> “People with chronic shame develop a shame-bound identity with an abiding sense of not being good enough, unlovable, unacceptable or worthless.”

CHRONIC SHAME

By John Andersen

CHRONIC SHAME IS A COMMON FACTOR IN MANY PSYCHOPATHOLOGIES

Even though chronic shame is a common contributing factor to the development and maintenance of many of the psychological problems our clients present with, it is surprisingly overlooked by many counsellors and psychologists. Yet effective therapy that generates lasting change necessarily involves resolving chronic shame when it is a contributing factor. This article first briefly lays down a theoretical framework for conceptualizing shame, followed by a brief literature review that demonstrates the extent to which chronic shame is linked to many common psychopathologies.

THEORETICAL FRAMEWORK

The word 'shame' refers to four distinct related psychological phenomena. Thus, theoretically, shame can be conceptualized as having four dimensions.

The first dimension is anticipatory shame. Research has found that this is experienced as anxiety regarding the prospect of humiliation or disgrace, and a sense of modesty that protects individual privacy. Anticipatory shame has an adaptive social function in inhibiting socially disapproved behaviour, supporting conformity to social norms, and as a sense of modesty and privacy that protects individual boundaries (Baumeister & Tice, 1990; Buss, 1990; de Hooge, Breugelmans & Zeelenberg, 2008; Nichols, 1991; Paternoster & Simpson, 1996; Pines, 1995; Scheff, 1988). The positive value of this sense of shame is reflected in The Talmud which states, "A sense of shame is a lovely sign in a man. Whoever has a sense of shame will not sin so quickly: but whoever shows no sense of shame in his visage, his father surely never stood on Mount Sinai."[1]

The second dimension is humiliation or public disgrace. This is the social event of being humiliated and publically disgraced by others. Social stigma is a chronic form of disgrace and marginalization. Disgrace is highly distressing because it is a powerful act of social rejection (Gilmore,1987; Smith, Webster, Parrott & Eyre, 2002). It is worth noting that Old Testament references to shame and disgrace primarily refer to this dimension of shame (Olyan, 1996; Steibert, 2002).

The third dimension is acute shame, an intensely painful emotional reaction that typically corresponds to, but is distinct from public humiliation and disgrace. We are all familiar with the intensely painful emotion of shame that makes us want to hide and simply disappear, which is frequently accompanied with scathing self-criticism and self-rejection. What is central to shame is a negative self-evaluation of possessing a basic flaw that renders the person unlovable or unacceptable. Behind the emotion of acute shame if a fear of abandonment, rejection, and loss of love according to Lewis (1992), whereas Kaufman(1985) recognized that it is evoked by breaking of the social bond with others.

1 Talmud, Nedarim fol 20 as cited in Carl Schneider, "A Mature Sense of Shame," in The Many Faces of Shame, ed. Donald L. Nathanson. London/New York: Guilford Press, (1987), 199.

A wide range of situations provide the antecedent conditions for the experience of acute shame. Failure to meet internal standards, social comparisons of being inferior, and public disgrace all provide evidence to support the case for this negative self-evaluation. A common factor in these situations that evoke acute shame is exposure to negative evaluation by others. Studies have found that exposure to negative evaluation by others, and public exposure of both moral transgressions and non-moral incompetence and inferiority can evoke acute shame (Gilbert, 1998; Smith, Webster, Parrott & Eyre, 2002).

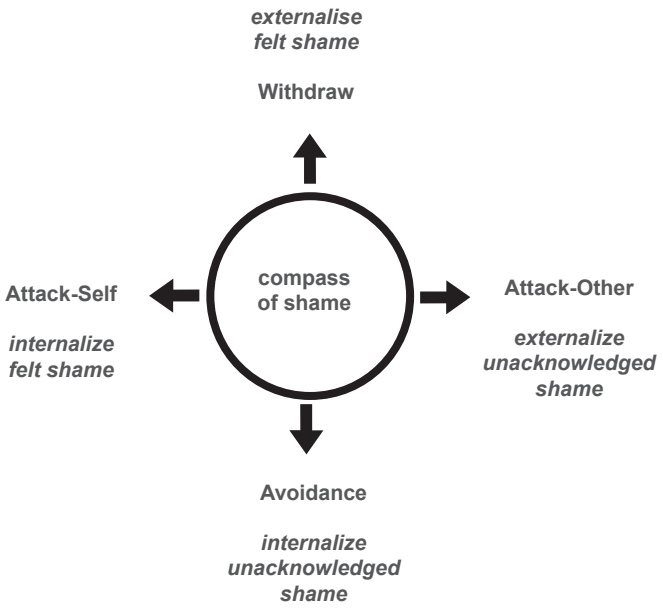
There is a complex relation between public disgrace and acute shame. The psychological impact of social rejection and disgrace is the result from an interaction between the appraised meaning of the social actions of rejection and the way a person chooses to respond to those experiences. For example, 1 Peter 4:14-16 exhorts those who are reviled (objects of public disgrace and humiliation) because they are Christians to not feel ashamed (acute shame), but regard it as a privilege and a blessing. The extent to which social rejection evokes a corresponding response of acute shame is influenced by whether the rejection is public or private, whether the intention is personal and specific or not personal, the relation between the person and the rejecters, the amount of social support, and the robustness of a person's self-esteem (Asher, Rose & Gabriel, 2001; Matos & Pinto-Gouveia, 2010).

The fourth dimension of shame is chronic shame. People with chronic shame develop a shame-bound identity with an abiding sense of not being good enough, unlovable, unacceptable, or worthless. As Nichols (1991:40) expressed it, "A pervasive sense of shame is the deep conviction that one is fundamentally bad, unworthy, inadequate, defective, and ultimately unlovable." According to Patel et al, (2007) and Pinto-Gouveia and Matos (2011) chronic shame results when a person incorporates memories of shame into their autobiographical narrative with the result that they become identity schema. Chronic shame manifests in shame-proneness, a low or unstable self-esteem, or a shame-bound identity. Shame-proneness refers to a vulnerability to acute shame and sensitivity to being shamed in social situations (Tangney, 1990).

Chronic shame has a complex relationship to acute shame. Acute shame is highly distressing because it calls into question the adequacy of our identity. A person recovers from shame intact when he or she is able to retain and reaffirm his or her identity following an experience of shame. When an experience of shame leads to a modification of one's identity in shameful terms, the impact of acute shame upon identity becomes internalized in the form of chronic shame. Repeated experiences of shame, which occur in abusive relationships, are much more likely to result in chronic shame, than isolated experiences of shame. It is chronic shame that we most often have to address in the counselling room.

DEFENCE SCRIPTS AGAINST SHAME

The aversive effect of shame makes it a powerful motivator for avoiding situations of humiliation and public disgrace. People generally develop defences against shame, which in turn, shape their social behaviour. Furthermore, people develop stylized defences against chronic shame. The presence of these defensive scripts is often the give-away that chronic shame is an underlying issue. Nichols (1991:98-102) has identified four defence scripts against shame, illustrated below:



These four defence scripts reflect whether or not people acknowledge their shame or suppress it, and whether people externalize the shame by blaming or projecting it onto others or internalize their shame and directing it against themselves. The clinical significance of these defence styles is that people generally do not openly manifest shame in counselling. Rather, the presence of a defence style points to underlying shame. So we need to be able to recognize these defence styles for what they are.

The first defence script is Withdrawal. It can be overt and physical or psychological and internal. This defence script reflects the action tendency of acute shame to hide and withdraw from the situation. Withdrawal commonly involves literally departing from the situation. It can take a more subtle form of becoming quiet and withdrawing from interaction, while remaining physically present, but disengaged.

The second defence script of Attack Self involves the person becoming his or her own shamer, because it is less humiliating to shame oneself, rather than openly acknowledge the humiliation of another. It can take the forms of self-criticism, self-derogation, and self-blame. Self-criticism takes the form of an internal dialogue characterized by self-contempt, self-hatred, or rage at oneself, which is a manifestation of inner alienation and self-rejection.

The third defence script is Avoidance. The avoidance script does not acknowledge the shame. There is little conscious awareness of shame, and avoidance operates at a subconscious level. Avoidance takes many forms. It can take the form of the psychological defences of disavowal, minimizing, denial, and distraction. It can involve repression of negative emotion leading to numbness, apathy, or boredom. Another set of avoidance strategies is to seek perfection, because the perfect self cannot be defective, which can amount to narcissism. This can manifest as over-conscientiousness and perfectionism, where a person must avoid mistakes at all costs.

The fourth defence script is Attack-Other. Shame is not acknowledged, but is generally masked under anger and rage. Blame is externalized onto other people. It can manifest as arrogance, contempt of others, or superiority. This defensive script involves projecting hurt and distress of shame onto other persons in the form of rage, anger and violence. It is the dynamic fuelling domestic violence. This defence script is very

damaging to relationships, and can reproduce a sense of shame in the objects of their attacks.

This dynamic cycle between shame and control characterized by reasserted control, rising tension, violent release of tension, and remorse is a feature of shame-bound family systems (Fossum & Mason, 1989). Research has found that partners with a high degree of shame-proneness are more likely to be emotionally abusive with their partners, and are more prone to anger outbursts, that can lead to episodes of violence (Dutton,vanGinkel & Starzomski, 1995; Harper & Arias, 2004; Harper, Austin, Cerone & Arias, 2005). A five year longitudinal study in New Zealand by Donnellan et al (2007) also found that chronic shame among adolescents was related to externalizing problems, aggression, poor school achievement, and delinquency.

CHRONIC SHAME AND PSYCHOPATHOLOGY

Chronic shame leads to the adoption of maladaptive schemas, which are negative shame-based core beliefs about oneself. These are expressed in self-statements such as, "You're a failure," You're no good," "You're totally useless," "You're worthless". Maladaptive schema reflect expectations and core self-beliefs of abandonment, rejection, mistrust, defectiveness, social isolation, incompetence, helplessness, failure, being unimportant, pessimism, emotional inhibition, self-punitiveness, perfectionism. These self-statements are generally very painful. Chronic shame, then involves the development of a habitual internal dialogue characterized by these kinds of self-shaming self-statements. Consequently, chronic shame is a very painful emotional condition to be in. This deep emotional pain lies behind the connection between chronic shame and a range of psychological problems and personality disorders.

Research suggests that shame contributes to the following psychopathologies: alcoholism, substance abuse, depression, eating disorders, social and general anxiety, obsessive compulsive disorder, post-traumatic stress disorder, sexual dysfunctions, paraphilias, antisocial personality disorder, borderline personality disorder, pathological narcissism, psychoanalytic neurosis, suicide, and violence (Harder, 1995; Harder, Cutler & Rockart, 1992; Kaufman, 1989; Tangney, Wagner & Gramzow, 1992).

The dynamic behind many psychopathologies is that they are either failures to achieve emotional self-regulation or maladaptive strategies for achieving emotional self-regulation. Emotional self-regulation takes precedence over impulse control, which means that during emotional distress, people are less likely to be self-controlled, but do impulsive and immediately gratifying behaviours to regulate affect. This phenomenon is pertinent to anger and other impulsive behaviours, eating for gratification, procrastination, and seeking immediate gratification. Giving emotional self-regulation precedence is motivated by the expectancy that emotional self-regulation that reduces distress in the short term will restore emotional equilibrium that will enable an unimpaired focus on pursuing personal goals (Tice, Bratslavsky & Baumeister, 2001).

Research suggests that there is a clear relationship between chronic shame and depression. Depression is generated and maintained through a complex interaction involving early childhood experiences, the development of pessimistic negative cognitive schema, and interpersonal social factors (Lara & Klein, 1999). Chronic shame has been widely implicated in depression through its association with negative cognitive schema (Lewis, 1987; Thompson & Berenbaum, 2006; Tilghman-Osborne et al, 2008). These include cognitive self-attributions characterized by high standards, self-criticism and self-blame, personal inadequacy, rejection by others. Negative over-generalized self-attributions also generated depression (Phillips, Hine & Thorsteinsson, 2010; Wisco, 2009). There appears to be a vicious cycle between negative self-attributions and depression in that when a person is in a low mood, he or she is more likely to engage in self-deprecation and negative ruminations that function to deepen and prolong the depressed mood (Brown & Mankowski, 1993; Cheung, Gilbert & Irons, 2004; Hammen et al, 1985; Mor & Winquist, 2002; Orth, Berking & Burkhardt, 2006; Spasojević& Alloy, 2001). Low self-esteem has been identified as a risk factor for developing depression, and also accompanies depression (Brown et al., 1986; Highfield et al., 2010; Maestas et al., 2008).

Chronic shame can also contribute to a number of anxiety disorders. Shame-proneness is associated with symptoms of social anxiety and generalized anxiety disorder. It is associated with the severity of obsessive compulsive disorder symptoms but not with the occurrence of the disorder itself (Fergus et al., 2010).

Chronic shame has also been identified as a contributing feature to complex chronic post-traumatic stress disorder (PTSD). PTSD can occur after a person has experienced a traumatic event that involved the threat or occurrence of a serious injury or fatality to oneself or someone else. Chronic shame has a complex two-fold relationship to PTSD in that it is both a risk factor, and also a consequence of trauma (Brewin & Holmes, 2003; Lee, Scragg & Turner, 2001; Stone, 1992). Traumatic events and disasters can evoke shame to the degree to which one's weakness and helplessness is revealed, and where the trauma leads to a shattering of one's assumptions regarding the nature of the universe (i.e., one's world view). Unacknowledged shame often disguised as survivor guilt increases the likelihood of developing chronic PTSD, depression, and substance abuse (Wilson, Drozdek & Turkovic, 2007). The personality fragility of shame-proneness is a risk factor in people developing PTSD after adult traumatic experiences (Lansky, 1995; Lee, Scragg & Turner, 2001). This is partly because of confusion regarding responsibility for the trauma in that they blame themselves for failing to prevent the trauma (Andrews et al., 2000).

Chronic shame in the forms of low self-esteem, bodily shame, and self-critical perfectionism is a causal factor in eating disorders (Hayaki, Friedman, & Brownell, 2002; Sanftner et al, 1995; Troop & Redshaw, 2012). Eating disorders can develop from an internalization of cultural standards of beauty and thinness that emphasize physical appearance as a contingency of self-worth, when combined with low self-esteem focused on body shame and anxiety about social acceptance (Bulik et al., 1991; Fitzsimmons-Craft, 2011; Wolson, 1998). When this line of thinking leads to a preoccupation with thinness as the solution, it becomes a recipe for developing an eating disorder (Keel, 2007; Kerr, 2006; Stice,2002). A history of child maltreatment, parental overprotection coupled with lack of warmth and acceptance, sexual abuse, or bullying and teasing by peers about appearance, increases the likelihood of subsequently developing an eating disorder (Keith, Gillanders & Simpson, 2009; Smolak & Mumen, 2002; Sweetingham & Waller, 2008). The key mediating factor between these events and eating disorders has been found to be the development of bodily shame (Slevec & Tiggemann, 2011).

Another way that shame interacts with eating disorders is that women with an eating disorder commonly experience shame and guilt with respect to eating. This subsequent shame and guilt about eating is a

feature of the eating disorder (Frank, 1991). The result is a dangerous vicious cycle whereby the solution of thinness is never met, but the preexisting bodily shame generates a relentless drive for ever losing more weight (Chemyak & Lowe, 2010). This drive is supported by increased dysmorphia or a perceptual bias regarding one's own fatness, regardless of how underweight the person is. What this means is that eating disorders are fundamentally a pathological acting out of shame. Consequently, the key issue that needs to be addressed in treating them is the high level of internalized shame and replacing it with core self-beliefs of adequacy and authentic pride (Goss & Allan, 2009).

There is a complex relationship between chronic shame and alcoholism. There are three types of motivations behind people engaging in illicit drug use. They are motivated either by a desire to enhance positive affect and greater stimulation sensation, for social affiliation in settings that involve drug use, or as a coping strategy for regulating or reducing negative affect. Research has found that drug addiction is most likely to result when drugs are utilized as a coping strategy for medicating and regulating negative affect. Many studies have found that alcoholics suffer from high levels of chronic internalized shame (Carpenter & Hasin, 1999; Cheetham, et al., 2010; Cooper et al., 1995; Halkitis, 2009; Holahan et al., 2001). Yet alcoholism itself destroys a person's sense of self-worth, and engenders shame on its own accord. So the evidence that alcoholics have high degrees of internalized shame reflects both these dynamics (Dearing, Stuewig & Tangney, 2005; O'Connor et al., 1994; Young, 1991). I have found that particularly with female addicts, I need to address chronic shame and low self-esteem first, and then build a sense of self-worth and positive self-esteem as a platform for addressing the addiction.

CLINICAL IMPLICATIONS

The review of research into the relationship of chronic shame to common psychological problems supports my contention that it is essential for counsellors to be vigilant for indirect indicators of the presence of chronic shame in our clients. The achievement of mental well-being requires identity change that involves the replacement of chronic shame with a sense of adequacy. This is achieved by addressing underlying identity issues, rather than addressing symptomatology

A common reason why therapy fails to lead to lasting change is that all too commonly counsellors and psychologists focus on addressing the symptoms the client is presenting at the cost of overlooking the underlying dynamics of chronic shame. For example, CBT with its emphasis on contesting maladaptive self-statements by rational statements, either results in more the person developing more sophisticated defences against shame or creating a head vs heart dynamic of internal conflict. If an underlying sense of chronic shame remains, it will tend to undermine on an emotional level CBT generated therapeutic change on the cognitive level. The result is that either therapeutic change needs to be externally maintained by ongoing therapeutic support, or there will be a reversion back to shame-based distress. Consequently, I believe that therapeutic change is unsustainable over the long haul unless supported by corresponding identity change.

Unless therapy addresses and removes chronic shame, the best outcome it can achieve is the replacement maladaptive defence strategies with more adaptive ones.

Achieving identity change from a shame-bound identity to a self-affirming identity will flow through to a corresponding modification in behaviour. Furthermore, this behavioural change will be self-sustaining because it is supported on an emotional level by a positive identity and self-esteem. Addressing chronic shame in therapy requires a transformation of a person's identity from a shame-bound identity to one based on a positive self-affirming view of the self, self-acceptance, and a stance of love and kindness towards oneself. Bringing about such a change can make therapy a life transforming experience. It can release new-found reserves of emotional resilience and positive creative emotional energy that can lead to a new life of emotional stability, self-worth, and productive creativity.

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