscious drive toward significance and belonging (Mosak & Maniacci, 1999). Mosak and
Maniacci stated within the lifestyle is the individual’s *private logic* or unique set of rules and beliefs. Private logic is based on understanding of self, others, and the world. When this private logic aligns with common sense, it is considered more useful and mentally healthy. When individuals develop private logic in opposition to common sense, it is considered a mistaken belief. Mosak and Maniacci (1999) stated within the Adlerian framework, psychological distress occurs when individuals develop mistaken beliefs about self, others, and the world that lead to feelings of inferiority, discouragement, and failure to successfully meet the tasks of life. The tasks of life include: work/occupation, social/community, love/intimacy/family, self-care, and spirituality (Mosak & Maniacci, 1999).

Purposeful behavior in Adlerian theory includes goal-directed behaviors (Dreikurs, 1953). As children, purposeful behavior may include achieving goals through misbehaviors. When the goal of attention and significance fails to achieve its goal (i.e., attention or connection) discouraged children may develop the goal of inadequacy, giving up all effort to contribute and participate within his or her environment (Dreikurs, 1953). As these children grow older, the goals of misbehavior contribute to the development of mistaken beliefs and lifestyle convictions about the self, others, and the world (Miller & Dillman Taylor, 2016).

According to Ansbacher and Ansbacher (1956/1964), Adler’s believed pathology was the result of a lack of connection and belonging with others. Additionally, Adler's inferiority feeling in its deepest sense is recognition of incompleteness and un-actualized potential. Striving away from inferiority (i.e., toward wholeness) is always ongoing, even within unconscious neurotic behavior (Adler, 1932). According to Ansbacher and Ansbacher (1956/1964), in Adler's view, superiority has less to do with interpersonal dominance and more to do with overcoming the feeling of inferiority. Thus, neurotic purposes of striving cohere in the organizing life style and
in the basic mistakes that become the basis for the individual's guiding fictions (e.g., unconscious goals).

According to Smith (2009), in writing about the inferiority feeling and the superiority striving, Adler viewed shame as part of a feeling of incompleteness. Adler more closely linked the inferiority feeling to shame in the following passage from Ansbacher and Ansbacher (1956/1964):

Because the feeling of inferiority is generally regarded as a sign of weakness, and as something shameful, there is a strong tendency to conceal it. Indeed, the effort of concealment may be so great that the person himself ceases to be aware of his inferiority as such, being wholly preoccupied with the consequences of the feeling and with all the details that subserve its concealment. (p. 119)

The Individual Psychology concepts of the inferiority feelings (i.e., recognition of incompleteness or un-actualized life potential), lifestyle analysis, and development of social interest are very important to the study of shame (Smith, 2009). Dixon and Strano (1989) believed it was important to differentiate between shame as one of the first negative experiences of affect and the feeling of inferiority.

The difference between shame and inferiority is that shame leaves the individual feeling hopeless, detached, and immobilized, often unable to respond (Smith, 2009). On the other hand, inferiority motivates the individual’s inner push to move from a minus to a plus. Further, inferiority activates, rather than arrests, goal-directed behavior. Smith stated inferiority feelings involve striving for superiority, and this striving is not for personal power or domination, but for overcoming the feeling of weakness, anxiousness, and inadequacy toward actualized potential.
Inferiority feelings are not negative or positive, instead, it is the content and direction that striving takes which dictates “usefulness” or “uselessness” (Manaster & Corsini, 1982). Mosak, Brown, and Boldt (1994), suggested that neurotics often try to place themselves in a superior position through suffering. Mosak et al. summarized the frequent quandary of “super-achievers” as individuals motivated to achieve extreme success in order to overcome feelings of inferiority or inadequacy, and still frequently suffer from depression, poor interpersonal relationships, and lack of life satisfaction. According to Dreikurs (1953), useless striving fails to incorporate the resolution of the three life tasks: work (which consists of contributing to the welfare of others), friendship (which embraces social relationships with comrades and relatives), and love (which is the most intimate union).

Individual Psychology draws two courses of empirical research together: affect regulation, the early learning processes of adapting feeling states through the interaction with a caregiver; and attachment theory, the behavior pattern science that studies behavior systems of emotion goal-correcting relationships between infant and caregiver (Cassidy, 1999). Individual Psychology and attachment theory provided an empirical foundation for the study of a wide range of psychopathology later in life. Zelazo and Cunningham (2007) reported attachment experiences affect executive (i.e., cognitive) functioning. Additionally, attachment experiences have a lasting impact on one’s understanding of how effective relationships work (Fonagy & Target, 1997). Attachment experiences either facilitate or constrict the child’s capacity for concern for others (Winnicott, 1965), which is, in essence, the Individual Psychology concept of social interest (Smith, 2009).

Seidler (2000) suggested research broadened the understanding of the complex and scientifically important nature of shame within the human developmental processes. For
instance, a shame state has an impact on one’s whole life, from initial affect and the development of the self. Through the lens of Individual Psychology, cognitive-affective generalizations have an impact on a child’s beliefs and perceptions (i.e., private logic).

According to Mosak and Maniacci (1999), Adler emphasized belonging as the primary factor for individual mental health which expands into the community at large. Closeness (belonging) was a transcendent variable that encouraged people to look outside and beyond the self to the needs of others and of the community itself. In addition, belonging encouraged the feeling of intimacy, empathy, and identification (Mosak & Maniacci, 1999).

Smith (2009) stated traumatic shame, affect regulation, and modulation of feeling states through a caregiver converged with the study of developmental attachment. Smith believed the empirical trends could be viewed as consistent with the Individual Psychology concepts of social interest, inferiority-superiority strivings, and lifestyle. Also, Smith stated Adler viewed shame as part of a feeling of incompleteness (Smith, 2009). Ansbacher and Ansbacher (1956/1964) also noted,

Neurotic purposes of striving cohere in the organizing lifestyle and in the basic mistakes that become the basis for the individual’s guiding fictions. Difficult question in life, dangers, emergencies, disappointments, worries, losses, especially those of loved persons, social pressure of all kinds may always be seen as included within the framework of the inferiority feeling, mostly in the form of the universally recognizable emotions and states of mind which we know as anxiety, sorrow, despair, shame, shyness, embarrassment, and disgust. (p. 117)

The Individual Psychology concepts of the inferiority feeling, lifestyle analysis, and development of social interest may be important to the study of shame. It may also be relevant
to distinguish shame (as one of the first negative experiences of affect) from the inferiority feeling (Strano & Petrocelli, 2005). According to Ellenberger (1970),

Shame is distinct from inferiority because shame leaves the individual feeling immobilized and often unable to respond. On the other hand, inferiority mobilizes the patient's inner push to go from a minus to a plus. It activates rather than arrests goal-directed behavior. The inferiority feeling involves the striving for superiority through power over others, or through weakness, anxiety, and inadequacy. Both create a goal of superiority but follow different routes to achieve it. (p. 612)

Adler suggested a link between feelings of inferiority and shame in the following passage:

The feeling of inferiority is generally regarded as a sign of weakness, and as something shameful, there is a strong tendency to conceal it. Indeed, the effort of concealment may be so great that the person himself ceases to be aware of his inferiority as such, being wholly preoccupied with the consequences of the feeling and with all the details that subserve its concealment. (Ansbacher & Ansbacher, 1956/1964, p. 119)

Schore (2001) believed the shame of being defective hindered the individual from the positive community feeling of belonging that came from contributing. Schore suggested Adler’s view, then, is that shame represses social interest and leads to a negative withdrawal from others due to the loss of a sense of worth and belonging. Individuals who cannot reduce shame are also more likely to lack social interest, do not develop empathy, and are at risk for problems with aggression (Schore, 2001).

Smith (2009) posited that shame is contextualized through several Adlerian concepts. These concepts include early parenting patterns and life experiences (i.e., family constellation, cultural/familial values, gender role expectations, the nature of interpersonal relationships within
the family of origin, and psychological birth order), purposeful behavior, lifestyle (i.e., private
logic/mistaken beliefs), and a purpose of social interest (Smith, 2009).

Connecting with others throughout life involves a process of learning and adjusting, which is key to well-being (Mosak & Maniacci, 1999). It is essential that one belongs and is connected to the five significant life tasks (e.g. work/occupation, social/community, love/intimacy/family, self-care, and spirituality). Shifron (2010) stated the life tasks represent one’s holistic circle of life. Mosak and Maniacci (1999) stated,

People attempt to meet the life tasks according to their life styles. The more we push our styles, values, and expectations upon life, the more it will push back. In the end, we must adapt to it, for it will only accommodate us for so long. If we cling too tightly to our demands, beliefs, and convictions, we have trouble meeting the requirements of the situation. For some people, the issue becomes one of evading these tasks of life, rather than meeting them. Their life styles and plans are not willing to adapt, and these people stubbornly refuse to admit that what they require of life is not what life is about. Adlerians attempt to learn how people adapt to their worlds. The test of an individual’s life style is how it meets the challenges of these tasks. (pp. 98-99)

One frequent criticism of Adlerian theory is that it does not include a comprehensive development model (Mosak & Maniacci, 1999). Ansbacher and Ansbacher (1956/1964) stated although Adler emphasized early childhood experiences as critical to the overall development of the child’s lifestyle, he did not explicitly outline a theory of development. The integration of developmental brain science, as well as the further integration of attachment theory, may help address this gap (Miller & Dillman Taylor, 2015).
Though brain science continues to evolve, certain principles are well established. According to Miller and Dillman Taylor (2015) the Center on the Developing Child summarized three well-supported principles of brain development: (a) experiences build brain architecture; (b) serve-and-return interaction (child/caregiver) shapes brain circuitry, and (c) toxic stress deraileds healthy brain development (p. 121). Siegel (2010) stated,

Early experiences affect the foundational architecture of the brain, shaping capacities for attention, social engagement, behavior, emotional regulation, intellect, etc. These principles along with understanding of the bottom-up progress of (physical) brain development, help explain the disproportionate impact of environmental and relations factors in early childhood on development. (Siegel, 2010, p. 122)

Miller and Dillman Taylor (2015) concluded,

Neuroscientists’ research largely compliments the central humanistic tenets of Adlerian theory, including social embeddedness, purposefulness of behavior, and holism. In addition to supporting existing Adlerian principles and practices, advances in neuroscience can also inform the continued evolution of the theory, allowing for the integration of neuroscience-informed developmental theory, conceptualization of functionality, and interventions. We believe this integration adds to Adlerian counselors’ understanding of the rationale and intentionality behind certain Adlerian principles and techniques and allows counselors to have another language (i.e., tool) to use in connecting with individuals and facilitating change. (p. 125)

Discussion

Ansbacher (1979) stated Adler was the first social psychologist to approach individuals, couples, and families from a systemic perspective. Bitter (1988) stated during the assessment
process, Adler attended to the family constellation (children than the parents), the child’s position and connections, and any resulting faulty or mistaken beliefs as to the degree of perceived belonging (social interest) within the family. Powers and Griffith (2012) suggested an individual’s movement in the life tasks is noted varyingly by a perceived plus or minus. Powers and Griffith stated Adler believed individuals must achieve a clear awareness of becoming a healthy, active participant within one’s community to achieve a sense of belonging.

As it pertains to many expressions of shame, both attachment theory and Individual Psychology share several basic constructs. First, the degree to which an individual’s needs are met in early relationships affects the level of social interest (belonging) and ability to complete life’s tasks. Second, while every family experience varies, there tends to be a common purpose/teleology of belonging (Shifron, 2010). In addition, Individual Psychology is an optimistic psychotherapy because one can resolve the absence a sense of belonging is considered a curable situation (i.e. uncover mistaken beliefs). Further, in Adler’s IP, every individual makes choices, and can learn how to feel belonging, whether it deals with the work, social, love or family tasks of life.

**Implications for Practice**

**Spirituality and meditation.** In support of Mosak and Dreikurs (1967/2000) addition of the spiritual and self tasks to Adler’s life tasks, social interest also ties into spirituality due to the encouragement of connection (Cheston, 2000). Dinkmeyer and Losoncy (1996) defined encouragement as “the process of facilitating the development of a person’s inner resources and courage toward positive movement” (p. 7). Azoulay (1999) added encouragement is the bridge between an individual’s outer and inner world. The act of encouragement recognizes effort, improvement, and contribution to accomplishment of a (life) task.
Ansbacher (1979) stated Adler believed social interest was represented in the life tasks of friendship, love, and work. In addition, mental health required the ability to successfully cope with significant challenges within these major areas of life. Ansbacher suggested Adler drew parallels between the concept of God and social interest. For example, God and social interest are the end products of striving for perfection. Further, Adler believed mature forms of spiritual faith provided the individual with the necessary courage to transcend destructive inner forces that inhibit the expression of community feeling.

Additionally, spirituality can be represented as transcendence-of-self, which paralleled Adler’s view on social interest and accompanying qualities, like empathy and compassion (Leak, 2006). Ansbacher (1968/1991) provided support that social interest is an extension of current views of empathy when he described the person with a highly developed social interest as the person who is “interested in the interests of others” and is “able to understand and appreciate their subjective experience, their private worlds, their opinions” (p. 37). Watts (1998) quoted Adler: “We must be able to see with the eyes of another, listen with the ears of another, to feel with the heart of another” (p. 5). “Empathy, one of the strongest antidotes to shame, is the skill or ability to tap into one’s own experiences in order to connect with an experience someone else related to us; compassion is the willingness to be open to this process” (Brown, 2007, p. 44).

Brown suggested developing a sincere ability to empathize would be a key factor for forgiving and mediating shame.

Luskin (2002) referred to proactive forgiveness as a choice. Proactive forgiveness involves self-growth followed by the release of resentment and the restoration of well-being. This process is accomplished by choosing to forgive the offender (i.e., shamer). Therapists are encouraged to recognize that developing social interest as a therapeutic goal applies to
forgiveness issues (McBrien, 2004). An operational definition of forgiveness can be described as a shift in motivation from revenge-seeking and avoidance of contact with the offender (i.e., shamer) to an increase in feelings of goodwill and movement toward reconciliation (McCullough, Worthington, & Rachal, 1997).

**Group therapy.** Hasting (2009) indicated that shame develops in childhood as a result of unmet attachment needs. Hasting contends that avoidant behaviors are prevalent in shame-based individuals because of the unmet attachment needs. Therefore, Hasting’s guidelines to assist clients in healing include both individual and group work. Hasting suggested group work is the most effective method of building empathy by observing the effects of shame vicariously through the experience of others. Additionally, grief work is encouraged as part of healing the shame associated with abuse. Group observations and the acknowledgment of loss can increase compassionate self-awareness and decrease shame (Hastings, 2009).

Group therapy can have several advantages when addressing shame. As painful as the presence of others may be, it is precisely the exposure of shame in the community of others that is pathway out of that shame (Alonso & Rutan, 1988). Further, the group therapy experience offers several potential advantages for the treatment of shame (Alonso & Rutan, 1988; Hahn, 1997; Lear, 1990; Tanttam, 1990). According to Shapiro and Powers (2011) Yalom stated there are several advantageous healing factors offered by group therapy treatment. For example, vicariously hearing and learning about others’ experiences; normalizing the trauma of shame; self-disclosure (i.e., ability to share shame secrets safely within the mutually vulnerable group); finding one’s voice after isolation; learning of compensating methods which may or may not work; repeated exposure in group that creates an empathetic bond with others allowing the building of self-esteem with genuine social interest.
Role of the therapist. According to Ferguson (2006), the Adlerian family constellation process involves identifying and describing the multigenerational family members and how they are variably and functionally linked together. When combined with early recollections, one’s lifestyle path is revealed, as well as the individual’s emotional situation (Shifron, 2010). These early recollections may give clues as to the individual’s success in establishing a sense of belonging, and the individual’s lifestyle indicates how one is, perhaps errantly, attempting to compensate for a lack of belonging. At times, within a family system, individual dysfunction helps sustain the dysfunction of the whole (Bitter, 1991).

Perhaps consequences of one’s current lifestyle provide enough discouragement that people are motivated to seek help to alleviate the resulting emotional discomfort or relational dysfunction. While the need to belong is basic for every human being, every individual finds different and unique ways to satisfy this need. The therapist’s role is to unfold the individual’s creative special methods and to encourage the person to use these constructively (Shifron, 2010). In other words, differentiation-of-self within a dysfunctional family dynamic, and moving (from a minus to a plus) away from one’s own previous reflexive, discouraging lifestyle are concurrent goals (O’Connell, 1978).

The therapeutic process. During the initial conversational interview sessions (whether individual or family group), after completing the required forms and disclosures, it is advantageous to discuss the subjective conditions: the presenting problem, history of the problem, patterns, consequences of the problem, and previous treatment efforts. The next step is an investigation of the objective life situation by asking Adler’s miracle question which Dreikurs referred to as “the question:” “How would your life be different if you did not have this problem? What would you do if you were completely well?” (as cited in Powers & Griffith,
2012, p. 73). Further, the therapist can create and review the family constellation (map). By identifying family member characteristics and relationship alliances, a broader, more accurate picture of the client’s family constellation can be used as a reference tool in conjunction with additional input from the client to arrive at a mutual understanding of the client’s lifestyle and choices (Powers & Griffith, 2012).

The therapist should be mindful that the experience of shame (among other factors) can discourage an individual’s hope, motivation, or ability to move toward potential while encouraging various forms of safe-guarding, or other maladaptive, afflictive traits (Ansbacher & Ansbacher, 1956/1964). Because there are distinct differences between shame and guilt, interventions need to reflect these differences for effective goals and treatment. Shame refers to a defective self while guilt is a result of causing distress in another human being (Parker & Thomas, 2009). Therefore, guilt can create empathy which may lead to repair through compassion. On the other hand, shame creates personal, inward stress toward the self, creating direct and indirect anger which may lead to withdrawing and moving away from repair. Appropriate interventions would include focusing on the experience—if the predominate issue is shame and actions—if the predominate issue is guilt (Parker & Thomas, 2009).

Shame can limit a person’s ability to fully function in society due to the development and prolonged maintenance of psychological issues (Cândea & Szentágotai, 2013). Additionally, shame can interfere with an individual’s self-efficacy and belief system. According to Baldwin, Baldwin, and Ewald (2006), self-efficacy is a person’s belief in his or her ability to carry out a goal or desired action. Baldwin et al. revealed that maladaptive shame affects a person’s ability to fully function in carrying out desired goals. Further, Baldwin et al. found that the reduction of
shame through the therapeutic relationship of safety and acceptance could increase functionality of the client.

According to Parker and Thomas (2009), the goal of therapy is to create a more empowered individual who is able to accept imperfection and become more accepting of self. Once the underlying shame has been addressed, the individual can move through guilt and, ultimately, to self-responsibility. In addition, to create a more empowered individual, the stance of the therapist must be distinctly different in dealing with guilt and shame. Since guilt comes from a place of wrong actions, it can be addressed through a more behavioral, other-centered approach to resolution; however, shame comes from an inward sense of defectiveness; therefore, the therapist needs to focus on a more affirming and accepting approach to healing. Because clients will tend to evade the topic of shame, the therapist needs to be particularly aware of the client’s nonverbal clues regarding shame.

According to Schmmenti (2012), physically avoidant behaviors such as looking away, limited eye contact, inappropriate laughter, or changes in speech patterns may be associated with underlying shame. The therapist’s personal client interaction should also be taken into account, as the use of silence may be seen as critical and judgmental. In fact, since disclosure is very difficult for a shamed individual, it is imperative that the therapeutic environment be warm and accepting (Cândea & Szentágotai, 2013).

Van Vliet (2009), surveyed individuals who had gone through shameful experiences to determine the role of attributions in their healing process. In the study, attributions were defined as causal explanations for events that occurred in the lives of these individuals. Through an interviewing process, several attributions of causality surfaced including feelings of self-blame,
negative self-judgments, falling short of an internal standard, falling short of expectations of others, feeling exposed or unattractive to others, and feeling powerless.

Van Vliet (2009) reported that through the stages of healing, participants revealed three general areas that assisted with the resolution of the shameful experience. First, participants became aware that there were contributing causes outside of themselves that caused the shameful event. This awareness lessened the self-blame. Second, participants became aware of their own humanity and normalized the situation by accepting their imperfections. Third, participants had a more hopeful outlook toward the future by taking responsibility for change whether through forgiveness or making amends. Additionally, effective therapy included a focus on self-responsibility and future change that could help move the client toward these more positive attributions (Van Vliet, 2009).

**Shame assessments.** Since shame is an underlying factor in many psychopathological conditions, the proper assessment tools are especially helpful. Although the instruments used to directly assess shame are limited, there are assessments that may help delineate the core symptoms of shame that lead to maladaptive behaviors and thought processes. An important element of any scale in the assessment of shame is a clear delineation between shame and guilt (Cândea & Szentágotai, 2013).

According to Pulakos (1996) Tangney consistently reported differences in the psychological and social correlates of shame and guilt. Although there was a substantial positive correlation between scales measuring shame and guilt, shame was differentiated in its measurement of externalization or acting outward. Baldwin et al. (2006) stated Tangney and Dearing created one such scale: TOSCA3. The test is based on 16 scenarios ranked on a Likert scale from 1 (*not likely*) to 5 (*very likely*). For each scenario, there was a response for guilt and a
separate response for shame. The survey clearly distinguished the difference between guilt and shame and that they can be independently measured. (Reliability of the test is .85 for shame and .74 for guilt.)

Vikan et al. (2010) stated a second common scale is Cook’s Internalized Shame Scale (ISS). The ISS contains 24 negatively-worded items, six positively-worded items, and 12 self-esteem questions. The ISS is rated on a 5-point scale from never to almost always (Vikan et al., 2010). The ISS has utilization with patients who suffer depression or anxiety when used simultaneously with the Beck’s Depression Inventory (BDI) and Beck’s Anxiety Inventory (BAI). Further, when using these three scales together, anxiety was more prominent than depression in those who are struggling with shame related issues (Vikan et al., 2010).

The DSM-5 (APA, 2013) includes inappropriate guilt as a component of major depressive disorder; however, from a theoretical and empirical point-of-view, it would be more appropriate to employ feelings of shame when defining this type of psychopathology (Kim et al., 2011; Tangney & Tracey, 2012; Tracey & Robins, 2004).

**Summary**

Although manifested differently in various cultures (Chilton, 2012), shame is a universal emotion across gender, culture, and society (Kaufman, 1992). Gilbert (2003) stated shame occurs when individuals see themselves as unattractive or defective. Shame is created through memories that are reinforced through repeated negative experiences in childhood developing a life narrative that includes a negative self-concept, loss of connection (Van Vliet, 2008), and feelings of rejection in multiple life tasks (Adler, 1932).

Gilbert (2003) stated shame can be externalized when focusing on the negative opinion and behavior of others toward the self or internalized when the individual actually self-identifies
as the negative opinion of others. Shame, is an innate affect primarily related to feelings of inferiority based on the judging behavior of others (Harper & Hoopes, 1990).

Although guilt and shame are both considered self-conscious emotions, they are distinctly different (Tangney & Tracy, 2012). Guilt is a self-conscious emotion with a focus on an individual or behavior which can be repaired through conscious action. Shame, on the other hand, is a self-conscious emotion with a focus on self-evaluation and appraisal of one’s own worth which results in feelings of worthless, hopelessness, and loneliness (Berkovski, 2015).

Both shame and guilt are experienced when a person behaves in a way that is considered morally or socially unacceptable; however, each differs in the interpretation of the event (Tangney et al., 1996). While individuals who experience guilt feel empathy and regret and move toward repair, shame-prone individuals lack empathy (Tangney, 1991) and experience feelings of inferiority and worthlessness and move toward isolation (Muris & Meesters, 2014). Research supports the claim that shame is strongly related to psychopathology while guilt is only moderately related to psychopathology (Muris & Meesters, 2014; Tangney, et al. 1992).

Shame is created in early development when a parent/caregiver unconsciously blocks the child’s attempt to reestablish a positive affective state (Beebe & Lachman, 2002). For example, a look of disgust, rather than one of joy, can cause disconnect and a break in attachment. When moved from a positive affective state into a decelerating negative affect state, a child does not have the ability to auto-regulate (Yard, 2014). The inability to auto-regulate causes such a painful distress state that the child begins to withdraw and strives to become “unseen.” Over time, the pain of shame produced through alienation, discouragement, failure, worthlessness, and defectiveness manifests in various secondary reactions such as fear, distress, and rage (Yard 1014). According to Individual Psychology, every child needs to belong (Adler, 1932) and
therefore, the inability to connect with others may result in various forms of pathology (Shifron, 2010).

Parenting is a very important aspect in developing a sense of belonging. While the reintegrative style of parenting involves the parent having positive interactions with the child through awareness and involvement, parental stigmatization involves such negative interactions as neglect, abuse, and/or hostility, and treating the child as socially defective (Pontzer, 2010). The environment created by the parental stigmatization (i.e., hostility and rejection) contributes to a child's lack of attachment and empathy and can lead to behaviors of hostility in social settings. Loader (1998) stated a culture of shame can even develop into physical, emotional, or relational abuse in which the child feels deeply flawed (Kaufman, 1998). Further, the effect on the child ultimately creates a generational cycle of shame responses (Kinston, 1987).

The development of shame, then, has its genesis in early development. As mistaken beliefs are triggered throughout childhood and into adulthood, an individual sees the self as defective and bad (Whelton & Greenberg, 2005). A shame-based individual develops a life narrative that supports the negative belief system (Bernsten & Rubin, 2007). Early shame memories become externalized as one sees the world as condemning and judgmental. In addition, shame memories become internalized as one begins to believe these messages as true. The shame-prone individual, often becomes stuck in feelings of worthless and powerlessness that interfere with many life tasks (Stuewig, et al., 2015).

Shame-proneness can be associated with several psychopathological manifestations including, depression, anxiety (Fergus, Valentiner, McGrath, & Jencius, 2010), eating disorders (Grabhorn et al., 2006), PTSD, social phobias (Fergus et al., 2010), conduct disorders (Pontzer, 2010), bipolar, and personality disorders (Brown et al., 2009). Starting in childhood, shame can
result in such disorders as anxiety and depression (Mills et al., 2015). To manage the discomfort of shame, a number of defensive tactics are used in an attempt to regulate emotions. These defensive tactics include a wide range of responses including aggression, indifference, and isolation (Loader, 1998), dependency, achievement sabotage, fantasy, perfectionism, (Schoenleber & Berenbaum, 2012) and chronic rage (Tangney et al., 1992; Tangney et al., 1996).

It is very important to distinguish between guilt and shame when creating effective interventions and treatment goals. Interventions should focus on actions such as other-centered repair if the prevailing issue is guilt related and personal empowerment through self-esteem building if the prevailing issue is shame related. The therapist’s demeanor needs to be very affirming and accepting when working with shame (Parker & Thomas, 2009). Effective therapy creates hope and helps the individual focus on self-responsibility, future change (Van Vliet, 2009), and increase self-efficacy (Baldwin et al., 2006).

Internal family systems looks at shame as a protective part that when transformed into a guilt response becomes repairable and allows the individual to become more compassionate and accepting of self (Sweezy, 2011). Compassionate mind training which is based on attachment theory, also focuses on self-acceptance and compassion. Compassionate mind training incorporates mindfulness techniques such as mindful acceptance, non-judgmental warmth, and distress tolerance (Gilbert & Procter, 2006). Bankard (2015) suggested mediation may be helpful in increasing self-compassion (Bankard, 2015).

Behavioral approaches to shame may be beneficial (Cândea & Szentágotai, 2013). Cognitive restructuring used in cognitive behavioral therapy may reduce fear of judgment. Other techniques might include the use of “opposite action” or acting “as if” to reduce avoidance and stop ruminating thoughts. Individual Psychology integrates many of these interventions
including the belief that the individual needs the courage to be imperfect, the use of Socratic questioning and “what if” statements.

Assessment tools to measure and delineate shame from guilt are very limited. The TOSCA3 (Baldwin et al., 2006) is a scale that includes separate responses in each of the 16 scenarios in the test to distinguish between guilt and shame. When used in conjunction with the Beck’s Depression Inventory and the Beck’s Anxiety Inventory, the Cook’s Internalized Shame Scale can be very effective in determined the effects of shame on an individual (Vikan et al., 2010).

With all the data and correlations taken together, the results suggest that assessing the distinction between guilt and shame may be very helpful when assisting individuals who present with aggressive or antisocial behaviors. While feelings of anger and acts of aggression may not be rooted in shame, shame is often an element of the behavior. It is especially important to consider this possibility because feelings of shame are often overlooked in clinical and educational settings. Further, interventions used for aggressive and acting out behaviors may be more effective when identifying and addressing feelings of shame and low self-worth, which may likely be involved in many instances of maladaptive responses to anger.

In the assessment process, it is important that clinicians should explore experiences of different types of childhood trauma (including bullying and teasing) and the impact that those experiences had on the individual’s emotions, cognitions, and behaviors in adulthood. Treatment programs may need to target the related social-emotional states of teasing and bullying (Sweetingham & Waller, 2007).
**Recommendations for Future Research**

Integration of Adler’s individual psychology (IP) with Bowen’s (1978) systemic family theory, which includes the differentiation of self from the family could add a motivating (for both the client and clinician) flow to therapy, and help the client understand and deal with family dysfunction. Frequently, a client may feel hopelessly trapped within an intergenerational family pattern of dysfunction and emotional reactivity accompanied by unpleasant and demeaning behaviors.

Adler’s family constellation, or family map, could become the foundational starting point to observe intergenerational relationship patterns (Shifron, 2010). Researchers could study the family dynamics, trends, and patterns of the resulting lifestyle path (Shifron, 2010). Future researchers could study the family constellation as it aligns with Bowen’s (1978) systemic family theory. Studies could include a focus on intra-familial and multigenerational relationships and the concept of the differentiation of self as a means to break the chain of intergenerational shame and dysfunction (Hurst et al., 1996).

**Conclusion**

What would it be worth to heal the wounds of shame? While the child cannot identify the shame emotion, the emotion none-the-less, may often cause a subconscious emotional “shadow” which is always ready to be triggered and obscure self-acceptance and/or belonging. Unless mediated, shame may represent a lifetime of never being quite right or good enough. Usually, the perpetrator is oblivious that he or she is passing on what they themselves may have been subjected to. Frequently, people do not realize shame can be addressed and never examine the impact of shame.
Addressing only the manifesting psychopathologies of shame, without addressing the root of the problem, is like trying to get rid of weeds by trimming off the top of the weed; it may look good for a while, but the cause of the problem has not been addressed and will surely reappear. When life satisfaction is continually undermined by shame, it offers a good reason to examine and understand shame by revealing the source, situations, and how unwittingly shame may have been an intergenerational process.

Uncovering and acknowledging the painful emotion along with its source may be the gateway to forgiveness, and the realization that the future can be different for future generations. Those memories may be rewritten, right-sized, or accepted and remembered as an unintentional burden upon a vulnerable, fragile mind. Memories may serve as a marker for how far one has grown and differentiated into a new, free self.

Empathy and compassion for the source of shame (e.g., a parent/caregiver) may give way to the realization of how the perpetrator did not realize there was another way to be. Self-forgiveness for carrying compromising mistaken beliefs at the core of one’s being for years, is worth the effort. In addition, self-forgiveness is worth the effort because of the impact it will have on various tasks-of-life relationships. Future research on shame would be beneficial to further understand the manifestations of shame and appropriate interventions for treatment.
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