CAN TELLING THE SHAME-EVOKING STORY IN AN ONLINE FORMAT REDUCE SHAME EXPERIENCED?

by

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Liberty University

A Dissertation Presented in Partial Fulfillment of the Requirements for the Degree

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ABSTRACT

Shame is a common experience for all humans. When shame is high for an individual, it can be debilitating and even paralyzing for that person. Shame can have a negative effect on how a person feels about oneself, destroy relationships, and lead to mental health disorders. In the counseling office, shame can delay or interfere with mental health care and create a barrier in the therapeutic alliance. Shame is often about being seen and tied to a distressing secret one holds. With the increase of online communication, people have become more comfortable sharing in a digital format. The purpose of this study was to explore whether sharing a shame-evoking secret in an online format can reduce the shame one is experiencing. Participants (n = 1002) were recruited via an online survey platform. The participants who indicated they had a shame-evoking secret were randomly assigned to one of two groups, one group had the opportunity to share the secret before taking shame inventories, and the other took the inventories without having shared their stories. The shame inventories included the experience of shame scale, the external and internal shame scale, and the other as shamer scale – 2. The story-telling group scored slightly lower across all shame inventories than the non-story-telling group. While the results were not enough to declare statistical significance, they are meaningful in opening the door to further research.

Keywords: shame, secrets, disclosure, internal shame, external shame, use of technology, online format

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CHAPTER ONE: INTRODUCTION

Shame is a common experience for humans, and disclosing shame is a difficult process. Consider an analogy of a baby being born: the only life this baby knows is within the womb, a place that feels like perfect protection and provision for all the child would need, until one day when the baby starts feeling pressed on all sides, longing for more. The perfect environment that provided the nutrients and protection for survival is also a dark and lonely place. The pressure gets to be too much. Perhaps the baby feels like life as they know it is over; they are getting pressed and pushed to their death, so they believe. It is uncomfortable, maybe even painful as they come out of that secret place. What feels like an impending death, is birth; it is the beginning of real life, one of freedom. Life outside of the womb of shame feels like an impossible dream for many, but once it is experienced, there is no turning back. Shame is often linked to a painful secret one is concealing (MacGinley et al., 2019). As people share these intimate secrets, no matter how difficult, painful, and anxiety-provoking the experience is before, during, and even immediately after, they have no regrets because they feel empowered, relieved, and released from shame (Farber et al., 2004). In these cases, people report that following their disclosures a sense of pride and authenticity is experienced (Farber et al., 2004). The purpose of this study is to learn more about helping individuals disclose secrets to discover this freedom from shame.

Background of the Problem

Historically from a cultural standpoint, it can be argued shame has been around as long as the existence of humans. Judaism, Christian, and Islamic traditions can all point to the birth of shame coinciding with the original disobedience of God by Adam and Eve in the Garden of Eden

(Genesis 3:7; Surah Al-A'raf 7:20-22). In these accounts, Adam and Eve ate the forbidden fruit, having been deceived by Satan or Shaitan. Even though they first saw it with their eyes, touched it with their hands, and bit it with their mouths, their response was to cover themselves with leaves when they felt a deep sense of shame. While eastern religions may not hold to the account of Adam and Eve, the intensity of shame recognized in these traditions is steep because there are both cultural expectations to strive for perfection and not fail, as well as a stigma surrounding seeking help for the emotional pressure felt (Finn & Rubin, 2014; Sharma & Tummala-Narra, 2014). Shame must be very delicately, yet quickly, approached with clients of these traditions because of this stigma; it is important to break down this barrier to increase a client's likelihood of continuing treatment (Finn & Rubin, 2014). Similarly, within religious contexts, there are histories revolving around the telling of secrets or confession. While in Judaism, confession has always been between a person and God, in the Christian tradition, this has changed over time, moving from public confession to private confession with a priest as a mediator (Turner, 2020). After the Reformation, when the church split between the Catholic and Protestants traditions, the Catholics continued priest-mediated confession while the Protestants went back to the early Judaic private confessions (Turner, 2020). Although controversial, confession was used successfully in the psychological setting in the late 1800s as a therapeutic methodology by Freud (Rebelsky, 1963). While the variance in the tradition of confession is apparent across different religions, the benefit of psychological improvement as a result of confession has been demonstrated among Buddhists, Catholics, Protestants, and Muslims (Rana et al., 2015).

Historically within psychological research, shame and guilt are often paired together to understand self-conscious emotions both in research and in clinical assessment (Tangney, 1990). Recently, research has begun to look at these as two separate constructs (Tangney, 1996). Shame

and guilt have emerged as two separate constructs because guilt does not demonstrate links to mental health disorders the way shame consistently does (Beck et al., 2011; Tangney, Wagner, & Gramzow, 1992). The major distinction between guilt and shame is this: guilt is when a person feels bad about what they have done (behavior), and shame is when one feels bad about who they are. This study will be considering only the construct of shame.

Shame can present positively in the aspect of motivation, where people are driven by shame or the fear of exposure, and as a result, perform well; however, when people are driven by performance like this and then perceive themselves as failing, shame hits even harder (Case et al., 2018; Wang et al., 2018). The context of performance as in this example would be considered external shame, which is shame founded on the perceived view of others. The other side of shame is internal shame, which consists of one's poor view of self and can include aspects like the way one looks, the way one acts or interacts with others, or a lack of competence in an area whether it is noticeable by others or not (Andrews & Hunter, 1997).

The degree to which a person feels shame varies, often dependent upon early childhood interactions with parents (Steiner, 2015). Parental rejection and harsh parenting in childhood have been linked to increased shame-proneness in adolescence, resulting in greater depression and delinquency (Stuewig & McCloskey, 2005). There are also significant correlations between childhood emotional abuse or neglect and internalized shame experienced later in adulthood (Fowke et al., 2012). In cases of adult victims of childhood sexual abuse, the shame is described as debilitating, profound, and highly aversive, causing maladaptive coping skills in relationships (Kim et al., 2009). In addition to relationship difficulties, other clinical presentations related to shame include dissociation, anger and aggression, obsessive-compulsive disorder, depression,

anxiety disorders, somatization, psychoticism, and interpersonal sensitivity (Allan et al., 2016; Dorahy, 2010; Muris et al., 2018; Platt & Freyd, 2015; Tangney, Wagner, & Gramzow, 1992).

Shame is also positively correlated with neuroticism; although, the relationship between these factors seems to vary depending on the study. Some studies report shame may mediate neuroticism (Reid et al., 2011), others say neuroticism seems to mediate shame (Peters et al., 2018), and many say the direction of the relationship is unable to be determined (Alcaraz-Ibanez et al., 2020; Christensen et al., 1993; Gamble, et al., 2006; Muris et al., 2018; Zarei, Momeni, & Mohammadkhani, 2018). Social expectations specific to the cultural context of the client also influence changes between shame and neuroticism (Darvill et al., 1992; Erden & Akbag, 2015; Johnson et al., 1987; Zhong et al., 2008).

Shame has emerged as the most common reason people keep secrets (Baumann & Hill, 2016), and secrets lead to other secrets (Squire, 2015). Secrets "protect" the individual, and this desperate need for protection one feels overrides the need to be known by telling the secret (Afifi et al., 2005). The longing one has to be known can feel too overwhelming when it comes to revealing a secret because telling involves remembering and reframing things that are not talked about (Squire, 2015). This is demonstrated both in the case of trauma, when a victim fears not being believed when telling the story (Bermudez et al., 2018), and with transgression, when the fear of one's deficiencies being made known results in hiding as Volk et al. (2016) mention.

Shame is commonly reported in research as a significant barrier for those seeking mental health care. This becomes increasingly difficult in treatment with clients who have experienced trauma such as sex-trafficking because of the time limits on victims' available treatment programs (Clawson et al., 2008). Clawson et al. explain the coping strategies these victims must adopt to survive lead them to keep involvement in trafficking a secret, including from their

therapist. Identifying cases involving shame are not always as evident. In fact, it is encouraged for any clinician working with a client who reports childhood maltreatment to be on high alert for the possibility that the client is experiencing high internal shame (Fowke et al., 2012). Early shame experiences are recorded in the memory as trauma and leave clients vulnerable to psychopathological symptoms as adults as they re-experience this shame trauma in the form of flashbacks, which causes heightened arousal and fear that interferes with normal processing (Matos & Pinto-Gouveia, 2010). Because shame memories function like trauma memories, targeting shame can improve treatment outcomes (Shahar et al., 2015). The evidence of this has proven true when adapting treatment for substance use disorder (Kirschbaum et al., 2019) and social anxiety disorder (Shahar et al., 2015) among other disorders, with one clinician urging the importance to first address shame before being able to successfully dive into deeper issues like anxiety and depression (Steiner, 2015).

It can take two years or more of twice per week psychotherapy for a client to reach the point of choosing to be vulnerable (Contreras et al., 2017). An online study about sexual behavior among women showed technology may play a role in influencing feelings of shame, where younger women who were more comfortable with using technology and perhaps used technology as part of their sexual behavior, showed less shame than older women (Dhuffar & Griffiths, 2014). These authors suggest it could be the familiarity the younger crowd has with technology, including the comfort they feel with disclosing shameful information online. Giving clients an opportunity to be creative has also shown to decrease levels of shame, which has been shown in using creative arts, such as drawing or painting (Wilson, 2000) and writing (Afifi et al., 2017; Brown, 2006). Some clients feel more confident in being able to share their secret if they were able to rehearse the story ahead of time (Afifi et al., 2005). For some, the experience of

being seen is what deters them from sharing their shame stories; the fear of the raw vulnerability required in revealing a secret gets in the way of clients being able to look at the distressing memory and work through it (Steiner, 2015).

Purpose of the Study

Understanding shame better is critical to excellence in serving clients since shame should be addressed directly, even if it presents itself under the disguise of many different symptoms (Wertheim et al., 2018; Zerbe, 2016). In the clinical setting, being able to share a shameful secret can alleviate distress the client is experiencing, whether that is through compassionate mind training (Gilbert & Procter, 2006), acceptance and commitment therapy, dialectical behavior therapy, or any form of talk therapy that involves psychoeducation where normalizing the client's experiences is a part of the counseling process (Weingarden et al., 2016). However, for some clients, the fear of being seen, or being emotionally naked, is too overwhelming, and shame becomes a barrier to treatment (Anderson & Clarke, 2019; Steiner, 2015; Zhang, et al., 2019).

The purpose of this study is to understand if telling the story in itself can reduce shame, outside of a therapeutic context and without a direct audience. The study will be conducted as an online survey starting with questions about one's tendency towards shame and secrecy. For participants indicating they are currently holding an important or distressing secret, they will be randomly assigned to either the story-telling group or the control group. The story-telling group will have the opportunity to share their secrets in an online format before taking the shame inventories. The control group will take the shame inventories before having the opportunity to share their stories. If the story-telling group reports lower average shame levels than the control group, it can be presumed sharing the secrets was effective in reducing shame. If this proves true,

it can inform clinicians for more effective intake procedures, as well as provide a strategy to help expedite treatment for any client.

Research Questions

The Problem

Escaping the shame cycle, which will be discussed in chapter two, can feel impossible to people. Often, they are uncertain how to begin that process, which is detrimental to their relationships, including within the clinical setting. Disclosing the shame means it is no longer a secret, and it can lose its power (MacGinley et al., 2019). However, disclosure can also open a person up to tremendous vulnerability (Shaughnessy M. J., 2018; Steiner, 2015).

With the aim of informing clinicians on how to help clients reveal their distressing secrets, this study seeks to answer the following questions:

1. Does telling a secret, or shame-evoking story, in itself (without an audience) reduce the level of shame felt?
2. Does sharing the secret, or shame-evoking story, change one's view of self?
3. Does sharing the secret, or shame-evoking story, change the perceived view of others?

In addition to these research questions, this study will measure a participant's likelihood of keeping secrets while also controlling for shame-proneness and neuroticism.

Assumptions and Limitations

An important limitation in this study is the immediacy in which the shame surveys and the story-telling take place. Research shows disclosing a secret can result in more negative emotions immediately after but shows relief later, meaning the act of telling may be initially difficult and painful but brings benefits to individuals in the long-term (Baumann & Hill, 2016).

If the distress involved in the telling of the story is because of the pressure felt from the listener, this may be indicated by lower shame felt regardless of the immediacy. On the other hand, if the distress is caused by the rumination and telling of memories, participants may likely still feel heightened emotional arousal while completing the survey. Another limitation to this study from a clinical standpoint is the participants will never meet the researcher; therefore, the results may differ if this was to be a part of a counseling intake assessment where the clients know they will meet face to face with the therapist in the near future.

One assumption in this study is the participants are taking the survey alone on a private computer or device, where there is no risk of another seeing their responses. If this is not true with any participant, it may limit the individual's sense of freedom to be completely honest, especially limiting how one would share the story of the distressing secret. Another assumption is the participants fall within a normal range of intellectual and emotional intelligence; although, this may not pose a limitation to the study because if a participant does not have the intelligence to understand emotions and social connections, it is likely they will also not know to hold a secret.

Definitions

For the purposes of this study, please consider the following glossary of terms:

Concealment/Secrecy

Concealment or secrecy is intentionally hiding information from another or others, holding a secret (Slepian et al., 2017).

Disclosure/Telling

Disclosure or telling refers to the revealing of a secret.

External Shame

External shame refers to the perceived view of negative evaluation from others (Shaughnessy M. , 2018; Sklidi, 2018).

Internal Shame

Internal shame refers to a negative evaluation of oneself (Andrews & Hunter, 1997); a private feeling of personal judgment of one's feelings, thoughts, fantasies, or characteristics (Gilbert & Procter, 2006; Matos & Pinto-Gouveia, 2010).

Neuroticism

Neuroticism refers to emotional instability, having the tendency to experience negative emotions or traits such as anger, anxiety, depression, immoderation, self-consciousness, or vulnerability (Donnellan et al., 2006).

Shame

Shame is the painful and debilitating negative emotion closely related to a person's identity, self-worth, and psychological distress shows itself through loss of self-esteem, self-respect, self-worth, virtue or moral integrity and can be accompanied by feelings of inadequacy, powerlessness, or smallness; self-consciousness or fear of failure or condemnation (Bogolyubova & Kiseleva, 2016; Budden, 2009; Weiss, 2010; Wilson, 2000).

Shame-proneness

Shame-proneness refers to the tendency to feel shame.

Significance of the Study

The implications of this study can be very meaningful in the clinical context. To equip a client to reveal a distressing secret more easily will allow it to be addressed in counseling, therefore, potentially reducing the length of treatment. This study will inform clinicians on

whether the use of technology can help with that telling. For example, if participants are willing to share their shameful secrets in an online survey, this could indicate the need to include appropriate questions on an online intake form that would give clients the opportunity to disclose such information. For clients seeking help for distress, this may help get past the hurdle of having to tell the secret for the first time, especially if they want the therapist to know but they cannot seem to physically get the words out. To this date, no study has considered whether telling the distressing secret or shame-evoking story in an online format could help reduce the shame felt by the individual. There is much research on shame and disclosure within the therapeutic relationship (Farber et al., 2004), but none on simply telling the story.

Theoretical/Conceptual Framework

In a grounded study with women on shame, vulnerability emerged as a surprising theme as the anecdote for shame (Brown, 2006). Brown explains the opposite of shame to be empathy, while shame brings feelings of being trapped, isolated, and powerless, empathy includes feelings of connection, freedom, and power. Empathy is the summation of acknowledging personal vulnerability, critical awareness, reaching out, and speaking shame (Brown, 2006). Brown encourages further research on the tenets of her theory, challenging researchers to find effective methods in using the theory. With the advancement in technology, and additionally the use of technology becoming especially familiar in a historical time of pandemic, it seems imperative to test whether the use of technology can be effective in reducing shame and making psychological treatment more gentle yet efficient. While all the aspects of shame resilience theory will not be tested in this study, many will be, including: recognition and awareness of shame, a part of the vulnerability aspect; demystifying and contextualizing, a part of the critical awareness piece; and increasing the understanding of shame by writing the story (Brown, 2006). While participants

will identify and name their shameful secret or experience, it is not being considered as part of the reaching out aspect of the theory, as would be customary (Brown, 2006), since there will not be the presence of others.

Organization of Remaining Chapters

In the remainder of this paper, there will be an extensive literature review in chapter two on the elements of shame, the dynamics of secrecy, and the potential use of technology in mental health. Chapter three contains the specifics about methodology for this study, including details about the participant sample, measures used, and how the data will be analyzed. Chapter four contains the data results and analysis. Chapter five discusses the implications of the results of this study and suggests further areas of research to pursue.

Summary

Shame is an intense, negative, debilitating emotion that is common to humankind (Scheff, 2001). Shame can be internal, referring to one's poor view of self (Andrews & Hunter, 1997), or external, referring to the way one perceives others view themself (Gilbert & Procter, 2006; Matos & Pinto-Gouveia, 2010; Sklidi, 2018). Shame is destructive in relationships (Alsaker et al., 2016; Tangney et al., 2007) and is correlated with psychological distress as well as other mental and physical ailments (Alvarez, 2019; Tangney J. P., Stuewig, Mashek, & Hastings, 2011). Shame causes people to withdraw in pain (Schalkwijk et al., 2019). Shame survives in one's life through secrecy, creating a shame spiral that often drives one into deeper loneliness (Frijns et al., 2013). Being able to share one's shame-evoking story, revealing the secret that is holding this shame power, could possibly be overcoming a significant hurdle to recovery (Contreras, Kallivayalil, & Herman, 2017; Wille, 2014). Because shame is often about a seen/unseen paradox (Shaughnessy M. J., 2018), removing the element of being seen by

removing a tangible audience may be a key factor in helping clients disclose their shame stories. This study seeks to learn whether using an online modality to prompt a story-telling opportunity can reduce the shame an individual feels; therefore, overcoming the hurdle of secrecy may lead to a quicker and more direct path to recovery. This could inform clinicians on effective uses of technology to help reduce initial shame felt, including open-ended questions on an electronic intake form. The benefits to this study can also equip current and future counselors for ethically serving clients with excellence.

CHAPTER TWO: REVIEW OF THE LITERATURE

This chapter will present the literature relevant to this study and demonstrate the broad effects of shame and the benefit to helping clients tell their shame stories. First, it will attempt to define shame, including distinguishing shame from guilt, humiliation, and embarrassment, and describing the experience of shame. Secondly, it will explain the difference and the relationship between internal shame and external shame. Thirdly, the dynamics of shame and how it operates to protect itself through secrecy, discounting or minimizing, striving for perfection, and disconnection from oneself and others will be presented (Dayal et al., 2015).

The role of shame in mental health will be discussed in terms of presentation of shame, the relation to other disorders, and how shame functions as it influences a client's behavior. The element of secrecy will be discussed more in depth, considering both the role keeping secrets has in preserving shame, and the role disclosing secrets has in potentially reducing shame. Shame in the clinical office and its influence on the therapeutic relationship will then be reviewed. Finally, the influence of technology in our society and whether it can be used to help facilitate the telling of a secret will be presented. This chapter will conclude with the hypotheses for this study.

Shame

While the experience of shame is universal to all human beings, it remains a topic considered taboo in many cultures, including western culture, which keeps it from being talked about (Clough, 2014; Mann, 2018; Shaughnessy M. J., 2018). The word 'shame' can evoke uncomfortable emotions because there is a stigma associated with shame (Leeming & Boyle, 2004; Scheff, 2003) describes as shame about shame, which keeps people from wanting to broach the subject at all. Shame has been described as an all-encompassing disturbance affecting

an individual's whole body with nervous energy (Shadbolt, 2009) limiting the person's capacity, well-being, and sense of agency (Frost, 2016). Shame is called an important force, not only in an individual's life, but also in the advancement in our society because of the vital role it plays in learning, which develops moral and social behavior (Van Vliet, 2008). Part of the power of the influence of shame is because it is silent and relatively invisible. When it is extreme enough, shame can pose a significant therapeutic challenge in counseling because it is subjective; what causes shame in one person may not cause it for another (MacGinley et al., 2019).

Shame can also be difficult in the counseling office because it is cyclical and may require sorting through layers of causes and effects. Social structural factors like class and poverty, and other personal social factors such as gender, cultural background, or the intersection of any of these factors, contribute to how one experiences shame (Frost, 2016). Parental behaviors affect how children respond to shame because they determine the attachment habits of future relationships (Claesson & Sohlberg, 2002). It has been argued that if a parent is overly critical to a child, it can lay the foundation for negative self-view, self-criticism, and low self-worth, building a shame-based schema (Shahar et al., 2015). This tends to snowball in its effect, because with each layer the child feels more shame and the necessity to conceal any faults (Shahar et al., 2015). This causes children to learn maladaptive coping strategies like aggression, avoidance, or dissociation (Joseph & Bance, 2019). When a child has developed this shame-based schema, they become unable to process adverse or traumatic experiences, perpetuating them into isolation which in turn puts them more at risk for future abuse and trauma, as illustrated by today's sex trafficking industry (Contreras et al., 2017). For example, shame-inducing experiences in childhood like sexual abuse, among others, can lay a foundation of vulnerability to becoming a victim of sex-trafficking (Fedina et al., 2019), in part because of the

normalizing of the way one would be “groomed” into experiences by a manipulation of relational bonding (Contreras et al., 2017). In a similar way to the traumatic bonding that can take place in the sex-trafficking scenario, relationally shame-based individuals will present with maladaptive interpersonal habits, like conflict avoidance, withdrawal, inability to problem-solve, or being highly critical of others (Porter et al., 2019). These may lead to other mental health factors such as anxiety or depression (Porter et al., 2019). It is important to be aware of the element of shame and how it can be an undercurrent to these and other problems presented in the counseling office, because at its worst, shame develops into a shame of existing- the shame moves from being ashamed of “who I am” to “that I am” (Wille, 2014) leaving the client with a deep feeling of being unworthy as a human being (Alsaker et al., 2016). In these instances, a strong relational dynamic will be more important than a behavioral approach to therapy, especially in establishing the therapeutic alliance (Contreras et al., 2017). Recognizing shame in a client may include lack of eye contact (and possibly gazing elsewhere) and hiding or downward movements of the head, indicating submission and trying to lessen the consequences of rejection or social damage (Van Vliet, 2008).

Defining Shame

To understand and recognize shame, it is important to distinguish it from other self-conscious emotions: guilt, embarrassment, and humiliation.

Guilt

When experiencing shame, a client often may not be able to differentiate between their personhood and behavior; a negative behavior may be immediately translated to a negative evaluation of themself (Tangney, 1991). To separate these two constructs would be to understand the difference between shame and guilt. If following a negative behavior, the evaluation is on the

behavior itself, the emotion is guilt (i.e., “I did something wrong/bad; I made a mistake”). On the contrary, if the negative evaluation falls on the self, that is shame (i.e., “[that just proves] I am wrong/bad; I am a mistake”) (Dean & Fles, 2016; Djeriouat & Tremoliere, 2020; Niedenthal et al., 1994). A person responding with guilt will be more likely to apologize and seek to make amends, whereas someone experiencing shame may want to escape, deny, or hide (Dean & Fles, 2016; Tangney et al., 2005). Guilt may be experienced in response to a behavior, but it is not typically compounding; shame can have a snowball effect in which shame gives birth to more shame, including shame about feeling shame (Feiring & Taska, 2005). Shame is the more painful emotion because one’s core self is at stake, not just the behavior being judged (Tangney, Stuewig, & Hafez, 2011) (Tangney et al., 2007). In clinical studies, shame has been associated with mental disorders like anxiety, depression, OCD, somatization, and paranoid ideation, while guilt has not shown similar psychological maladjustment and in some cases has shown negative correlation (Tangney, 1995)

Embarrassment

Embarrassment does not carry the weight of morality, like shame and guilt do (Tangney et al., 2007). While the emotional charge connected to shame is overwhelming and lasts in the memory for a long time (Wille, 2014), embarrassment is more fleeting (Brown, 2012). Embarrassment tends to arise from surprising and relatively trivial accidents or humorous events, and comes with obvious physiological changes, like increased heart rate and blushing (Tangney et al., 1996). While embarrassment happens in front of a crowd of strangers and acquaintances and can lead to humor, shame is often felt alone and brings about disgust and anger (Miller & Tangney, 1994; Tangney, Miller, Flicker, & Barlow, 1996). Embarrassment becomes easy to

joke about later with the understanding one is not alone in their experience, where shame is not joked about and involves a deep feeling of being alone (Brown, 2012).

Humiliation

Humiliation is distinguished from shame by the element of deserving (Brown, 2012). Brown explains if a person experiences something as humiliating, they understand it was not deserved, whereas a person experiencing it as shame believes it was deserved. For example, a professor responds to a student's answer in class by calling the student "stupid." The humiliated student comes home and explains to whomever will listen, "you won't believe what a jerk my professor is" or "you won't believe what he did to me today." The shamed student is angry at themself for being stupid, or for speaking up in class, believing that is what they deserved; they do not tell anyone else about their experience.

Experiencing Shame

Shame is a painful and debilitating emotion closely related to a person's identity, self-worth, and psychological distress (Bogolyubova & Kiseleva, 2016; Weiss, 2010). It is multi-faceted and shows itself through loss of self-esteem, self-respect, or self-worth; loss of virtue or moral integrity; feelings of inadequacy, powerlessness, or smallness; self-consciousness or fear of failure or condemnation; withdrawal from social relationships; or suicidal ideation (Budden, 2009; Wilson, 2000). It is also associated with a sense of exposure and the desire to hide; lack of trust; feelings of weakness; rejection or being damaged; and a belief one is flawed, leaving the person feeling unworthy of acceptance or belonging (Brown, 2006; Duncan & Cacciatore, 2015; Leeming & Boyle, 2004; Ryan-DeDominicis, 2020). Feelings of shame include feelings of being worth less than others or being different in a negative way and excluded (Alsaker et al., 2016), and even wanting to 'sink into the floor' and disappear (Hack & Martin, 2018). Some

have described shame as: excruciating, devastating, consuming, noxious, the worst feeling ever, small, diminished, and filleted (existing as a boneless piece of meat) (Brown, 2006). Shame attacks a person's dignity in a crippling manner, leaving one feeling paralyzed with profound fear, disappointment, and anxiety, and often alone as one rarely feels comfortable talking about a shame experienced with another (Shaughnessy M., 2018).

Cultural and Gender Influences on Shame

While the emotions connected to shame are universal, the way one experiences shame and responds to it can be dictated by the culture they live in and what it says concerning shame. For example, in an individualistic society shame may be defined as feeling small or damaged, whereas in collectivist culture, it may feel more like rejection or abandonment (Leeming & Boyle, 2004). The response factor culture can influence is whether one responds to shame in self-defense or in a pro-social way, which can turn into a productive force in society (Probyn et al., 2019). When experiencing a personal failure, the self-defensive or pro-social response will be determined by whether the individual is more concerned about salvaging the damage done to their self-image or social image (Gausel et al., 2016). This also interacts with the political climate of the time. For example, if there is wrongdoing of a group towards another, individuals within that group who feel higher shame about the treatment of others will be more motivated towards pro-social behavior and restitution (Gausel et al., 2012). A similar response has been demonstrated on a personal level. Individuals who tend to blame others for their behaviors, will continue to act in destructive ways, while those who have a negative view of themselves will be motivated to hide or avoid when experiencing shame, constructively leading to recidivism (Tangney et al., 2014). The negative side of this is shame can also be used to bully people, even if the intentions are for good, one can shame another into desired behavior (Mayer et al., 2017).

Gender identity also influences how one experiences shame. A shame event, like many stressful circumstances, places any person in a predicament of responding with a fight, flight, or freeze mentality (Maack et al., 2015). Women typically connect feelings of shame with those of embarrassment, while men lean more towards a connection to feelings of guilt (Duncan & Cacciatore, 2015). Taylor et al. (2000) argues women are biologically bent to "tend and befriend" in stressful situations, meaning they seek out social bonds to survive even in trauma. This tendency to grasp relationally to people in stressful circumstances can make it even more difficult for women to escape the shame cycle (Contreras et al., 2017). In men, on the contrary, shame coincides with a lack of social bonds or community and often falls under a diagnosis of depression (Scheff, 2001). Because gender, culture, economic status, and anything else that contributes to inequality all play a part in how shame is experienced, it is critical to understand the dynamics of shame and how it operates (Frost, 2016).

Inter- and Intra-personal Dynamics of Shame

Shame has internal and external elements to it that can be interrelated. M. J. Shaughnessy (2018) refers to the seen-unseen paradox, explaining how shame requires being seen or caught by another, which requires the existence of others and feels dishonorable. However, this seen-unseen paradox can also be triggered by self-reflection, where one imagines the judgment of others (Shaughnessy M. J., 2018). In the latter, internal shame can function in a positive way by predicting the response of others and resulting in different behavior; therefore, protecting the individual from the external shame. This fear of shame can cause a person to work harder and strive for perfection, which externally benefits the individual as they are publicly seen as moral or professional regardless of the internal shame that drives them (Clough, 2014; Smith & McElwee, 2011). External shame threatens social bonds; internal shame protects the person from

public or social shame (Scheff, 2001). It is important to distinguish between the different constructs of internal and external shame and understand the roles and relationship they may have for a client. Internal shame refers to the primary, unconscious, inborn, primitive, sensory kind of shame based on survival and triggered by either physical or psychic danger, where external shame is the secondary kind of shame that refers to a conscious, social shame evoked by social situations and danger to their image (Sklidi, 2018).

Internal shame. Internal shame refers to a private feeling one has in connection to their personal judgment of their own feelings, thoughts, fantasies, or characteristics (Gilbert & Procter, 2006; Matos & Pinto-Gouveia, 2010). Ubiquitous shame, which is common to everyone, helps form a person from birth (Mann, 2018) and is connected to attachment in the early developmental stages (Clough, 2014). For example, when a child is told 'no' by a parent and feels like they are in trouble, they are experiencing an aspect of shame that alters their future behavior (Clough, 2014; Mahtani et al., 2018). When shame is traumatic in the developmental process, it feels like marginalization, a place of disgust and without dignity (Shadbolt, 2009). Considering Erikson's second stage of development, autonomy versus shame, shame comes from a child's sense of helplessness or loss of control (Wilson, 2000). Wilson describes the development of shame as either being healthy and represented by "what I did" (guilt), or toxic, which becomes about "what I am." That toxic shame, which again is often related to the connectedness a child feels in parental attachment, can lead to shame-proneness in adulthood (Mahtani et al., 2018). The parents are not necessarily traumatizing their children; however, they are not equipping them to deal with shame when a trauma does arise. Shame emerges as a key factor in describing the 'traumatized sense of self' which includes feeling shame and guilt as one sees the self as underserving and insignificant, and can develop into seeing the self as defective,

defiled, and unworthy (MacGinley et al., 2019). This internal shame that has grown with trauma is described as a fragile scar on one's core identity that activates a state of fragmentation when the person confronts an experience resembling, or appearing to resemble, the original trauma (Sklidi, 2018).

One internal shame regulation strategy is to attack the self, which is characterized by self-blame and anger towards the self, which magnifies the felt need to withdraw, escape, and hide (Schalkwijk et al., 2019). Even in cases of childhood abuse, the victim will often blame it on themself, attributing to some aspect of how they are as a person, like 'weak' for example (Dorahy & Clearwater, 2012). This shame becomes an unchangeable, unconditional feeling about themself (Dorahy & Clearwater, 2012). Shame experienced as an assault on self can attack the core identity of a person, which can cause: a) any positive self-concept to turn into seeing the self as bad, flawed, disgusting, inferior, worthless, or unattractive; b) damage to the individual's connection with others as the painful experience brings isolation and a desire to disappear, and c) any sense of power or control to diminish which might play out by shutting down or ignoring, forgetting, suppressing, or denying the shaming event happened (Van Vliet, 2008). Some describe the shame experience as a crossroads of reflection, where they redefined their concept of self and their core identity, aspects, and values (Mayer et al., 2017). The result can often be self-hatred, self-disgust, and feelings of inadequacy stemming from feeling out of control (Rance et al., 2017). In other cases, shame events caused people to redefine themselves as defiled, impure, immoral, and irredeemable even though the circumstances were under violent coercion (Son, 2018). Shame can become crippling as one feels shame about feeling ashamed (Shadbolt, 2009), or feels helpless and confused as the shame is fueled by the awareness of the irrationality of one's thoughts (Rance et al., 2017). Shame is a powerful, painful emotion that

involves a global negative evaluation of the self (Tangney et al., 1998). It is possible one can believe the lies of shame long enough to develop a shame/self-hatred balance that eventually provides an emotional protection of sorts because no one is disappointed by the object of one's hatred (Janin, 2015). And when one feels this shame of existing, they have reached a point of complete and merciless rejection of themself; the naked self has become a disgusting self, experienced as boundless hate and contempt towards self (Wille, 2014).

External shame. When shame is external, it becomes more of a social event involving being judged or shamed by others (Gilbert & Procter, 2006; Matos & Pinto-Gouveia, 2010); although, the sense of exposure can be in front of a real or imagined audience (Tangney et al., 1998; Tangney, Stuewig, & Hafez, 2011). When shame has developed early in life, feeling ignored, excluded, criticized, or rejected by others can cause the shame-based schema to activate, which may present as intrusive thoughts, emotional avoidance, hyperactivity, or fragmented states of mind or dissociation (Castilho et al., 2017). This may leave a client feeling inadequate or inferior, being self-critical, feeling self-conscious, experiencing others as better than self, or engaging in obsequious behaviors, and can create a fertile ground for social anxiety disorder (Shahar et al., 2015). Along with the intense feelings of crisis and disgrace, shame can also be accompanied by milder feelings like embarrassment, shyness, modesty, and humiliation (Scheff, 2001).

Coping with external shame can vary with the person and situation at hand. Some will go into fight or flight mode, where they will either choose to avoid and withdraw, hiding from the situation and others, or they may attack others by lashing out in anger and blaming them (Schalkwijk et al., 2019). For some, this anger will turn into a fierce competitive drive where the social threat causes one to put forth any effort to prove themself as desirable and acceptable to

others (Ingevaldson et al., 2016). This mentality can develop out of a general fear of failure, where one fears shame, worthlessness, or disappointing others and builds unrealistic expectations of themself (Tortoriello & Hart, 2019).

Social exposure of failing or wrongdoing evokes shame (Djeriouat & Tremoliere, 2020). When an intensely negative quality becomes public, it spoils the person's social identity (Levenson et al., 2017) resulting in the person experiencing a devaluation of themself in shame as they accept this perspective of others (Stotz et al., 2015). Choosing to 'live in the minds of others' as an easily reject-able person causes self-contempt and leaves a person feeling vulnerable to an unsafe world (Gilbert & Procter, 2006). Even if there was not an overt event to trigger this, experiencing 'self-as-shame' is also adopted by people based on their perception of them being shameful, since they feel that way themselves, encouraging them to conceal life experiences from others (Dorahy & Clearwater, 2012). This is true even if the source of shame is not one's own behavior. One woman described feeling the pressure to keep her mother's suicide a secret for fear of being judged as a bad daughter; she feared others seeing her as the cause of her mom's death (Allphin, 2018). In general, external shame is considered a secondary shame because the damage is not so prominent, meaning there is a possibility for change and progress (Sklidi, 2018). This is when pro-social behavior can be predicted by shame (Gausel et al., 2016).

The intertwining of internal and external shame sometimes cannot be separated. Shame is cocreated as people both judge themselves and experience being judged, which can make connecting and engaging with others uncertain (Shaughnessy M., 2018). The self-stigma interacts with the social stigma, not only intensifying the feelings of shame but also keeping these individuals from seeking help (Long, 2018), ultimately becoming a breeding ground for even more shame as people live in secret, unable to gain mastery over life experiences (Contreras

et al., 2017). Shame can appear interpersonally, dwell within, and reappear interpersonally in a cyclical fashion, robbing a person of the joy and excitement of life (Shadbolt, 2009). One man described finding joy in something he was good at and shame coming in to tarnish it all (Dorahy & Clearwater, 2012).

How Shame Protects Itself

Women have described experiencing shame as being caught in a web, stuck, trapped, and entangled by unattainable or conflicting expectations that cannot be met, leaving them feeling powerless and isolated (Brown, 2006). The tough thing about being stuck in shame is the perceived inability to escape. Shame makes every effort to protect itself through secrecy, discounting or minimizing, disconnection from others, striving for perfection, and disconnection from self (Dayal et al., 2015).

Secrecy

While shame is a common experience to all mankind, it is often considered to be taboo in most cultures, continuing to make it more powerful as people avoid talking about their experiences and even feel uncomfortable using the word ‘shame’ at all (Scheff, 2014). Refugee women from eight different countries illustrate this as they reported shame connected to their bodies and sexuality, saying they were unable to ask questions or talk about themselves as sexual beings, including menstruation, resulting in feelings of confusion and isolation (Ussher et al., 2017). In cases of childhood sexual abuse, the lived experience becomes such a shameful secret for the child, which also isolates from support or potential assistance (Bogolyubova & Kiseleva, 2016). Shame can significantly impede a child’s recovery; it requires more effort to help a child disclose sexual abuse when there is shame present than with children who do not express shame (Hamilton et al., 2016). Shame serves as an impediment to recovery because it motivates the

individual to avoid the exposure necessary to process the abuse, putting the individual at risk for the shame spiral, leading to more behaviors that continue to diminish the road to recovery (Feiring & Taska, 2005). As people choose to live in secrecy, it is not uncommon for them to create cultures of secrecy within their families, leaving a legacy of shame impacting generations to come (Wong et al., 2017). People in shame believe the helpless, flawed self should never be revealed to another, or others will sadistically expose it to everyone; that fear keeps them in a 'safe' and tragically sad and lonely place of being unacknowledged and unknown (Sklidi, 2018). In the long run, secrets kept from others can prove destructive; first with confusion and anger for the individual, and then with destroying relationships between the secret keeper and the one it is being hidden from (Rober et al., 2012).

Discounting or Minimizing

Secrecy surrounding shame is often referred to as hiding. A person may not choose to physically hide from others; however, they may choose to hide a shame experience or consequential feelings. It is often easier for a person to deny shame, or any thoughts, beliefs, or behaviors that cause shame, because it is too painful to expose (Adams & Robinson, 2001). This may include denying the existence of a shame event altogether or may include minimizing the effects as "no big deal." This can also explain the choice to lash out or blame others as a defense mechanism, which may really be an attempt to not be seen by directing the attention to someone else.

Striving for Perfection

Striving for perfection perpetuates the concept of secrecy; it is controlling the perception of others in an effort to protect shame from being revealed (Dayal et al., 2015). For example, in some cultures, including Chinese and Asian-American, there are simultaneous pressures to

perform perfectly and keep all emotions to oneself (Zhong, et al., 2008). In the effort to put forth the image of perfectionism, shame has proven to be a motivator for some to engage in spiritual or religious activities (Simpson et al., 2016). While religion can be a significant part of the healing process for those suffering with chronic shame, a poor image of God could also intensify the shame cycle as one struggles with what he feels is failure (Park, 2016). Shame poses a barrier to authenticity, and authenticity is linked to positive psychological adjustment and interpersonal well-being; therefore, creating a space for clients to share their stories and develop self-compassion can attribute to recovery (Zhang et al., 2019).

Disconnection from Self

One way to deal with intense feelings of shame is dissociation, which disconnects a person from their feelings (Dorahy, 2010). Studies suggest shame influences the emergence of dissociation (MacGinley et al., 2019). This becomes complicated when one experiences shame as a result of trauma in childhood because for a child it may be the only means for survival; the dissociation protects the child from the traumatic feelings (Allphin, 2018). In the case of childhood sexual abuse, higher levels of shame are associated with higher levels of dissociation, and this appears to be a predictor of revictimization (MacGinley et al., 2019). People who have experienced chronic trauma will make use of dissociative splitting to protect the severely injured psyche, having a shame-based secret authentic self and the compensatory functioning false self (van der Merwe & Swartz, 2015). To some extent, this can exacerbate the shame experience as others only see the functioning self that compensates for the true self an individual chooses to keep hidden, leaving them feeling unknown and uncertain how others would respond if they really knew what was beneath the surface.

Disconnection from Others

As discussed, there is a direct connection between shame and relational conflict (Kim et al., 2009). Scheff (2001) discusses this in specific ways as he talks about discovering shame unintentionally as he worked with a group of men. Scheff noticed two significant factors amongst the men he observed shame in: first, none of them seems to have a secure bond with another person; and secondly, they all lit up when speaking of a time they remembered when they were a part of a community. He categorized the result of shame in these men into two patterns of behavior, resentment which he defined as a shame/anger sequence where the anger is directed outward, and guilt which is a shame/anger sequence where the anger is directed inward. Although both behaviors destroyed social bonds for these men and they felt like outsiders, asking the right questions and respectfully listening to them seemed to change how they were feeling and caused treatment to be more effective (Scheff, 2001).

The Role of Shame in Mental Health

Shame and mental disorders

Shame has negative implications for social adjustment and psychological well-being (Niedenthal et al., 1994), and is linked with eating disorders, substance use disorder, depression, anxiety, suicidal ideation, anger and violence, bullying, and sexual violence (Alvarez, 2019). Shame was found to be a central factor in both body dysmorphic disorder and obsessive-compulsive disorder, and increased the risk for functional impairment, depression, and suicide for those suffering from those disorders (Weingarden et al., 2016). With body shame, the impairment in emotional regulation in response to failure at self-enhancement efforts, or a lack of recognition or admiration from others, can increase risk in other areas of mental health (Jaksic et al., 2017). Shame involving childhood trauma and abuse, at any intensity, has also been linked

to PTSD, in addition to depression and anxiety, altering emotional dispositions by adolescence (Szentagotai-Tatar et al., 2015). Emotional abuse, and the early childhood memories associated with it, also predicts shame and its role in the development and maintenance of social anxiety disorder (Shahar et al., 2015). Shame about one's appearance can significantly mediate the relationship between pathological narcissism and suicidal ideation particularly in the context of narcissistic vulnerability (Jaksic et al., 2017). This may be explained in part by both the positive association between narcissism and pride (Tracy et al., 2009) and the way pride seems to protect shame (Randell et al., 2018).

Shame is positively linked to both the development and maintenance of substance use disorder (Hernandez & Mendoza, 2011). Shame-prone children who start using alcohol and a greater variety of drugs at a younger age, tend to drive under the influence more often, and participate in other riskier deviant behaviors like unprotected sex, compared to their non-shame-prone peers (Stuewig et al., 2015). Shame-prone inmates also have more psychological problems, including alcohol and drug use, impulsivity, and criminogenic thinking patterns than their non-shame peers (Tangney, Stuewig, Mashek, & Hastings, 2011). The connection of shame to substance use disorders is demonstrated amongst different age and life stage populations, showing a similar vicious cycle of shame leading to more shame (Dearing et al., 2005).

Shame with Anger and Relationships

Shame that is unacknowledged progresses into anger, and eventually rage and violence, the anger masking the shame (Chandler, 2020; Joseph & Bance, 2019). One man explained feeling like he remained helpless, caught in a vicious cycle of shame, fear, further shame, and rage (Sklidi, 2018). Children that experience shame connected to childhood physical abuse can be easily aroused with anger and act out with misdirected hostility (Keene & Epps, 2016).

Misplaced anger is not only the result of childhood trauma, in fact the link between shame anger directed at others is true across the lifespan; shame is connected to displaced aggression, including that with malevolent intentions (Tangney, Wagner, Hill-Barlow, Marschall, & Gramzow, 1996). Physical aggression tends to be a shame-related response for men when they feel a threat to their masculinity (Gebhard et al., 2019). Interestingly, these authors also explain men who experience shame are more likely to feel their masculinity threatened, which continues another cycle of shame, aggression, and blame. Shame being positively related to anger, resentment, irritability, suspiciousness, and the tendency to blame (Tangney, Wagner, Fletcher, & Gramzow, 1992) can have some obvious effects on relationships. The familiar shame-prone person that struggles with anger is the one who keeps everything stuffed inside, the anger boils until like a volcano, it explodes destructively affecting everything and everyone in its reach. This contributes to another shame cycle where the person is not only in distress, but causing distress, and feels shame around being the kind of person who would harm another (Tangney, 1991). These individuals do recognize their anger causes long-term negative consequences for themselves and their relationships (Tangney et al., 2007). Whether they tend to deflect and excuse themselves from blame or punish themselves in an attempt to atone for their wrongdoings, shame does not allow them to forgive themselves, and they do not get emotionally restored (Griffin et al., 2016). For women who are victims of interpersonal violence, they begin to develop a deep sense of shame and secrecy around their relationship the longer they stay, and this shame affects their work and other relationships (Alsaker et al., 2016). On a potential positive side, a shame-prone individual may have fewer opportunities for multiple sex partners, due to the lack of confidence on navigating interpersonal relationships (Stuewig et al., 2009). Shame can protect, even if it is in an unhealthy way.

Individuals that respond in shame to interpersonal conflict, like withdrawing, avoiding, criticizing, or other maladaptive ways, report poor relationship satisfaction (Porter et al., 2019). Social cognitive theory explains this is due to shame's ability to impair their problem-solving skills; shame diminishes their confidence and self-efficacy when it comes to implementing solutions (Covert et al., 2003). Instead, shame tends to focus the attention on the negative self-concept as opposed to the harm done, placing priority on protecting the self and not on restoring a positive sense of self or repairing the relationship (Dean & Fles, 2016). For clinicians, when working with couples, focus should not only be on improving communication, but consideration should also be given to treating the shame which will consequently reduce feelings of anxiety and depression positively affecting the relationship (Wertheim et al., 2018).

Shame and Neuroticism

For more than three decades, shame and neuroticism have shown to be positively correlated with each other (Johnson et al., 1989). Other than this relationship consistently being true, the research varies greatly. Some report shame is not a mediator for neuroticism (Zarei et al., 2018) and equally shame is not mediated by neuroticism (Muris et al., 2018). One example of the pattern of correlation being clear but the directionality of the relationship being undetermined is this: perfectionism may increase anxiety, anxiety may increase shame, and mixed with other factors, like self-consciousness and a tendency to be embarrassed, together influence neuroticism (Christensen et al., 1993). This struggle to determine the direction in relationship has also shown true for weight and body issues (Alcaraz-Ibanez et al., 2020), as well as in clients with a history of childhood sexual abuse (Gamble et al., 2006). While neuroticism is considered one of the big five personality traits, high levels of neuroticism are not innate to a person but can change depending on life experiences; people who experience childhood trauma are more likely to

develop neuroticism in adulthood (Boillat et al., 2017; Ogle et al., 2014). Further, in the same way shame has been associated with dissociation, neuroticism also shows to be connected to impairment of memory with those who experienced trauma in childhood (Lin et al., 2017). Neuroticism has also been linked to coping in the form of denial (Ewert et al., 2018).

The positive association with shame could also be because neuroticism begets perfectionism, and depending on the culture, there could be extreme social expectations of perfectionism (Darvill et al., 1992). Some assert the relationship between shame and neuroticism does not significantly change from one culture to another, in terms of the tendency of shame-prone people to be more neurotic (Erden & Akbag, 2015). However, others report the roles between shame and neuroticism differ vastly across some cultures (Zhong, et al., 2008), including Koreans measuring lowest on shame but highest in neuroticism, Chinese measuring highest in shame but intermediate on neuroticism, and Americans having intermediate levels of shame but rating the lowest in neuroticism, again seeming to depend on whether shame is used as a mechanism for social control (Johnson et al., 1987).

Whether one is experiencing shame from trauma, transgressional shame (Reid et al., 2011), or body shame (Miner-Rubino et al., 2002), there seems to be a common link between shame and neuroticism. When neuroticism seems to mediate shame (Peters et al., 2018) or the opposite when the "inability to defend against shame activates facets of neuroticism" (Reid et al., 2011, p. 266), both can lead to maladaptive behaviors, which is why it is suggested to target shame when working with clients with high levels of neuroticism (Paulus et al., 2016).

Other Ways Shame May Present

Shame will likely be behind the scenes since it is a self-conscious emotion involving the evaluation of self and the perceived evaluation of others (Matos & Pinto-Gouveia, 2010). It

could also be a specific aspect one concludes from evaluation of an enduring flaw that is wrong with the core of their being (Leeming & Boyle, 2004). Overtly being critical of or shaming oneself can also be used as a defense mechanism, protecting the client from full exposure in social situations, which becomes difficult because the self-criticism only maintains and compounds the shame, preventing the restructuring of the shame schema and resulting in continued concealment of any perceived deficiencies (Shahar et al., 2015). The feelings of shame like sadness, fear, overwhelmingness, disrespect, embarrassment, or feeling one is bad, wrong, or ineffective (Bunkers, 2018; Dayal et al., 2015) are aspects that are considered overt, undifferentiated shame- painful feelings that socially display as feeling peculiar, shy, bashful, awkward, bothered, miserable, or even funny (Scheff, 2014). Scheff also explains there can be bypassed shame present, which may be fleeting or have little or brief emotions attached to it that can show itself by rapid thought, speech, or behavior that might seem obsessive.

Secrets

Hiding

Being taught to go to any lengths to manage one's public image on top of being highly motivated to protect the deeply internal parts of self, lays the foundation for secrecy (Afifi & Caughlin, 2006). Secrecy is the intentional concealment of information from others (Slepian et al., 2017). Secrets can be an active withholding by hiding or denying, it may also be the individual is simply unable to tell, perhaps stuck in the balance of wanting to disclose but not having the words to express the secret or feeling physically unable to get them out (McElvaney et al., 2012). Secrecy, because of the inhibition of speech, is fatiguing because it consumes mental resources (Slepian et al., 2019). Although, with any secret keeping, the higher the commitment to conceal, the greater the tendency for the mind to wander to the secrets at

inopportune times, requiring more mental energy to keep the secret, and consequently leading to lower well-being for the individual (Slepian et al., 2017). Secrets that evoke feeling shame are even more likely to invade a person's thoughts at irrelevant times, furthering the emotional toll on the individual (Slepian et al., 2020). While keeping a secret may protect one's reputation, it also inhibits that individual from connection to others, especially with respect to the subject matter of the secret (Slepian, Halevy, & Galinsky, 2019).

Secrets create a bond between those who share it, making the act of keeping the secret one of loyalty (Buscemi, 2015). By the age of four or five, people are already willing to pay a cost for this loyalty in the effort to keep another's secret (Misch et al., 2016). Perhaps the most obvious loyalty group for anyone is one's own family. Looking carefully at any family will likely reveal secrets, whether they are hiding in plain sight, known by some, or understood as off limits for conversation by all (Imber-Black, 2014). Aesthetics drives family secrets (Orgad, 2017), which is often easier to see about others. The intention behind keeping a family secret may be to protect others (Tener, 2018). One mother reported protecting their family history of gender oppression and sexual violence in an attempt to protect her daughter, hoping it would bring redemption to her daughter's generation; however, history repeated itself resulting in the silence of the daughter and continued secrets (Szlyk et al., 2019). When hiding becomes a priority and part of the "family rules," children work hard to restore social order and perform as normal as they can, facing the dilemma of whether to talk about their experience or to remain loyal, keeping the secrets and following the rules (Werner & Malterud, 2016). The pressure of upholding the integrity of the family by keeping the secrets can be too much for any child; the secret keeping relationship in itself becomes another secret, which may be linked to more secrets (Imber-Black, 2014). The struggle between feeling hopeless in hiding or losing any approval

from the family may surpass the threshold of stress for a child (Szlyk et al., 2019). From a cultural standpoint, this has been illustrated in the adolescent Latina population as this pressure is considered to attribute to more suicide attempts than adolescents from other cultures (Szlyk et al., 2019).

Adolescence can become a pivotal time for developing a tendency to keep secrets, as they are in the life stage of discovering their own identities. Secrecy is an important factor in predicting an adolescent's feelings of emotional autonomy (Finkenauer et al., 2002). Adolescents tend not to disclose information for fear they may lose the autonomy they are beginning to experience, which can put them in danger physically in cases such as community violence, but also mentally with anxiety and depression if paired with poor parental relationships, compounding with the secrets (Dinizulu, et al., 2014). It is common for adolescents to avoid disclosure because they falsely assume everyone else is coping effectively while they are failing, and holding those secrets deprives them of an integral source of social support (Finkenauer et al., 2002). If their secrets involve delinquency, there is a greater likelihood of further delinquent behavior; the secrecy and delinquency reinforce each other (Frijns et al., 2010). Not wanting to reveal weakness even to one's best friend can also contribute to depression, although for young adolescent girls this lessened compared to boys' experiences only when paired with high levels of secrecy from her parents (Laird et al., 2013). Over time, adolescent girls who feel pressured to keep secrets from their moms experience more depression and anxiety and report a loss of intimacy and connection with their moms (Kearney & Bussey, 2014). Keeping secrets reduces feelings of belonging, which is mediated by the feelings of inauthenticity and lower self-disclosure (Newheiser & Barreto, 2014), and is described by feeling like an imposter, a shell, façade, pretense, and as having little genuine identity (Spermon et al., 2013).

In cases of adult survivors of childhood sexual abuse, shame is the most reported reason for not disclosing and seeking help, whether it is the secret itself, or anticipation of further shame and condemnation, either influenced from words of the perpetrator or awareness of how taboo the subject is, women will choose to conceal their abuse (MacGinley et al., 2019). In cases of trauma that was kept secret for long periods of time, the silencing and secrecy can cause a secondary betrayal trauma that can lead survivors to create a split in personality to presumably protect the public from seeing what is unknowable about them (van der Merwe & Swartz, 2015). Even former perpetrators talk about an ever-present shame that is too painful to talk about, so they chose to handle their secrets by limiting relationships to those they felt had lower risks of revelation of their past, resulting in less satisfaction in relationships because they emotionally distanced themselves from their partners (Ingevaldson et al., 2016).

Keeping secrets from one's social support system can be particularly detrimental (Laird et al., 2013). One example of physical danger is self-harm, where shame is the foundation associated with development and secrecy is the required element to perpetuate the behavior (Davis & Lewis, 2019). Self-concealment has repeatedly been positively correlated with depression, anxiety, and other physical symptoms (Frijns et al., 2010; Larson & Chastain, 1990; Wertheim et al., 2018). The mental rumination secrets demand causes a disconnection from and deprivation of support and validation, leading to isolation and loneliness (Frijns et al., 2013), and loneliness leads to more secrecy, which leads to more loneliness and other problems (Frijns & Finkenauer, 2009). This is similar to the shame cycle discussed, where individuals feel so much pressure to protect the shame by keeping up appearances and hiding their secret, lying to others, thus contributing to deeper shame (Alsaker et al., 2016; Orgad, 2017).

Disclosure

Sharing a secret is risky; there is no guarantee it will be protected and that one will not suffer the pain of betrayal when the other tells without consent (Buscemi, 2015). Sometimes hurt can come with feedback one receives after disclosing a secret, perhaps feeling the fear of rejection has come true (Afifi & Caughlin, 2006). Although, this was not found to be the ordinary experience of disclosure according to Afifi & Caughlin, who seemed surprised at the relatively small range of reactions to disclosure with most reporting their experience as very good. Even though the process of sharing secret aspects of one's past can be painful, that along with the desire for change seems to be the remedy for shame (Zerbe, 2016). In fact, revealing a shameful secret often proves to be physically beneficial for the individual, easing the worry and decreasing stress (Afifi & Caughlin, 2006). Disclosure of secrets also appears to decrease depressive moods, increase self-concept, increase self-control (Frijns & Finkenauer, 2009) and has a negative correlation with depression and delinquency (Frijns et al., 2010).

Shame influences a person's decision to disclose or not, and if they can find the courage to choose disclosure, it is the beginning of a new life, one of growth and recovery represented by the process of healing and connection in relationships that are no longer stifled by secrets (MacGinley et al., 2019). For some, this may be found in a safe friend that understands the significance of holding secrets (Allphin, 2018). Whether telling a friend or a therapist, the disclosure experience tests the waters for future revelations, setting the individual on a path of continued growth in healthiness, because more telling leads to less secrets to hold power over them (Frijns et al., 2013). The risk one is taking to expose themself as vulnerable is a real and difficult one (Ingevaldson et al., 2016). One person explained regardless of the overwhelming fear of exposure, being able to talk (even though it felt painful at time) about the shame

experiences made it stop being a shameful secret, breaking the negative bonds they had with others based in the secret (Sklidi, 2018).

Telling or writing one's story, as opposed to simply venting emotions that may be connected, proves to be more beneficial from a health and mental health standpoint because it offers the opportunity to make meaning in the reflection (Kelly et al., 2001). In fact, in a study comparing talking, writing, and avoiding disclosure of shame, writing about it decreased anxiety more than the other means (Afifi et al., 2017). Providing the opportunity for creativity allows a client to express shame, which dissipates its power, eliminating it from being shame any longer (Levine, 2012). People who are convinced to write about undisclosed trauma, or secrets in a confidential and anonymous manner, report greater physical and psychological benefits than those who write only about trivial things (Kelly & Yip, 2006).

Shame and Secrets in the Clinical Office

Distinguishing between self-esteem issues and shame will be helpful when considering symptoms related to a client's presenting problem. Shame is birthed from situations and intensifies with every shame event, while self-esteem is constant and not connected to a specific incident (Porter et al., 2019). People are likely not going to name 'shame' as a symptom, as often times they do not know about or understand shame until they learn about it in therapy and are then able to recognize their feelings of shame and discuss it with honesty (Alvarez, 2019). Prior to this understanding, a client may project their own feeling of rejection onto the clinician, fearing he is seen as disgusting, nauseating, and a burden the therapist regrets taking on, which can tremendously affect transference and countertransference in the therapeutic relationship, thus making shame an obstacle to treatment (Wille, 2014). Part of this is explained by the strong correlation between both fears of self-compassion and of receiving compassion as reported from

the fears of compassion scales (Kirby et al., 2019). Therefore, compassion-focused therapies may be most effective, as well as acceptance and commitment therapy or dialectical behavior therapy-strategies that offer psychoeducation about shame which can help normalize their experience and involve mindfulness which can help them approach their shame and shame responses without judgment (Weingarden et al., 2016). Multicultural understanding is also crucial in working with shame, as the shame experience can be more complicated in minority cultures, not only ethnically but socioeconomically and in consideration of sexual orientation (Chandler, 2020).

Considerations for the Mental Health Relationship

Staying silent on shameful matters can be detrimental to a person's psyche and body, destroying one's sense of self, physical well-being, and normal developmental progress; people carry secrets in their bodies (Zerbe, 2019). The physical stress keeping a secret has on a body can present itself in a variety of ways and may appear as inexplicable ailments (Zerbe, 2019). Carrying the secrets also show a greater risk for the development and for quicker progression of other diseases, such as cancer and other infectious diseases, including HIV; the act of confiding those secrets leads to long-term reduction in disease rates (Kelly & Yip, 2006). Holding onto shameful secrets is a burdensome weight. Still, clients feel discouraged from sharing their secrets, sometimes because they feel like it is pointless to disclose things that might threaten others' reputations, or even their own if they are not believed, or the shameful event is confusing for them, where they might be asking what their memories are (Tener, 2018). Tener discusses the importance of the professional relationship here, where a client can explore and feel approval within a formal societal system, especially when the family system prioritizes keeping the secret and silencing as central for functioning. The stigma associated with the secret, and even with unsolicited help being offered, usually intensifies the shame and becomes a deterrent from

seeking help (Ryan-DeDominicis, 2020). Therefore, understanding the way shame operates and how it affects disclosure or protects vulnerability can provide insight for clinicians to better support clients (MacGinley et al., 2019). There is a relationship between secrecy and psychosomatic disease (Kelly & Yip, 2006). Shame is often carried in the body of a client, along with and connected to their deepest needs; therefore, attending to the secrets, the impact of shame, and the body's defenses are all important in the progression of recovery (Zerbe, 2016). Psychoeducation about shame and secrets can also be helpful in allowing the client to know they are not alone, easing the struggle with self-esteem as distance is created between them and the secret, which helps them to share that which they would otherwise just ruminate (Afifi & Caughlin, 2006).

A fundamental task of the clinician is to creatively consider how to help the client be able to share the story in a safe and non-threatening way (Spermon et al., 2013). This will have to be navigated intentionally because shame memories are negatively associated with self-compassion and emotional intelligence (Castilho et al., 2017). Since self-compassion helps cultivate authenticity, this should be an element of the space the clinician provides- the platform to tell the story and unload the weight of secrets the client has been carrying; this is the beginning of the road to healing (Zhang, et al., 2019). One woman explained she could feel her secret wanting to be "vomited up" and how the storytelling was essential in her healing and in equipping her for future success (Spermon et al., 2013). In cases of trauma, the disclosure may likely be revealed in parts and not in a linear timeline (Contreras et al., 2017). The clinician should also be hypersensitive to issues of countertransference as secrets are revealed, so to not disturb the processing for the client, as the uncovering of secrets is pivotal in addressing shame and progressing in treatment (Zerbe, 2016). Being aware of personal feelings like this will also help

if the client misses a session or two after disclosing the secret, which can be common (Contreras et al., 2017). When a client's maladaptive behavior patterns come to light during treatment, they can often feel exposed, and their shame can grow (Schalkwijk et al., 2019), which can stem from the original fear of judgment the client faced as they wrestled with the stigma and the prejudice towards them in their decision to seek help (Long, 2018). Not only does shame and secrecy prevent people from seeking help, but some also even report being afraid to search on the internet for self-help books or websites (Levenson et al., 2017). In the context of a family, when parents allow the stigma to prevent them from seeking help, they often leave their children with important needs unmet that could be provided with professional support; instead, the children are left holding the family secrets (Werner & Malterud, 2016). Kids know when something is wrong and need a space to tell their experiences, speak their minds, and ask questions (Rober et al., 2012).

Shame is not a struggle of clients alone. Counselor trainees have shown to surround themselves with secrecy because of the expectation they feel of mental health professionals being without mental health issues (Dayal et al., 2015). Knowing both the pressure of these professionals and the fact shame is ubiquitous, Brown (2012) stresses clinicians should not treat shame until they have worked through their own shame. The benefit of clinicians working through their own shame is that choosing vulnerability demonstrates a common humanity; it does not just relieve the caregiver of shame but also opens the door of healing for others through compassion and modeling (Kim, 2017).

Technology

Technology is constantly advancing in our society and has even been accelerated over the last year amid the COVID-19 pandemic. Consequently, the research on technology and its

influences on vulnerability are slim; however, there seems to be a foundation in place to see the potential for the future. Various communication technologies are offering new opportunities for people to share their experiences with others (Rains & Brunner, 2018) where they are not only broadcasting self-disclosure but using these technologies and adjusting their communication behaviors to meet their instrumental needs for personal connection with others (Bazarova & Choi, 2014). Facebook is one of those social networking sites (SNS) that has shown technological communication to predict relational closeness (Ledbetter, et al., 2011), and it is presumed as these SNS have added applications within their sites, like personal direct messaging, the correlations may be stronger today. Although, even with self-disclosing more online, this is not indicative of greater vulnerability, for people are more easily able to navigate within their comfort zones as they decide what and how to share information (Bazarova & Choi, 2014). On another side of SNS, when one is communicating one-on-one on an online dating site, the anonymity leads to a tendency to share personal information quickly resulting in hyper-personal relationships in the online context (Baker & Hastings, 2013). So how can it be determined if online technologies can help with mental health and particularly in dealing with shame?

As discussed, shame is a deterrent to seeking help, and more so as the level of shame increases for a person. However, these individuals are not opposed to reaching out online as demonstrated by those who self-harm (Davis & Lewis, 2019) and sexual perpetrators (Brennan et al., 2018) who engaged in anonymous conversation via online message boards about their struggles. Davis and Lewis suggest the anonymous appeal to virtual methods may be what bridges the gap for those stuck in the shame surrounding self-harm and the help they need for recovery. Shame also emerged as a theme within online posts from sex offenders (Brennan et al.,

2018). In one study, and in another, perpetrators wished online counseling services, hotlines, or even books would have been available to help them before they got themselves into trouble because they did not know who to talk with about what was going on with them (Levenson et al., 2017).

When people perceive trust, they are willing to make personal disclosures online (Joinson et al., 2010). As these authors discuss, even if there is a weak guarantee of privacy, people still disclose based on situational cues. Therefore, the wording displayed online has a significant effect on the responses one might receive. Technology can create and mediate positive and meaningful experiences contributing to one's well-being; they just must be designed intentionally for both the function desired and the interaction of the process (Diefenbach et al., 2017). Because both emotional and factual disclosures can be identical online, whether the person perceives another human on the other end of a chat box or not (Ho et al., 2018), this could prove effective in working with clients on shame. An online format for initial disclosure could reduce the physical discomfort of sharing, and sharing can reduce the level of shame felt (Hamilton et al., 2016). When it is strangers communicating, removing the sight and sound aspects of communication, and using text-based communication technology only seems to increase the amount and intimacy of personal disclosure (Ruppel, 2015). If a person is motivated by relief goals in self-expression, the disclosure will be as intimate as a scenario with relationship development goals (Bazarova & Choi, 2014). With shame in particular, giving an anonymous open-ended opportunity to share one's story is sensitive to the dynamics of the shame experience, but it could be more effective if paired with a follow-up interview which would allow for more understanding of meaning (Leeming & Boyle, 2013). With people being willing to write about shame (Afifi et al., 2017; Leeming & Boyle, 2013) and knowing shame is

a barrier to seeking help, online treatment or structured self-help programs may be instrumental to engaging individuals in the beginning of therapy (Anderson & Clarke, 2019).

Hypotheses

With respect to the literature, the following hypotheses are predicted for this study:

Hypothesis 1a: Participants with higher levels of shame-proneness will result in higher levels of shame.

Hypothesis 1b: Participants with high shame-proneness will have a greater reduction in shame felt after telling the secret.

Hypothesis 2: Participants who conceal a distressing secret will report higher levels of shame than those who are not concealing a secret.

Hypothesis 3: Participants who tell the secret in the online format will report lower levels of shame than the non-story-telling group

Hypothesis 4: Participants who share the secret in the story-telling group will report lower levels of internal shame than the non-story-telling group.

Hypothesis 5: Participants who share the secret in the story-telling group will report lower levels of external shame than the non-story-telling group.

Summary

Shame is a painful, debilitating emotion that affects a person at the core of their identity and self-worth and can contribute to a multitude of psychological distress (Bogolyubova & Kiseleva, 2016). While shame is a common human experience (Mann, 2018), just the word ‘shame’ creates discomfort (Leeming & Boyle, 2004) making it a taboo subject (Shaughnessy M. J., 2018). Shame is an all-encompassing disturbance (Shadbolt, 2009) described as excruciating,

consuming, and devastating, leaving a person feeling weak, exposed, rejected, powerless, inadequate, and damaged (Brown, 2006; Budden, 2009).

Shame differs from other self-conscious emotions in significant ways. While guilt is a negative feeling about a behavior (I did something bad), shame is a negative feeling about oneself (I am bad) (Dean & Fles, 2016). While embarassment may cause some of the same physiological sensations, shame is not fleeting the way embarrassment is; at some point people feel freedom to laugh about having been embarrassed where shame is not joked about (Brown, 2012). Humiliation differs from shame in the aspect of deserving, meaning when a person is humiliated and shamed, they feel they deserved the humiliation, where as without the element of shame he understands it was undeserved (Brown, 2012).

Shame is experienced differently by each person (MacGinley et al., 2019). Shame is influenced by the expectations of one's culture (Leeming & Boyle, 2004) and can be influenced by one's gender (Duncan & Cacciatore, 2015). People may compensate for shame with pro-social behavior and be extraordinarily productive in society (Probyn et al., 2019), or they may be swallowed by the feeling of personal failure and just want to hide or disappear (Hack & Martin, 2018). Shame has both internal and external elements to it, internal being the intense negative view of oneself (Matos & Pinto-Gouveia, 2010), and external being the fear of how others perceive oneself, whether the 'others' are real or imaginary (Tangney, Stuewig, & Hafez, 2011). Shame is also powerful and functions to protect itself through secrecy, discounting or minimizing, disconnection from others and oneself, and striving for perfection (Dayal et al., 2015).

Shame has negative implications on social adjustment and psychological well-being (Niedenthal et al., 1994), and has been linked with: eating disorders, depression, anxiety,

substance use, violence, suicide, obsessive-compulsive disorder, posttraumatic stress disorder, changes in emotional disposition, and increased risk of deviant behavior (Alvarez, 2019; Stuewig et al., 2015; Szentagotai-Tater et al, 2015; Weingarden et al., 2016). Shame can evoke anger and aggression, and can have destructive consequences for clients in their relationships (Tangney et al., 2007). Shame has consistently shown to be positively correlated with neuroticism for decades (Johnson et al., 1989) and across different cultures (Erden & Akbag, 2015); although, whether there is any causal relationship between shame and neuroticism has been hard to determine (Alcaraz-Ibanez et al., 2020; Christensen et al., 1993; Gamble, et al., 2006; Muris et al., 2018; Zarei et al., 2018). When working with a client, shame will likely be behind the scenes (Matos & Pinto-Gouveia, 2010), but may be revealed in self-criticism or defense mechanisms, which in turn is an effort to continue hiding shame (Shahar et al., 2015).

Secrets can play a critical role in the dynamics of shame because the active withholding of information adds to the shame cycle (Slepian et al., 2019), whether by hiding, denying or being unable to find the words to express the secret (McElvaney et al., 2012). Disclosing a secret can be risky because the results are unpredictable (Afifi & Caughlin, 2006; Buscemi, 2015). Regardless of how painful it may be for one to disclose a secret, the benefits to the individual may not only be a remedy to shame (Zerbe, 2016) but may also include improved psychological, physical, and relational well-being (Afifi & Caughlin, 2006; Frijns & Finkenauer, 2009; Frijns et al., 2010). Because shame can be so powerful yet silent, behind the scenes of a client's presenting problem, addressing shame and helping the client with disclosure in the clinical office is not only crucial but must be handled with wisdom and delicacy (MacGinley et al., 2019).

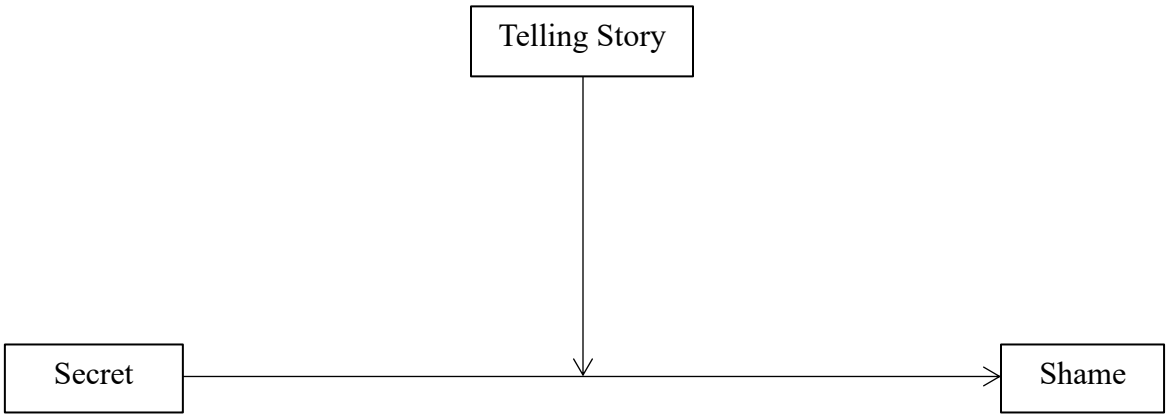
The increase in familiarity and comfort with technology in today's society has resulted in online platforms being a place of disclosure and connection with others (Bazarova & Choi,

2014). Although, the use of technology with disclosure has not been investigated from a therapeutic standpoint. The purpose of this study was to learn whether disclosing a shame-evoking secret in an online format can reduce the level of shame felt by an individual.

CHAPTER THREE: METHOD

Based on the element of secrecy that allows shame to hold its power, the purpose of this study is to determine whether sharing the secret will reduce the shame felt by the individual. This study is a simple moderation model, model 1 (Hayes, 2018), as illustrated in figure 1 below.

Figure 1- Model 1



Measures

Six measures will be used in this study: the guilt and shame-proneness scale (GASP) and the mini-international personality item pool scale for neuroticism (mini-IPIP neuroticism) to account for possible covariates, the self-concealment scale (SCS) for elements of secrecy, and the external and internal shame scale (EISS), the other as shamer scale- 2 (OAS-2), and the experience of shame scale (ESS) all measuring different aspects of shame. In addition, participants who indicated they held a shame-evoking secret also received a prompt with the opportunity to tell the secret.

The Guilt and Shame Proneness Scale (GASP)

The GASP was designed to measure a person's inclination to experience shame and guilt in relation to a number of personal transgressions (Cohen et al., 2011). This is the first measure

to distinguish between external and internal shame, which have proven to be distinct constructs; the shame sub-scales consist of negative self-evaluation (NSE) for internal shame and withdrawal [for others] for external shame (Cohen et al., 2011). Participants were asked to rate each statement on a 7-point Likert scale, one indicating very unlikely to 7 indicating very likely. This measure was included in the study to measure shame-proneness as a covariate.

Reliability and Validity

The GASP shows internal reliability, and the four-factor, four scale design was confirmed. The GASP has shown to be reliable amongst college students and adults (Cohen et al., 2011).

Sample Items

An example statement from the shame withdraw scale is, “after making a big mistake on an important project at work in which people were depending on you, your boss criticizes you in front of your coworkers. What is the likelihood that you would feign sickness and leave work?” A similar item from the shame NSE scale states, “you give a bad presentation at work. Afterwards your boss tells your coworkers that it was your fault that your company lost the contract. What is the likelihood that you would feel incompetent?”

The Mini-International Personality Item Pool Scale for Neuroticism (mini-IPIP neuroticism)

The mini-IPIP for neuroticism is a subscale of the mini-IPIP, which is a 20-item short form of the original 50-item international personality item pool-five factor model measure developed by Lewis Goldberg (Donnellan et al., 2006). The original IPIP was the first of its kind to be a reliable measure of personality intended for the public domain and was highly correlated with other personality measures including Costa and McCrae’s NEO Personality Inventory,

which has been considered a standard in the field (Goldberg, 1999). The mini-IPIP consists of subscales for each of the big five personality traits, containing four items for each trait, two written in a positive direction and two keyed in the negative (scored reversely), where participants rate each statement on a five-point Likert scale indicating how well each statement describes them (Donnellan et al., 2006).

Reliability and Validity

The mini-IPIP is considered a practical short form version of the IPIP, and has shown to have good convergent, discriminant, and criterion validity as well as good test-retest reliability over a few weeks to several months (Donnellan et al., 2006). Support has also been documented in a factor analysis, concluding this is a suitable short-form measure of personality (Cooper et al., 2010). The neuroticism subscale of the IPIP is highly correlated with both the NEO five factor inventory (NEO-FFI) and the Eysenck personality questionnaire- revised short form (EPQ-R) (Gow et al., 2005).

Sample Items

One item on the neuroticism subscale written in a positive direction is, “Have frequent mood swings.” An item written in the negative direction is, “Am relaxed most of the time.”

The Self-Concealment Scale (SCS)

The SCS is a 10-item self-report measure looking at: a) the tendency to keep things to oneself, b) having a secret deemed distressing or secret negative thoughts about oneself, and c) having apprehension about sharing personal information with others (Larson & Chastain, 1990). Participants are asked to rate each statement on a five-point Likert scale, one meaning strongly disagree to five indicating strongly agree (Larson & Chastain, 1990).

Reliability and Validity

The SCS has demonstrated good reliability and validity with the internal consistency ranging from α= .83 to .90, and a test-retest between r = .74 and .81 (Cramer & Barry, 1999; Larson & Chastain, 1990; Wertheim, et al., 2018).

Sample Item

The first statement on the scale is, "I have an important secret that I haven't shared with anyone" (Larson & Chastain, 1990).

The Experience of Shame Scale (ESS)

The ESS is a 25-item questionnaire based on an interview measure from Andrews and Hunter (1997) and measures four areas of character shame, three areas of behavioral shame, and bodily shame (Andrews et al., 2002). For each of these eight areas of shame, there are three related items concerning an experiential, cognitive, and behavioral component (Andrews et al., 2002). Participants are asked to respond to each question on a one to four Likert scale, one being not at all and four being very much.

Reliability and Validity

The ESS shows high internal consistency (α = .92) and high test-retest reliability (r = .83) (Andrews et al., 2002), along with good construct validity (Vizin et al., 2016).

Sample Item

The first question on the ESS is, "have you felt ashamed of any of your personal habits?" (Andrews et al., 2002).

The External and Internal Shame Scale (EISS)

The EISS is an eight-item self-report inventory, four measuring external shame and four measuring internal shame, where participants rate statements describing shame-related experiences on a scale from zero to four, zero indicating never and four signifying always (Ferreira et al., 2020). There is an external and internal shame statement for each of four domains found to be present in both aspects of shame: inferiority/inadequacy, sense of isolation/exclusion, uselessness/emptiness, and criticism/judgment (Ferreira et al., 2020).

Reliability and Validity

The EISS total scale shows high reliability with a Cronbach alpha of .89, and Cronbach alphas of .80 for external and .82 for internal shame subscales (Ferreira et al., 2020). The external shame subscale shows strong and significant correlations to the OAS-2 (Ferreira et al., 2020).

Sample Item

The sample statements to be rated for the inferiority/inadequacy category are, “other people see me as not being up to their standards” (ES) and “I am different and inferior to others” (IS) (Ferreira et al., 2020).

The Other as Shamer Scale- 2 (OAS-2)

The OAS-2 was developed from the internalized shame scale (Cook, 1988), and modified to measure external shame instead of internal (Goss et al., 1994). The OAS-2 is a shorter version of the original 18-item OAS, only including the highest rated prompts, resulting in the eight-item scale (Matos et al., 2015). Participants are asked to rate statements on a five-point scale from 0, meaning never, to 4, indicating almost always (Matos et al., 2015).

Reliability and Validity

The OAS-2 shows good internal consistency, ranging from α = .82 to .89, and has good concurrent and divergent validity with a high correlation to the OAS (r = .91) (Matos et al., 2015; Saginno, et al., 2017).

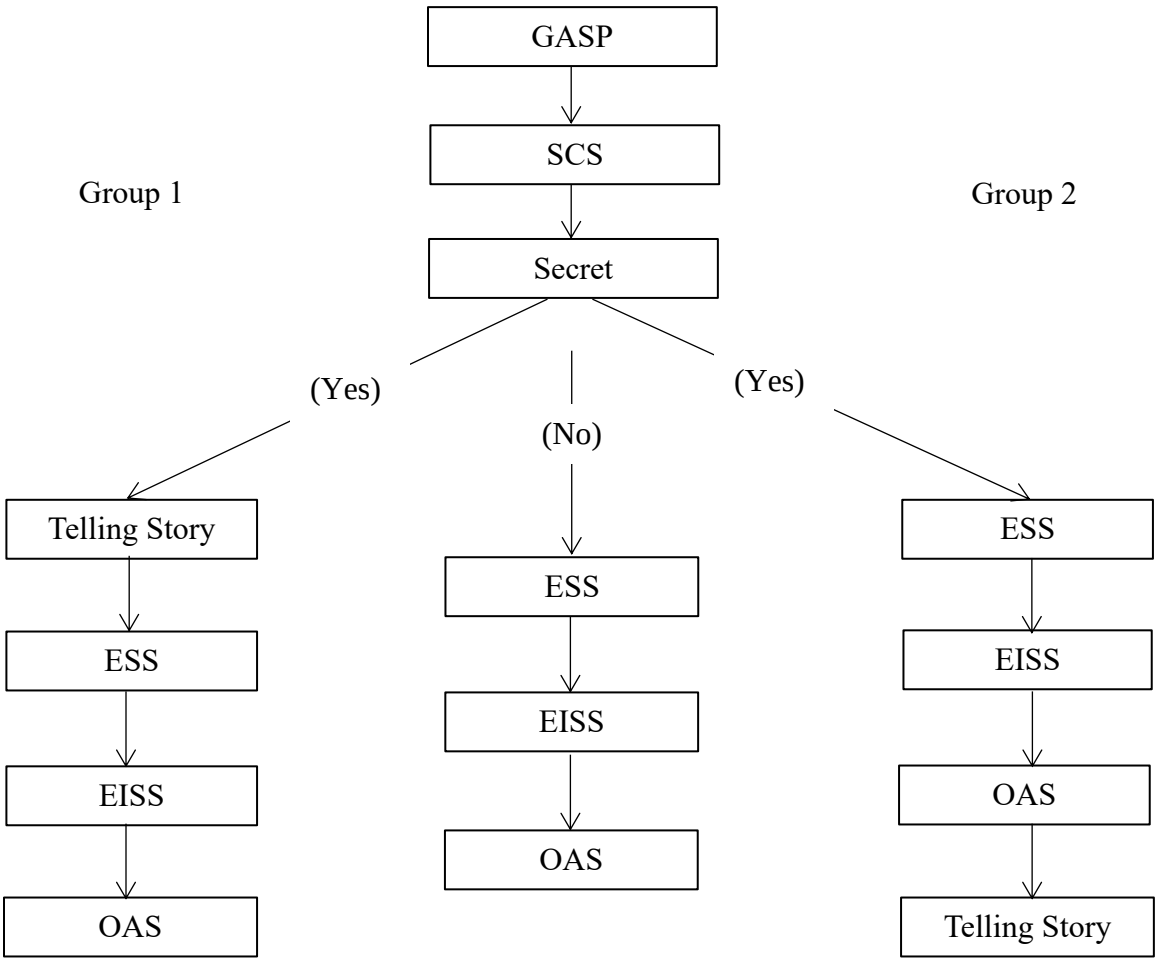
Sample Item

One statement is, "I feel others see me as not good enough" (Matos et al., 2015).

Participants and Procedure

The participants for this study were recruited through Amazon's Mechanical Turk online survey protocol and consisted of adult volunteer participants. The survey started with four demographic questions, and then went into the selected measures. The first eight questions were the shame subscale of the Guilt and Shame Proneness Scale (Cohen et al., 2011). The next ten questions were the Self-Concealment Scale (Larson & Chastain, 1990). If the participant answered 'no' to the first question of the self-concealment scale, indicating they did not have a secret, then the survey skipped to the shame inventories, and the participant was finished. If the answer was 'yes,' indicating there was an important secret, then the participant was randomly assigned to one of two groups: 1. The story-telling group, and 2. The control group. The story-telling group received a prompt asking them to think about an important or distressing secret they had as they answered the rest of the questions. The first question categorized their secret as: 'something I experienced/something done to me,' 'something I did,' or 'something I do.' These participants were then asked to share the story of their secret in the box provided. Following this, they were given the three shame inventories. The control group had the same categorical question and then immediately took the three shame inventories. They had the chance to tell their stories as the last prompt. The process of this study is illustrated in Figure 2.

Figure 2- The Procedure



Data Analysis

The first analysis looked at shame-proneness and how that factored into the results (hypotheses 1a, b). The next comparison was done between the 'yes' groups and the 'no' group, specifically to see if the study confirmed holding a secret led to higher levels of shame felt (hypothesis 2). The next comparison looked at shame levels between the story-telling group and the control group. Because this was a cross-sectional study with random group assignment, it was assumed the groups will be comparable. If the shame levels of the story-telling group were on average less than the control group, that indicated telling the story did lessen the shame felt. If

the control group showed lower shame levels, then it was concluded sharing the story increased the shame felt (hypotheses 3-5). All analyses were done using SPSS PROCESS (Hayes, 2018).

While many studies have looked at the influence shame has on relationships and psychological and physical health, very few studies have sought to understand shame resilience (Brown, 2006) and they only focused on the treatment of other disorders (Alvarez, 2019; Dayal et al., 2015; Hernandez & Mendoza, 2011; Ryan-DeDominicis, 2020). This was the first study to spotlight shame reduction and can have a huge impact on mental health treatment. Even in working with clients, the opportunity for a client to share a distressing secret during an online intake could prove to bypass what has before been a hurdle to treatment (Contreras et al., 2017).

Summary

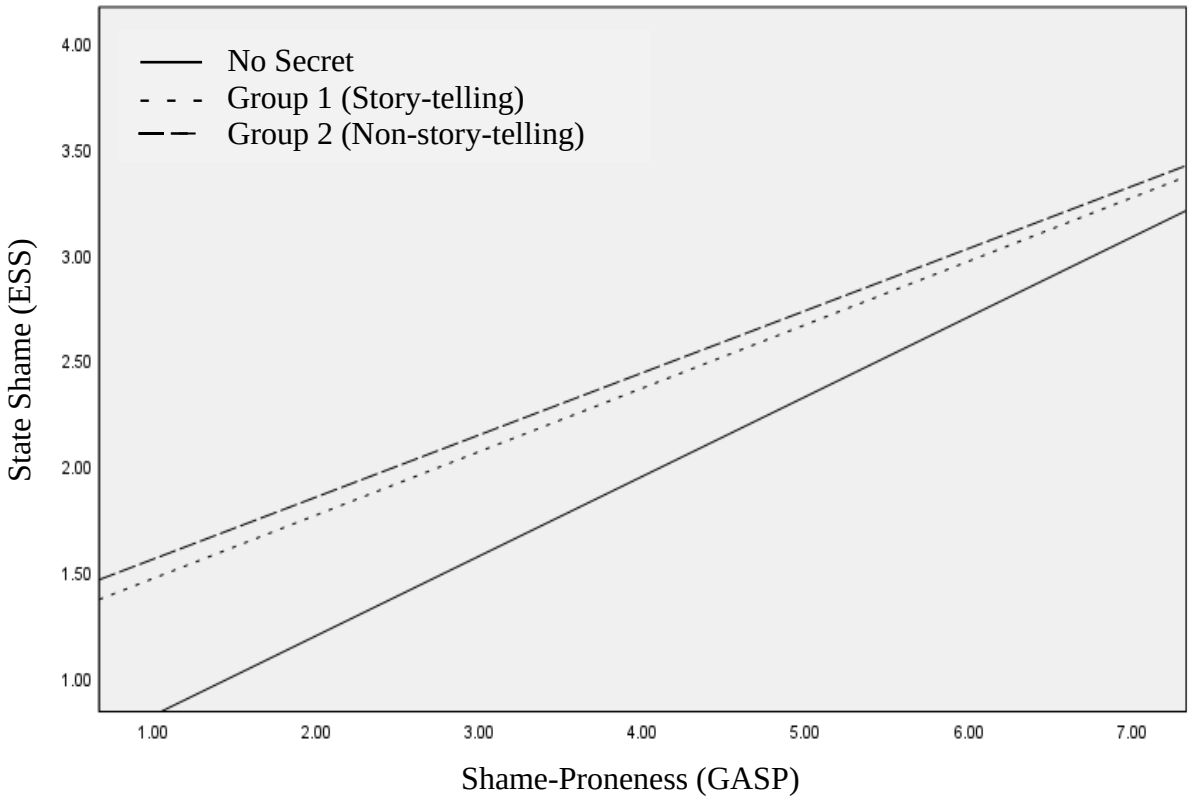
This study had three groups: a) a group that measured shame levels for participants who indicated they did not have a secret, b) a story-telling group that had the opportunity to tell their secret before taking the shame inventories, and c) the non-story telling group (control) that took the shame inventories before receiving the prompt to tell their secret. The proneness to keep a secret (Larson & Chastain, 1990), experience shame (Cohen et al., 2011), and experience neuroticism (Donnellan et al., 2006) were all controlled for. The shame inventories included measures of state shame (ESS) (Andrews and Hunter, 1997), external and internal shame (EISS) (Ferreira et al., 2020) and (OAS-2) (Goss et al., 1994). All Analyses were done using SPSS PROCESS (Hayes, 2018).

CHAPTER FOUR: RESULTS

The purpose of this study was to determine whether sharing a shame-secret in an online format could reduce the shame that one experiences. This chapter will report the results beginning with preliminary analyses done to confirm previous research. The research questions will then be presented with the corresponding hypotheses and results of the data analyses. What is presented in this chapter is strictly data and will not contain any interpretation of meaning for the findings. There were 1002 participants in this study: 605 males, 393 females, and 4 that reported 'other' as their gender. Of the 1002 participants, 478 reported having no secret, 237 were in the story-telling group, and 287 were in the control or non-story-telling group.

Preliminary Confirmatory Hypotheses

Graph 4.1- State Shame and Shame-proneness



The Role of Shame-Proneness

It was hypothesized that participants who scored higher in shame-proneness would report higher levels of shame. Three tests were done on the data set to investigate the relationship between shame proneness and shame experienced. Test one was a simple correlation between GASP and shame inventories (ESS, EISS, OAS-2). All results showed a positive and statistically significant correlation: GASP vs. ESS = .496; GASP vs. EISS = .409; GASP vs. OAS-2 = .419. Test two was a regression analysis between GASP and the shame inventories. All resulted in positive and statistically significant coefficients for GASP with r^2 terms of .246 (ESS), .167 (EISS), and .176 (OAS-2). Test three was a regression test between GASP and the shame inventories with covariates of age, gender, and neuroticism. All resulted in positive and statistically significant coefficients for GASP with r^2 terms of .448 (ESS), .406 (EISS), and .388 (OAS-2).

It was also hypothesized that participants with high shame-proneness would show a greater reduction in shame felt after telling the secret than that of the low shame-proneness group. This hypothesis was tested with an independent sample t-test to determine if there was a difference in means for Group 1 vs Group 2. High shame proneness was defined by a mean score of 4.5 or greater on the GASP scale from 1 to 7 and low shame proneness was defined as 3.5 or less, creating the high and low shame-proneness groups. Separate comparisons were made between the high shame-proneness groups and the low shame-proneness groups. The results indicated that across all the shame inventories that the mean for group 1 was lower than the mean for group 2 in both high and low groups; however, the difference between the means was not statistically significant beyond the .05 level to compare the high group with the low group. The differences in the means on a scale from one to seven were: .0595 high and .3012 low (ESS),

.1344 high and .077 low (EISS), and .0912 high and .0782 low (OAS-2). The 95% confidence intervals ranged from -.09452 to .21338 (ESS- high GASP), -.02223 to .62464 (ESS- low GASP), -.09874 to .36763 (EISS- high GASP), -.35569 to .50966 (EISS- low GASP), -.17168 to .35409 (OAS-2- high GASP), and -.42374 to .58009 (OAS-2- low GASP).

Secrets and Shame

It was hypothesized that participants who conceal a distressing secret would report higher levels of shame. Three tests were done to compare the 'yes' groups (indicated 'yes' to having a secret), n = 534, with the 'no' group (indicated 'no' to having a secret) n = 478. Test one was independent samples t-test across all shame inventories that compared means for the secret group against the no secret group. Results showed statistically significant differences in means for all inventories with *p*-values of <.001 (ESS, EISS, and OAS-2) and t-scores of -8.752 (ESS), -4.641 (EISS), and -4.716 (OAS-2). The 95% confidence intervals ranged from -.50473 to -.31984 (ESS), -.42616 to -.17289 (EISS), and -.47002 to -.19379 (OAS-2). Furthermore, the average of the secret group across all shame inventories was greater than the average of the no secret group. Test two was a regression model across all shame inventories as dependent variables with covariates of shame-proneness (GASP) and neuroticism (mini-IPIP neuroticism) and the dichotomous indicator variable for comparing the secret group to the no secret group. Results showed statistically significant positive coefficients for the dichotomous indicator variable for each regression model for each of the three shame inventories. This means that the regression models agree with earlier t-tests as they show that the coefficient for the dichotomous indicator variable shows that the secret group is greater than the no secret group for all shame inventories, with the values of the coefficients being .322 (ESS), .164 (EISS), and .194 (OAS-2). The r^2 terms for the three regression equations were .482 (ESS), .393 (EISS), and .376 (OAS-2). Test

three was a regression test across all shame inventories considering covariates of shame-proneness, neuroticism, gender, and age with the same dichotomous indicator variable for comparing the secret group to the no secret group. The results showed statistically significant coefficients for the dichotomous indicator variable for comparing the secret group to the no secret group across all shame inventories, with the value of the coefficients being .342 (ESS), .178 (EISS), and .216 (OAS-2). This means that the third test agreed with the earlier two in that the secret group is greater than the no secret group for all shame inventories. The r^2 terms for the regressions were .493 (ESS), .412 (EISS), and .396 (OAS-2).

Research Questions

1. **Does telling a secret, or shame-evoking story, in an online format reduce the level of shame experienced?**

Figure 4.1

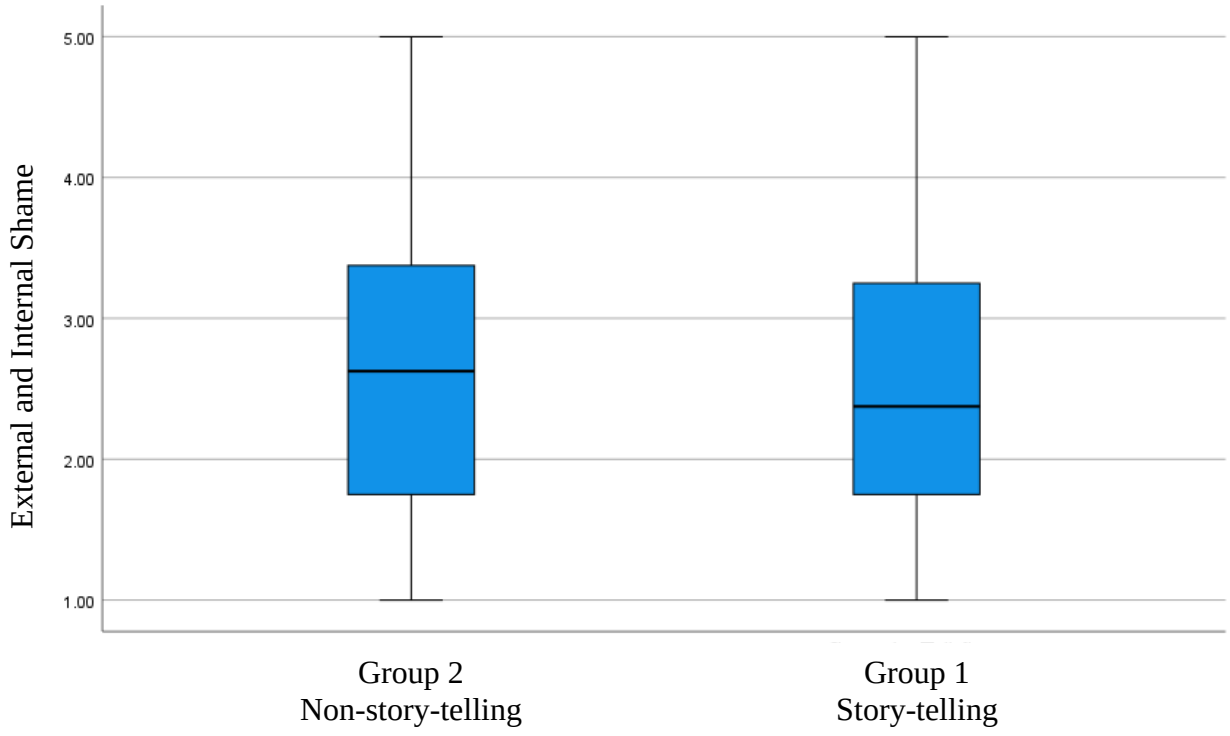


Table 4.1- ESS

Process Model Results for Moderation Model

Source	*b*	*se*	*t*	*p*	*LLCI*	*ULCI*
Constant	.8926	.1422	6.2763	<.001	.6132	1.1720
Self-Concealment	.4851	.0395	12.2864	<.001	.4076	.5627
Group 2 vs Group 1	-.1910	.2085	-.9159	.3601	-.6006	.2186
SCS x G2 vs G1	.0313	.0578	.5407	.5889	-.0824	.1449

Table 4.2- EISS

Process Model Results for Moderation Model

Source	*b*	*se*	*t*	*p*	*LLCI*	*ULCI*
Constant	.5743	.2129	2.6932	.0073	.1551	.9917
Self-Concealment	.5973	.0591	10.1051	<.001	.4812	.7134
Group 2 vs Group 1	-.0310	.3121	-.0992	.9210	-.6442	.5823
SCS x G2 vs G1	-.0316	.0866	-.3643	.7158	-.2017	.1386

Table 4.3- OAS-2

Process Model Results for Moderation Model

Source	*b*	*se*	*t*	*p*	*LLCI*	*ULCI*
Constant	.2057	.2407	.8547	.3931	-.2671	.6785
Self-Concealment	.6968	.0668	10.4281	<.001	.5655	.8280
Group 2 vs Group 1	.1522	.3531	.4310	.6666	-.5414	.8458
SCS x G2 vs G1	-.0797	.0980	-.8130	.4166	-.2722	.1129

Hypothesis 3: Participants who tell the secret in the online format will report lower levels of shame than the non-story-telling group

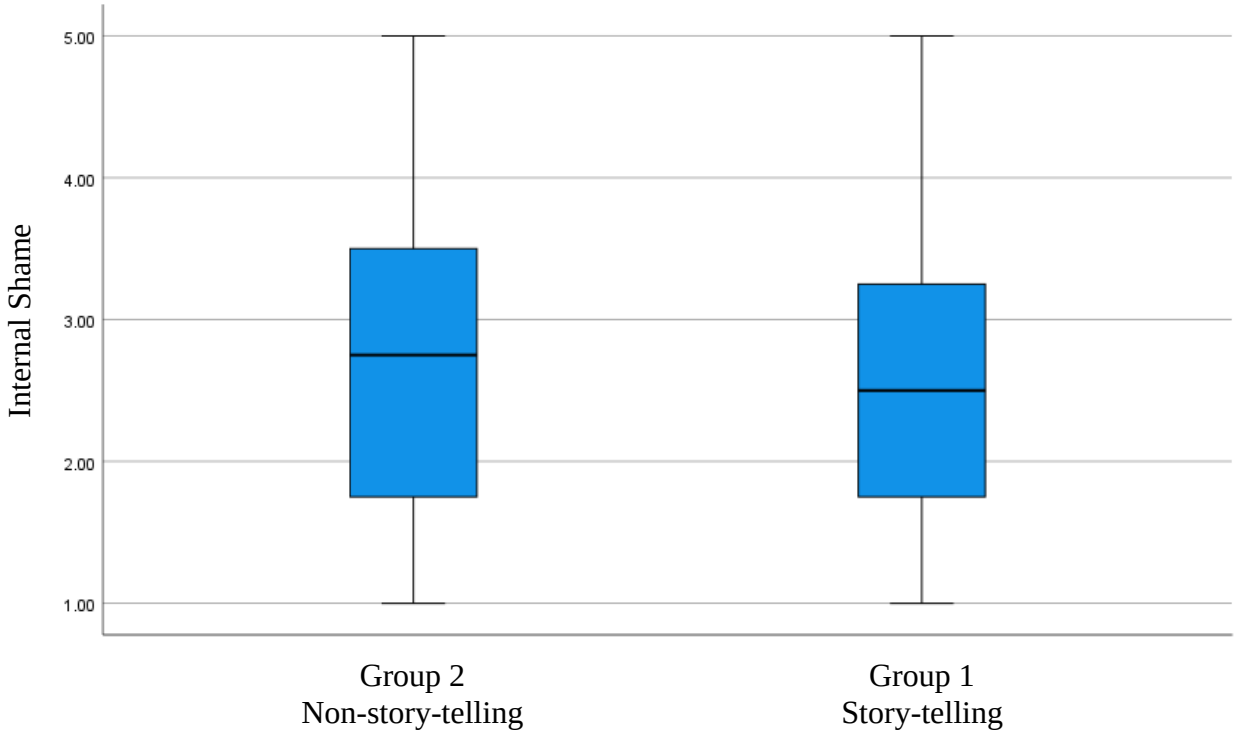
Three tests were completed on the data set to investigate the differences between the story-telling group (Group 1) and the non-story-telling group (Group 2) to determine whether disclosure resulted in lower levels of reported shame (Figure 4.1). The first test was an independent samples t-test. The results showed there were no statistically significant differences between group 1 and group 2, with *p*-values of .191 (ESS), .102 (EISS), and .188 (OAS-2) and with t-scores of 1.310 (ESS), 1.636 (EISS), and 1.320 (OAS-2). The 95% confidence interval ranged from -.04105 to .20545 (ESS), -.02857 to .31284 (EISS), and -.06348 to .32321 (OAS-2). Test two was a regression analysis with covariates of GASP and mini-IPIP neuroticism and the dichotomous indicator variable of Group 1 vs. Group 2. The results showed no statistically significant coefficients for the Group 1 vs. Group 2 indicator across all shame inventories with r^2 terms of .373 (ESS), .327 (EISS), and .312 (OAS-2). Test three was the analysis of the Model 1 (Hayes, 2018), a simple moderation model with X = SCS, y = {ESS, EISS, OAS-2}, and W =

Group 1 vs Group 2 indicator. The results are displayed in table 1 (ESS), table 2 (EISS), and table 3 (OAS-2). Across all three analyses, there was found to be no statistically significant coefficients for the interaction term and had r^2 terms of .3680 (ESS), .2630 (EISS), and .2629 (OAS-2).

2. **Does sharing the secret, or shame-evoking story, change one's view of self?**

Hypothesis 4: Participants who share the secret in the story-telling group will report lower levels of internal shame.

Figure 4.2 – Internal Shame



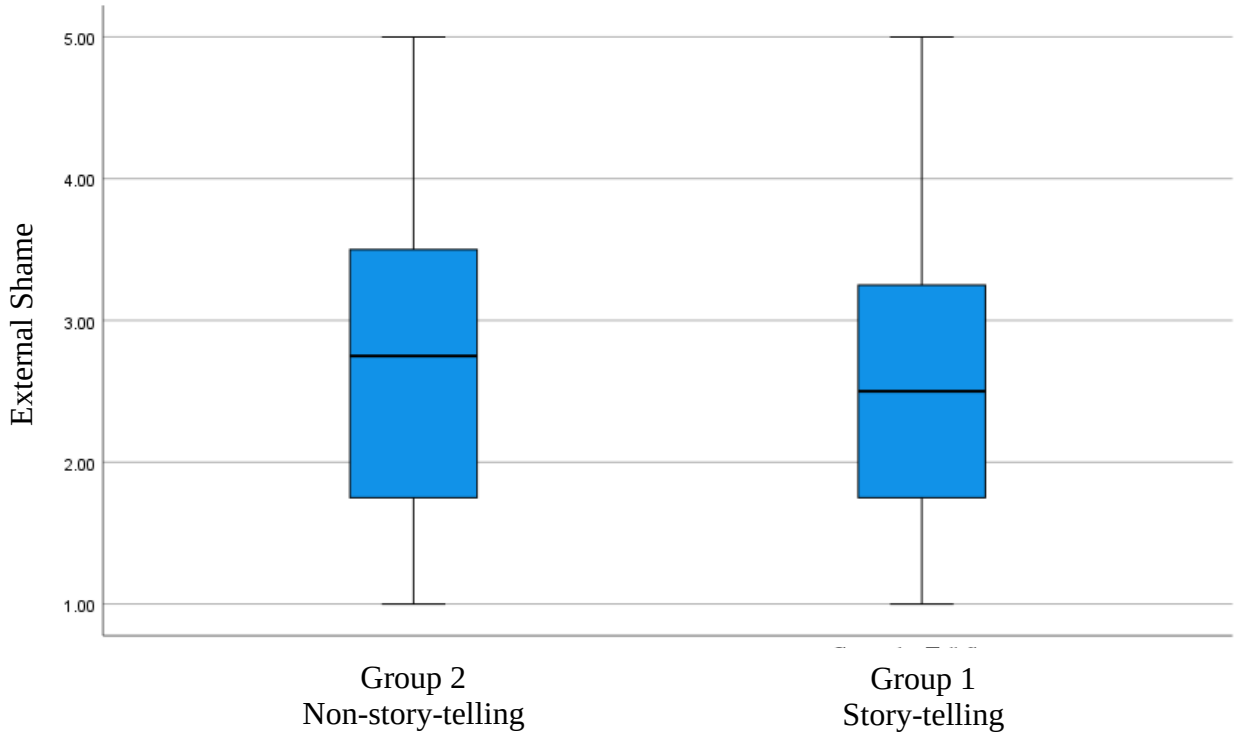
Two tests were completed to investigate whether sharing the shame-story lowered the reported levels of internal shame of participants by comparing Group 1 with Group 2 (Graph 3). Test one was an independent samples t-test with the internal measures of the EISS. Results showed no statistically significant difference between the two groups with a *p*-value of .204, a t-

score of 1.272, and a 95% confidence interval between -.06560 and .30654. Test two was a regression analysis for EISS internal measures with covariates of GASP and mini IPIP-N and the Group 1 vs. Group 2 indicator variable. Results showed no statistically significant coefficient for the Group 1 vs. Group 2 (-.071) with a r^2 term of .297.

3. **Does sharing the secret, or shame-evoking story, change the perceived view of others?**

Hypothesis 5: Participants who share the secret in the story-telling group will report lower levels of external shame.

Figure 4.3- External Shame



Four tests were completed to determine whether participants who were in the story-telling group (Group 1) reported lower levels of external shame than the non-story-telling group (Group 2) illustrated in Figure 4. Test one was an independent samples t-test between Group 1 and

Group 2 for the external elements of the EISS. The results showed no statistically significant difference between the groups with a *p*-value of .063 and a t-score of 1.866. The 95% confidence intervals ranged from -.00867 to .33629 (EISS) and -.06348 to .32321 (OAS-2). Test two was a regression analysis for the EISS with covariates of GASP and mini IPIPN. There was no statistically significant coefficient for the Group 1 vs Group 2 indicator, with a -.071 *b* and a r^2 term of .297. Test three was an independent samples t-test for the OAS-2. There were no statistically significant differences between the means of Group 1 and Group 2 with a *p*-value of .188 and a t-score of 1.320. Test four was a regression analysis for OAS-2 with covariates of GASP and mini IPIP-N and the Group 1 vs. Group 2 indicator. The results showed no statistically significant coefficient for the Group 1 vs Group 2 indicator, with a -.080 *b* and a r^2 term of .312. An additional test run on the external shame data was a correlation analysis with the external elements of the EISS and the OAS-2. Results were a .884 correlation coefficient, which is statistically significant.

Summary

Results in the data analyses showed a statistically significant positive correlation between shame proneness (GASP) and all three shame inventories (ESS, EISS, OAS-2). The secret-keeping groups (Group 1 and 2) scored higher across all shame inventories compared to the group indicating they did not have a secret. Group 1 scored slightly lower across all shame inventories after telling their secret; however, not reflecting statistical significance. Similarly, Group 1 showed evidence of lower external shame and internal shame levels separately than Group 2, but not of statistical significance. Finally, a correlation between the external elements of the EISS and the OAS-2 show statistical significance; therefore, adding validity to the new EISS.

While much of the results did not show statistical significance, there were consistencies in the pattern of data that cannot be ignored like Group 1 scoring lower than Group 2 across all shame inventories. There are meaningful conclusions and exciting implications for both practice and research that will be discussed in the next chapter.

CHAPTER FIVE: SUMMARY, CONCLUSIONS, & RECOMMENDATIONS

Summary

Shame is the painful and debilitating negative emotion closely related to a person's identity, self-worth, and psychological distress (Bogolyubova & Kiseleva, 2016) that is often linked to a painful secret (MacGinley et al., 2019). Disclosing shame can be incredibly difficult, painful, and anxiety-provoking (Farber et al., 2004). The purpose of this study was to investigate whether telling a shame-secret in an online format could reduce the shame one experiences with the hopes of informing clinicians on a potential strategy to help clients with disclosure.

In the online survey, the participants were asked, "Is there something in your life that has happened or that you have done that you either do not want others to know or that you have intentionally kept from them?" If the participants answered 'no' they were directed to complete three shame inventories: the experience of shame scale (ESS) (Andrews et al., 2002), the external and internal shame scale (EISS) (Ferreira et al., 2020), and the other as shamer scale- 2 (OAS- 2) (Matos et al., 2015). If the participants answered 'yes' to the question, indicating that they did have a secret, they were randomly assigned to one of two groups. The experimental group was given a prompt inviting them to share as much of this secret as they could in a text box. After writing their shame-evoking story, they were given the same three shame inventories. The control group, who also indicated having a secret, were directed first to the shame inventories without telling the secret.

The findings showed a correlation between having a secret and experiencing shame, which was expected. The experimental group scored slightly lower on all shame inventories after telling their secret; however, not with statistical significance.

Conclusions

Shame-Proneness

Participants with higher levels of shame-proneness reported higher levels of shame; therefore, hypothesis 1a is accepted. As illustrated in graph 1, the higher participants scored on GASP, the higher they scored on shame. This was true across all three groups tested: the no secret group, the story-telling group (Group 1), and the non-story-telling group (Group 2). Much of the research uses shame measures interchangeably to measure shame and shame-proneness, even though the constructs are separate. Shame refers to the state of emotion and shame-proneness is the tendency to experience that emotion (Ceclan & Nechita, 2021). The purpose of most studies is look at either shame or shame-proneness and the impact they might have on certain psychological or even physical conditions. Shame research may use shame-proneness as a covariate, but typically does not measure the correlation between the two. Only one known study investigated the correlation between shame-proneness and shame levels (Semb et al., 2011). This study used a standard measure for shame-proneness and a single question to measure the intensity of state shame (Semb et al., 2011). Even with both of these measured, the purpose of the study was to look at other symptoms (Semb et al., 2011). The results in this study were not surprising, but they may be the first to compare shame-proneness to the severity of shame experienced.

It was undeterminable whether participants with high shame-proneness resulted in a greater reduction in shame felt after telling the secret; therefore, the null hypothesis must be accepted that there is no difference between the means of these groups. Because the t-tests themselves were not statistically significant, it was impossible to draw conclusions about the significance of an insignificant test. The only conclusive evidence was that across all shame

inventories, the story-telling group scored slightly lower, but not to the point of statistical significance for both the high GASP group and the low GASP group. The best way to measure this hypothesis would be to do a before and after test of the same measures. In this case, the EISS would be the best to measure a change in shame because it is a brief test and measures both internal and external shame factors (Ferreira et al., 2020). If the results in this study resulted in statistical significance, the difference in means between shame-proneness and shame levels could have indicated greater change in shame for one group. However, for future study the before and after tests should be considered.

Secrets and Shame

Participants who concealed a distressing secret reported higher levels of shame; therefore, hypothesis two is accepted. Shame is not only often linked to a painful secret that one is keeping (MacGinley et al., 2019), but it has also become the most common reason that people keep secrets (Baumann & Hill, 2016). For many, secrets have protected shame felt; although, they have also created barriers to being known by others (Afifi et al., 2005). The results in this study correlated with previous research, showing higher shame across all three shame inventories for those who had a secret compared to those who did not, indicating that secrecy may play an important role in shame experienced. These results are what was expected. In future research involving the nature of the secret, it is possible that different types of secrets result in higher intensity of shame experienced.

The Online Disclosure

Participants who told the secret in the online format reported lower levels of shame than the non-story-telling group. However, because the difference was not enough to be statistically significant, hypothesis three must be rejected. Participants who shared the secret in the story-

telling group also reported lower levels of internal shame than the non-story-telling group. Again, because the difference was not enough to be considered statistically significant, hypothesis four must also be rejected. Similarly, participants who shared the secret in the story-telling group reported lower levels of external shame than the non-story-telling group. The difference was also not enough to be considered statistically significant; therefore, hypothesis five must be rejected.

While the results were not statistically significant in indicating a difference between the story-telling group and the control group, the consistency of the story-telling group scoring even slightly lower on all shame inventories should be considered meaningful. Disclosing a secret heightens a person's experience of shame before, during, and immediately following disclosure (Farber et al., 2004). Therefore, it would have been reasonable to expect the story-telling group (Group 1) to report higher shame levels than the non-story-telling group (Group 2). However, higher shame levels were not reported by Group 1, meaning the disclosure in the online format resulted in lower levels of shame than previous research (Afifi et al., 2005; Buscemi, 2015; Farber et al., 2004). The results of this study correlate with other research involving people being asked to write about secrets or undisclosed trauma (Kelly & Yip, 2006). Participants in Kelly and Yip's study reported physical and psychological benefits as compared to a control group who wrote about trivial things. One explanation of these results could be how clients experience internal and external shame simultaneously, where the interaction between the two is what becomes debilitating for people (Contreras et al., 2017; Long 2018). Having the secret told in an online format removed the external shame factor at that moment, which may have left the internal shame more manageable. From a clinical perspective, this makes the results of this study seem promising in being able to help clients experience relief from the effects of shame. A

possible explanation for the results not approaching statistical significance may be correlated with the amount of people in the original pool of participants who indicated having a secret but were eliminated because of not answering the disclosure prompt. Approximately 400 were dismissed from the study for this reason, the majority of which were assigned to the story-telling group. It is possible that these discarded entries scored high on shame proneness and may have experienced even more relief after sharing the story. On the other hand, it may be reasonable to believe that these participants experienced too much shame that put them beyond the threshold for sharing their shame-stories. The most likely option for dismissal was simply participants rushing through the survey and not wanting to take the time to write a response. In any case, the additional responses could have yielded statistically significant results.

Implications for Practice

With clients who experience high levels of shame, the social stigma interacting with the self-stigma may be what intensifies the feelings of shame (Long, 2018) and sending a client tumbling into a secret abyss unable to gain mastery over their life (Contreras et al., 2017). If this online format could separate external shame from internal shame, it can reduce the effects of their interaction. Therefore, allowing the client to deal with one aspect at a time, which would be more manageable. This can help a client begin to take mastery over those things that seem to have fallen out of their control. The hurdle of shame to seeking help (Long, 2018) or even to disclosing a secret (Contreras et al., 2017) can be lowered for clients, helping them take this jump with less effort and time needed to prepare.

In counselor education, there may be a two-fold benefit to this study. First, if this online protocol proves to be helpful, then there is an ethical lesson provided by these results in caring for a client using the best methods possible. Secondly, the importance of disclosing secrets,

putting words to shame stories, can also inform better self-care for future clinicians as they will be faced with the expectation that they must be without mental health issues (Dayal et al., 2015). For counselor educators, it is important to remember the role of evaluating mental health concerns among students because many will enter the academic program prior to recovery, some knowingly and some unaware of the work they have ahead of them (Dayal et al., 2015). As educators, it is likely for this to appear during parallel processing with students in practicum and internship, so recognizing the dynamics of shame and the influences it has both in the clinical and supervisory relationships will be crucial in the professional development of these future counselors (Giordano et al., 2013). It is important to note that within supervision this may evolve over time. Students with high shame proneness may rate their supervisory relationship strong in the beginning, but over time this shows to invert, meaning that students do not rate their working alliance with their supervisor strong after only five sessions of meeting together (Bilodeau et al., 2012). Using the same online methodology in an assignment allowing students to disclose apprehensions they have about their internship in the beginning of the semester, or feelings about their training experiences throughout, may be helpful in navigating the supervisory relationship and in helping equip them as clinicians.

Implications for Research

The implications of this study for future research are exciting. Further investigation of separating external shame from internal shame could have tremendous value in practice. Also, further investigation of shame and the telling of a distressing secret could be helpful. In this study, more than 600 participants were eliminated before the data analysis process mostly because of the failure to answer the secret question. One explanation that should be investigated is whether this group scored higher on shame than those who completed the question, which may

determine there is a shame threshold for sharing a secret in an online format. Although, this may also be explained with the survey being through Mechanical Turk, and people may more easily share in a HIPAA compliant online system instead. On the other hand, sharing in a HIPAA compliant platform may mean they will see the face of the reader in the future, which may also be a deterrent. These things should be investigated more.

Other research implications would be those of multicultural interest. The online format of research is great for reaching across racial and cultural boundaries; although, analyses involving race or culture were not done for this study. It would be interesting to see how different cultures experience shame, whether they are more or less likely to share in an online format, and whether the nature of the secret matters in relation to cultural values. Since in many cultures shame remains taboo, likely along with seeking help (Clough, 2014; Mann, 2018; Scheff, 2014), it would also be interesting to know if the online format might increase chances for them to pursue treatment. With telehealth growing so much in the past year, this may become an easier next step for some. Additionally, studying the nature of the secret, and the age of the secret would be enlightening and potentially helpful for clinicians to strategize care for clients. The nature of the secret could range from identity issues, struggles with health or mental health, a direct consequence of their own choice or behavior, a consequence of another's choice or behavior, among other things. There are only a few studies that have looked at categorizing types of secrets but have not considered culture or shame directly (Vangelisti, 1994; Wegner & Lane, 1995; Yalom, 1970). Although, the importance of considering cultural differences in relation to secrets has been noted (Wismeijer, 2011). There are traditional and religious values that shape different cultures in unique ways that influence shame, self-concealment, and attitudes about seeking help that could be critical for clinicians to understand (Arjmand & Ziari, 2020; Castaneda, 2021;

Masuda, Anderson, & Edmonds, 2012). While cultural concealment is negatively correlated with therapy outcomes, the therapist's effects are stronger predictors of success which provides hope for work to be done (Drinane, Owen, & Tao, 2018). There are no known studies considering the age of the shame-secret and how that affects the shame experience; however, it would be interesting to study this along with the age and gender of the participants and how the passage of time can change the experience of shame. One longitudinal survey on secret-keeping and the fear of disclosure was found; however, the time elapsed is only two weeks (Davis et al., 2020). It is unknown whether a longitudinal study across the lifespan could work. Once someone reveals having a secret, there may be a greater chance of disclosure as if the secret of having a secret diminishes the shame associated with it. On the other hand, some argue that as time passes there is less likelihood of disclosure either because the secret-keeper is too invested in keeping the secret or because they feel like the appropriate time to disclose the truth has passed (Davis et al., 2020).

Recommendations

From a research standpoint, pulling trauma into the fold could be very informative, particularly using the revised adverse childhood experiences scale (ACES) (Finkelhor et al., 2015) and the childhood trauma questionnaire- short form (CTQ-SF) (Bernstein et al., 2003). Shame-proneness is often correlated with a lack of secure attachment in childhood, which may be indicative of childhood trauma (Mahtani et al., 2018). It is likely that adults may be unaware of the trauma or neglect they experienced as a child, or unaware of the way it has influenced their life and relationships today (Allphin, 2018; MacGinley et al., 2019).

In practice, it is recommended that clinicians use an online intake form that would include questions that would invite clients to share potential shame-secrets. The questions should

include normalizing shame and secrecy and may include a disclaimer that the client will not be asked to talk about any of it until they are ready. Other questions that include specifics of the dynamics of relationships would also be helpful, as it may help the clinician to gain insight into relational patterns and history of the client. Example prompts or questions are, “please describe your relationship with your parents and other adults in your family while growing up” and “please describe any known family history of medical issues, substance abuse, physical/sexual/verbal abuse, and/or neglect.” (SimplePractice, 2021) or “can you think of a time that you were asked to do something that made you uncomfortable in exchange for clothing, food, housing, drugs, legal help, etc.?” (Contreras et al, 2017). In online platforms, clinicians are given the freedom to add, reword, and arrange questions to customize their own intake forms (SimplePractice, 2021).

Limitations of the Study

There are several limitations to this study that should be noted. First, the anonymous online format with paid survey-takers presents some problems like dishonesty. It is possible that participants rushed through their answers without careful consideration in wanting to get paid quickly. It is also possible that people were dishonest with either their answers or their identity, which could have allowed them to get paid more than once but skews the results if the same person participated several times. Every effort was made to eliminate these cases, but any uncertainty resulted in inclusion. Several respondents’ answers to the secret question were not grammatically understandable, indicating that these participants may not have spoken English well. There is a concern that they may not have understood the questions in the survey; however, since the survey was set for English-speakers only, it seemed redundant to eliminate them on this basis. Participants who answered the secret question with irrelevant answers, such as a cut and

pasted quote from a book, article, or the question itself and any confirmable duplicate entries were eliminated before processing data. In all, more than 600 responses were discarded.

Another limitation to translating the results into practice is the anonymity. There is no guarantee that clients would disclose their shame stories or secrets when they are aware of a future face-to-face meeting with the reader, their counselor. However, adding more specific questions like this to an online intake form could prove to advance the therapy process, especially since the client already initiated counseling by making an appointment. Adding a line with the questions or in the instructions that assured clients they would not be asked to talk about their answer until they are ready, may also help encourage disclosure. The shame will likely not go away but being able to lessen the impact of it slightly may help a client to bring it up and therefore process through the shame secret.

Summary

Much research has been done on shame, secrecy, and disclosure; however, this is the first to consider an online format in helping clients to tell their shame stories. People who hold secrets score higher on shame then those who do not, and since shame can be debilitating (Bogolyubova & Kiseleva, 2016; Kim et al., 2009; Scheff, 2001), finding a way to help clients share their stories is critical in the ethical care of them. While the results of sharing the story did not appear to be statistically significant because they fell into the range of random error, it cannot be considered random that the story-telling group scored lower on shame across all shame inventories. One meaningful explanation for this is the possibility that disclosing a secret in an online format separates the internal and external shame experiences. In a face-to-face setting, the interaction between the internal and external shame elements is what becomes debilitating for a client (Contreras et al., 2017). Further investigation of the roles of internal and external shame,

secrets, disclosure, and the use of online formats should be continued, along with other factors such as race, religion, gender, and age. The implications of this research can lead to better, ethical, and more efficient care of clients.

References

Adams, K. M., & Robinson, D. W. (2001). Shame reduction, affect regulation, and sexual boundary development: Essential building blocks of sexual addiction treatment. *Sexual Addiction and Compulsivity, 8*(1), 23-44. doi:10.1080/10720160127559

Afifi, T. D., Olson, L. N., & Armstrong, C. (2005). The chilling effect and family secrets: Examing the role of self protection, other protection, and communication efficacy. *Human Communication Research, 31*(4), 564-598. Retrieved from https://academic.oup.com/hcr/article-abstract/31/4/564/4331542

Afifi, T. D., Shahnazi, A. F., Coveleski, S., Davis, S., & Merrill, A. (2017). Testing the ideology of openness: The comparative effects of talking, writing, and avoiding a stressor on rumination and health. *Human Communication Research, 43,* 76-101. doi:10.1111/hcre.12096

Afifi, W. A., & Caughlin, J. P. (2006). A close look at revealing secrets and some consequences that follow. *Communication Research, 33*(6), 467-488. doi:10.1177/0093650206293250

Alcaraz-Ibanez, M., Sicilia, A., & Paterna, A. (2020). Examining the associations between the big five personality traits and body self-conscious emotions. *PsyCh Journal, 9,* 392-401. doi:10.1002/pchj.324

Allan, R., Eatough, V., & Ungar, M. (2016). "I had no idea this shame piece was in me": Couple and family therapists' experience with learning an evidence-based practice. *Cogent Psychology, 3,* 1-16. doi:10.1080/23311908.2015.1129120

Allphin, C. (2018). An unhealable wound: Left by suicide. *The Journal of Analytical Psychology, 63*(5), 641-655. doi:10.1111/1468-5922.12449

Alsaker, K., Moen, B. E., Baste, V., & Morken, T. (2016). How has living with intimate partner violence affected the work situation? A qualitative study among abused women in Norway. *Journal of Family Violence, 31,* 479-487. doi:10.1007/s10896-016-9806-2

Alvarez, D. V. (2019). Using shame resilience to decrease depressive symptoms in an adult intensive outpatient population. *Perspectives in Psychiatric Care, 56,* 363-370. doi:10.1111/ppc.12443

Anderson, S., & Clarke, V. (2019). Disgust, shame and the psychosocial impact of skin picking: Evidence from an online support forum. *Journal of Health Psychology, 24*(13), 1773-1784. doi:10.1177/1359105317700254

Andrews, B., & Hunter, E. (1997). Shame, early abuse, and course of depression in a clinical sample: A preliminary study. *Cognition and Emotion, 11*(4), 373-381. doi:10.1080/026999397379845

Andrews, B., Qian, M., & Valentine, J. D. (2002). Predicting depressive symptoms with a new measure of shame: The experience of shame scale. *British Journal of Clinical Psychology, 41,* 29-42. doi:10.1348/014466502163778

Arjmand, R., & Ziari, M. (2020). Sexuality and concealment among Iranian young women. *Sexualities, 23*(3), 393-405. doi:10.1177/1363460718797047

Baker, N. M., & Hastings, S. O. (2013). Teaching self-disclosure through an activity exploring disclosure research and online dating sites. *Communication Teacher, 27*(3), 132-136. doi:10.1080/17404622.2013.775471

Baumann, E. C., & Hill, C. E. (2016). Client concealment and disclosuer of secrets in outpatient psychotherapy. *Counselling Psychology Quarterly, 29*(1), 53-75. doi:10.1080/09515070.2015.1023698

Bazarova, N. N., & Choi, Y. H. (2014). Self-disclosure in social media: Extending the functional approach to disclosure motivations and characteristics on social network sites. *Journal of Communication, 64*, 635-657. doi:10.1111/jcom.12106

Beck, J. G., McNiff, J., Clapp, J. D., Olsen, S. A., Avery, M. L., & Hagewood, J. H. (2011). Exploring negative emotion in women experiencing intimate partner violence: Shame, Guilt, and PTSD. *Behavior Therapy, 42*, 740-750. doi:10.1016/j.beth.2011.04.001

Bermudez, L. G., Parks, L., Meyer, S. R., Muhorakeye, L., & Stark, L. (2018). Safety, trust, and disclosure: A qualitative examination of violence against refugee adolescents in Kiziba camp, Rwanda. *Social Science & Medicine, 200*, 83-91. doi:10.1016/j.socscimed.2018.01.018

Bernstein, D. P., Stein, J. A., Newcomb, M. D., Walker, E., Pogge, D., Ahluvalia, T., . . . Zule, W. (2003). Development and validation of a brief screening version of the childhood trauma questionnaire. *Child Abuse and Neglect, 27*, 169-190. doi:10.1016/S0145-2134(02)00541-0

Bilodeau, C., Savard, R., & Lecomte, C. (2012). Trainee shame-proneness and the supervisory process. *The Journal of Counselor Preparation and Supervision, 4*(1), 37-49. Retrieved from http://repository.wcsu.edu/jcps/vol4/iss1/3

Bogolyubova, O. N., & Kiseleva, E. V. (2016). Experiencing Shame. *Russian Education and Society, 58*(11), 675-695. doi:10.1080/10609393.2016.1342191

Boillat, C., Schwab, N., Stutz, M., Pflueger, M. O., Graf, M., & Rosburg, T. (2017). Neuroticism as a risk factor for child abuse in victims of childhood sexual abuse. *Child Abuse & Neglect, 68*, 44-54. doi:10.1016/j.chiabu.2017.03.018

Brennan, C. L., Swartout, K. M., Cook, S. L., & Parrott, D. J. (2018). A qualitative analysis of offenders' emotional responses to perpetrating sexual assault. *Sexual Abuse, 30*(4), 393-412. doi:10.1177/1079063216667917

Brown, B. (2006). Shame resilience theory: A grounded theory study on women and shame. *Families in Society, 87*(1), 43-52. doi:10.1606/1044-3894.3483

Brown, B. (2012, November 30). Men, women and worthiness: The experience of shame and the power of being enough. Houston, TX, USA: Sounds True. Retrieved from https://www.soundstrue.com/products/men-women-and-worthiness

Budden, A. (2009). The role of shame in posttraumatic stress disorder: A proposal for a socio-emotional model for DSM-V. *Social Science and Medicine, 69*(2009), 1032-1039. doi:10.1016/j.socscimed.2009.07.032

Bunkers, S. S. (2018). Shame on you. *Nursing Science Quarterly, 31*(2), 109-110. doi:10.1177/0894318418755737

Buscemi, R. (2015). Raymond Buscemi on secrets: Hide and seek: The life of a secret. *Jung Journal, 9*(4), 82-85. doi:10.1080/19342039.2015.1083832

Case, G. A., Pippett, K. A., & Lewis, B. R. (2018). Shame. *Perspectives on Medical Education, Supplement 1,* 12-15. doi:10.1007/s40037-018-0429-6

Castaneda, N. (2021). “It’s in our nature as daughters to protect our familias... you know?": The privacy rules of concealing and revealing Latina child sexual abuse experiences. *Journal of Family Communication, 21*(1), 3-16. doi:10.1080/15267431.2020.1856851

Castilho, P., Carvalho, S. A., Marques, S., & Pinto-Gouveia, J. (2017). Self-compassion and emotional intelligence in adolescence: A multigroup mediational study of the impact of

shame memories on depressive symptoms. *Journal of Child and Family Studies, 26,* 759-768. doi:10.1007/s10826-016-0613-4

Ceclan, A.-A., & Nechita, D.-M. (2021). The effects of self-compassion components on shame-proneness in individuals with depression: An exploratory study. *Clinical Psychology and Psychotherapy,* 1-8. doi:10.1002/cpp.2560

Chandler, A. (2020). Socioeconomic inequalities of suicide: Sociological and psychological intersections. *European Journal of Social Theory, 23*(1), 33-51. doi:10.1177/1368431018804154

Christensen, B. J., Danko, G. P., & Johnson, R. C. (1993). Neuroticism and the belief that one is being scrutinized and evaluated by others. *Personality and Individual Differences, 15*(3), 349-350. doi:10.1016/0191-8869(93)90228-U

Claesson, K., & Sohlberg, S. (2002). Internalized shame and early interactions characterized by indifference, abandonment and rejection: Replicated findings. *Clinical Psychology and Psychotherapy, 9,* 277-284. doi:10.1002/cpp.331

Clawson, H. J., Salomon, A., & Grace, L. G. (2008). *Treating the hidden wounds: Trauma treatment and mental health recovery for victims of human trafficking.* Washington, D.C.: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Retrieved from https://humantraffickinghotline.org/sites/default/files/Treating%20the%20Hidden%20Wounds%20-%20HHS.pdf

Clough, M. (2014). Atoning shame? *Feminist Theology, 23*(1), 6-17. doi:10.1177/0966735014542374

Cohen, T. R., Wolf, S. T., Panter, A. T., & Insko, C. A. (2011). Introdcuing the GASP scale: A new measure of guilt and shame proneness. *Journal of Personality and Social Psychology, 100*(5), 947-966. doi:10.1037/a0022641

Contreras, P. M., Kallivayalil, D., & Herman, J. L. (2017). Psychotherapy in the aftermath of human trafficking: Working through the consequences of psychological coercion. *Women & Therapy, 40*(1-2), 31-54. doi:10.1080/02703149.2016.1205908

Cook, D. R. (1988). Measuring shame: The internalized shame scale. In *The treatment of shame and guilt in alcoholism counseling* (pp. 197-215). New York, NY: The Haworth Press, Inc.

Cooper, A. J., Smillie, L. D., & Corr, P. J. (2010). A confirmatory factor analysis of the mini-IPIP five-factor model personality scale. *Personality and Individual Differences, 48,* 688-691. doi:10.1016/jpaid.2010.01.004

Covert, M. V., Tangney, J. P., Maddux, J. E., & Heleno, N. M. (2003). Shame-proneness, guilt-proneness, and interpersonal problem solving: A social cognitive analysis. *Journal of Social and Clinical Psychology, 22*(1), 1-12. doi:10.1521/jscp.22.1.1.22765

Cramer, K. M., & Barry, J. E. (1999). Psychometric properties and confirmatory factor analysis of the self-concealment scale. *Personality and Individual Differences, 27*(4), 629-637. doi:10.1016/S0191-8869(98)00222-0

Darvill, T. J., Johnson, R. C., & Danko, G. P. (1992). Personality correlates of public and private self consciousness. *Personality and Individual Differences, 13*(3), 383-384. doi:10.1016/0191-8869(92)90120-E

Davis, C. G., Brazeau, H., Xie, E. B., & McKee, K. (2020). Secrets, psychological health, and the fear of discovery. *Personality and Social Psychology Bulletin,* 1-15. doi:10.1177/0146167220946195

Davis, S., & Lewis, C. A. (2019). Addiction to self-harm? The case of online postings on self-harm message boards. *International Journal of Mental Health and Addiction, 17,* 1020-1035. doi:10.1007/s11469-018-9975-8

Dayal, H., Weaver, K., & Domene, J. F. (2015). From shame to shame resilience: Narratives of counselor trainees with eating issues. *Qualitative Health Research, 25*(2), 153-167. doi:10.1177/1049732314551988

Dean, K. K., & Fles, E. H. (2016). The effects of imdependent and interdependent self-construals on reactions to transgressions: Distinguishing between guilt and shame. *Self and Identity, 15*(1), 90-106. doi:10.1080/15298868.2015.1082500

Dearing, R. L., Stuewig, J., & Tangney, J. (2005). On the importance of distinguishing shame from guilt: Relations to problematic alcohol and frug use. *Addictive Behaviors, 30,* 1392-1404. doi:10.1016/j.addbeh.2005.02.002

Dhuffar, M. K., & Griffiths, M. D. (2014). UNderstanding the role of shame and its consequences in female hypersexual behaviours: A pilot study. *Journal of Behavioral Addictions, 3*(4), 231-237. doi:10.1556/JBA.3.2014.4.4

Diefenbach, S., Hassenzahl, M., Eckoldt, K., Hartung, L., Lenz, E., & Laschke, M. (2017). Designing for well-being: A case study of keeping small secrets. *The Journal of Positive Psychology, 12*(2), 151-158. doi:10.1080/17439760.2016.1163405

Dinizulu, S. M., Grant, K. E., Bryant, F. B., Boustani, M. M., Tyler, D., & McIntosh, J. M. (2014). Parent-adolescent relationship quality and nondisclosure and mediators of the

association between exposure to community violence and psychological distress. *Child and Youth Care Forum, 43,* 41-61. doi:10.1007/s10566-013-9224-z

Djeriouat, H., & Tremoliere, B. (2020). Shame and guilt situational identification in subclinical primary psychopaths. *Current Psychology, 39,* 238-245. doi:10.1007/s12144-017-9756-8

Donnellan, M. B., Oswald, F. L., Baird, B. M., & Lucas, R. E. (2006). The mini-IPIP scales: Tiny-yet-effective measures of the big five factors of personality. *Psychological Assessment, 18*(2), 192-203. doi: 10.1037/1040-3590.18.2.192

Dorahy, M. J. (2010). The impact of dissociation, shame and guilt on interpersonal relationships in chronically traumatized individuals: A pilot study. *Journal of Traumatic Stress, 23*(5), 653-656. doi:10.1002/jts.20564

Dorahy, M. J., & Clearwater, K. (2012). Shame and guilt in men exposed to childhood sexual abuse: A qualitative investigation. *Journal of Child Sexual Abuse, 21,* 155-175. doi:10.1080/10538712.2012.659803

Drinane, J. M., Owen, J., & Tao, K. W. (2018). Cultural concealment and therapy outcomes. *Journal of Counseling Psychology, 65*(2), 239-246. doi:10.1037/cou0000246

Duncan, C., & Cacciatore, J. (2015). A systematic review of the peer-reviewed literature on self-blame, guilt, and shame. *OMEGA- Journal of Death and Dying, 71*(4), 312-342. doi:10.1177/0030222815572604

Erden, S., & Akbag, M. (2015). How do personality traits effect shame and guilt?: An evaluation of the Turkish culture. *Eurasian Journal of Educational Research*(58), 113-132. doi:10.14689/ejer.2015.58.4

Ewert, C., Gaube, B., & Geisler, F. M. (2018). Dispositional self-compassion impacts immediate and delayed reactions to social evaluation. *Personality and Individual Differences, 125*, 91-96. doi:10.1016/j.paid.2017.12.037

Farber, B. A., Berano, K. C., & Capobianco, J. A. (2004). Clients' perceptions of the process and consequences of self-disclosure in psychotherapy. *Journal of Counseling Psychology, 51*(3), 340-346. doi:10.1037/0022-0167.51.3.340

Fedina, L., Williamson, C., & Perdue, T. (2019). Risk factors for domestic child sex trafficking in the United States. *Journal of Interpersonal Violence, 34*(13), 2653-2673. doi:10.1177/0886260516662306

Feiring, C., & Taska, L. S. (2005). The persistence of shame following sexual abuse: A longitudinal look at risk and recovery. *Child Maltreatment, 10*(4), 337-349. doi:10.1177/1077559505276686

Ferreira, C., Moura-Ramos, M., Marcela, M., & Galhardo, A. (2020). A new measure to assess external and internal shame: Development, factor structure and psychometric properties of the external and internal shame scale. *Current Psychology*, 1-10. doi:10.1007/s12144-020-00709-0

Finkelhor, D., Shattuck, A., Turner, H., & Hamby, S. (2015). A revised inventory of adverse childhood experiences. *Child Abuse & Neglect, 48*, 13-21. doi:10.1016/j.chiabu.2015.07.011

Finkenauer, C., Engels, R. C., & Meeus, W. (2002). Keeping secrets from parents: Advantages and disadvantages of secrecy in adolescence. *Journal of Youth and Adolescence, 31*(2), 123-136. doi:10.1023/A:1014069926507

Finn, M., & Rubin, J. B. (2014). Psychotherapy with Buddhists. In P. S. RIchards, & A. E. Bergin (Eds.), *Handbook of psychotherapy and religious diversity* (Second ed., pp. 347-369). Washington, D.C.: American Psychological Association.

Fowke, A., Ross, S., & Ashcroft, K. (2012). Childhood maltreatment and internalized shame in adults with a diagnosis of bipolar disorder. *Clinical Psychology and Psychotherapy, 19*, 450-457. doi:10.1002/cpp.752

Frijns, T., & Finkenauer, C. (2009). Longitudinal associations between keeping a secret and psychosocial adjustment in adolescence. *International Journal of Behavioral Development, 33*(2), 145-154. doi:10.1177/0165025408098020

Frijns, T., Finkenauer, C., & Keijsers, L. (2013). Shared secrets versus secrets kept private are linked to better adolescent adjustment. *Journal of Adolescence, 36*, 55-64. doi:10.1016/j.adolescence.2012.09.005

Frijns, T., Keijsers, L., Branje, S., & Meeus, W. (2010). What parents don't know and how it may affect their children: Qualifying the disclosure- adjustment link. *Journal of Adolescence, 33*, 261-270. doi:10.1016/j.adolescence.2009.05.010

Frost, L. (2016). Exploring the concepts od recognition and shame for social work. *Journal of Social Work Practice, 30*(4), 431-446. doi:10.1080/02650533.2015.1132689

Gamble, S. A., Talbot, N. L., Duberstein, P. R., Conner, K. R., Franus, N., Beckman, A. M., & Conwell, Y. (2006). Childhood sexual abuse and depressive symptom severity: The role of neuroticism. *The Journal of Nervous and Mental Disease, 194*(5), 382-385. doi:10.1097/01.nmd.0000218058.96252.ac

Gausel, N., Leach, C. W., Vignoles, V. L., & Brown, R. (2012). Defend or repair? Explaining responses to in-group moral failure by disentangling feelings of shame, rejection, and

inferiority. *Journal of Personality and Social Psychology, 102*(5), 941-960. doi:10.1037/a0027233

Gausel, N., Vignoles, V. L., & Leach, C. W. (2016). Resolving the paradox of shame: Differentiating among specific appraisal-feeling combinations explains pro-social and self-defensive motivation. *Motivation and Emotion, 40*, 118-139. doi:10.1007/s11031-015-9513-y

Gebhard, K. T., Cattaneo, L. B., Tangney, J. P., Hargrove, S., & Shor, R. (2019). Threatened-masculinity shame-related responses among straight men: Measurement and relationship to aggression. *Psychology of Men & Masculinities, 20*(3), 429-444. doi:10.1037/men0000177

Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology and Psychotherapy, 13*, 353-379. doi:10.1002/cpp.507

Giordano, A., Clarke, P., & Borders, L. D. (2013). Using motivational interviewing techniques to address parallel process in supervision. *Counselor Education & Supervision, 52*, 15-29. doi:10.1002/j.1556-6978.2013.00025.x

Goldberg, L. R. (1999). A broad-bandwith, public domain, personality inventory measuring the lower-level facets of several five-factor models. *Personlaity Psychology in Europe, 7*, 7-28. Retrieved from http://admin.umt.edu.pk/Media/Site/STD/FileManager/OsamaArticle/26august2015/A%20broad-bandwidth%20inventory.pdf

Goss, K., Gilbert, P., & Allan, S. (1994). An exploration of shame measures- I: The other as shamer scale. *Personality and Individual Differences, 17*(5), 713-717. doi:10.1016/0191-8869(94)90149-X

Gow, A. J., Whiteman, M., Pattie, A., & Deary, I. J. (2005). Goldberg's 'IPIP' big-five factor markers: Internal consistency and concurrent calidation in Scotland. *Personality and Individual Differences, 39*, 317-329. doi:10.1016/j.paid.2005.01.011

Griffin, B. J., Moloney, J. M., Green, J. D., Worthington, Jr., E. L., Cork, B., Tangney, J. P., . . . Hook, J. N. (2016). Perpetrators' reactions to perceived interpersonal wrongdoing: The associations of guilt and shame with forgiving, punishing, and excusing oneself. *Self and Identity, 15*(6), 650-661. doi:10.1080/15298868.2016.1187669

Hack, J., & Martin, G. (2018). Expressed emotion, shame, and non-suicidal self-injury. *International Journal of Environmental Research and Public Health, 15*(890), 1-18. doi:10.3390/ijerph15050890

Hamilton, G., Brubacher, S. P., & Powell, M. B. (2016). Expressions of shame in investigative interviews with Australian Aboriginal children. *Child Abuse & Neglect, 51*, 64-71. doi:10.1016/j.chiabu.2015.11.004

Hayes, A. F. (2018). *Introduction to mediation, moderation, and conditional process analysis: A regression-based approach* (Second ed.). New York, NY: The Guilford Press.

Hernandez, V. R., & Mendoza, C. T. (2011). Shame resilience: A strategy for empowering women in treatment for substance abuse. *Journal of Social Work Practice in the Addictions, 11*(4), 375-393. doi:10.1080/1533256X.2011.622193

Ho, A., Hancock, J., & Miner, A. S. (2018). Psychological, relational, and emotional effects of self-disclosure after conversations with a chatbot. *Journal of Communication, 68*, 712-733. doi:10.1093/joc/jqy026

Imber-Black, E. (2014). Will talking about it make it worse? Facilitating family conversations in the context of chronic and life-shortening illness. *Journal of Family Nursing, 20*(2), 151-163. doi:10.1177/1074840714530087

Ingevaldson, S., Goulding, A., & Tidefors, I. (2016). Experiences of intimate relationships in young men who sexually offended during adolescence: Interviews 10 years later. *Journal of Sexual Aggression, 22*(3), 410-422. doi:10.1080/13552600.2016.1177125

Jaksic, N., Marcinko, D., Hanzek, M. S., Rebernjak, B., & Ogrodniczuk, J. S. (2017). Experience of shame mediates the relationship between pathological narcissism and suicidal ideation in psychiatric outpatients. *Journal of Clinical Psychology, 73*(12), 1670-1681. doi:10.1002/jclp.22472

Janin, C. (2015). Shame, hatred, and pornography: Variations on an aspect of current times. *The International Journal of Psychoanalysis, 96*, 1603-1614. doi:10.1111/1745-8315.12417

Johnson, R. C., Danko, G. P., Huang, Y.-H., Park, J. Y., Johnson, S. B., & Nagoshi, C. T. (1987). Guilt, shame, and adjustment in three cultures. *Personality and Individual Differences, 8*(3), 357-364. doi:10.1016/0191-8869(87)90036-5

Johnson, R. C., Kim, R. J., & Danko, G. P. (1989). Guilt, shame and adjustment: A family study. *Personality and Individual Differences, 10*(1), 71-74. doi:10.1016/0191-8869(89)90180-3

Joinson, A. N., Reips, U.-D., Buchanan, T., & Paine, C. B. (2010). Privacy, trust, and self-disclosure online. *Human-Computer Interaction, 25*(1), 1-24. doi:10.1080/07370020903586662

Joseph, M., & Bance, L. O. (2019). A pilot study of compassion-focused visual art therapy for sexually abused children and the potential role of self-compassion in reducing trauma-related shame. *Indian Journal of Health and Well-being, 10*(10-12), 368-372.

Kearney, J., & Bussey, K. (2014). The impact of pressured information management on boys' and girls' psychological functioning. *Journal of Applied Developmental Psychology, 35,* 234-244. doi:10.1016/j.appdev.2014.01.002

Keene, A. C., & Epps, J. (2016). Childhood physical abuse and aggression: Shame and narcissistic vulnerability. *Child Abuse and Neglect, 51,* 276-283. doi:10.1016/j.chiabu.2015.09.012

Kelly, A. E., & Yip, J. J. (2006). Is keeping a secret or being a secretive person linked to psychological symptoms? *Journal of Personality, 74*(5), 1349-1369. doi:10.1111/j.1467-6494-2006.00413.x

Kelly, A. E., Klusas, J. A., von Weiss, R. T., & Kenny, C. (2001). What is it about revealing secrets that is beneficial? *Personality and Social Psychology Bulletin, 27*(6), 651-665. doi:10.1177/0146167201276002

Kim, J., Talbot, N. L., & Cicchetti, D. (2009). Childhood abuse and current interpersonal conflict: The role of shame. *Child Abuse & Neglect, 33,* 362-371. doi:10.1016/j.chiabu.2008.10.003

Kim, K. (2017). The power of being vulnerable in Christian soul care: Common humanity and humility. *Journal of Religion and Health, 56,* 355-369. doi:10.1007/s10943-016-0294-8

Kirby, J. N., Day, J., & Sagar, V. (2019). The 'flow' of compassion: A meta-analysis of the fears of compassion scales and psychological functioning. *Clinical Psychology Review, 70,* 26-39. doi:10.1016/j.cpr.2019.03.001

Kirschbaum, M., Barnett, T., & Cross, M. (2019). 'For pain, no shame' and 'my secret solace': Accounts of over-the-counter codeine dependence using Q methodology. *International Journal of Drug Policy, 73,* 121-128. doi:10.1016/j.drugpo.2019.10.002

Laird, R. D., Bridges, B. J., & Marsee, M. A. (2013). Secrets from friends and parents: Longitudinal links with depression and antisocial behavior. *Journal of Adolescence, 36,* 685-693. doi:10.1016/j.adolescence.2013.05.001

Larson, D. G., & Chastain, R. L. (1990). Self-concealment: Conceptualization, measurement, and health implications. *Journal of Social and Clinical Psychology*, *9*(4), 439-455. doi:10.1521/jscp.1990.9.4.439

Ledbetter, A. M., Mazer, J. P., DeGroot, J. M., Meyer, K. R., Mao, Y., & Swafford, B. (2011). Attitudes toward online social connection adn self-disclosure as predictors of Facebook communication and relational closeness. *Communication Research*, *38*(1), 27-53. doi:10.1177/0093650210365537

Leeming, D., & Boyle, M. (2004). *Psychology and Psychotherapy, 77*, 375-396. doi:10.1348/1476083041839312

Leeming, D., & Boyle, M. (2013). Managing shame: An interpersonal persective. *British Journal of Social Psychology, 52,* 140-160. doi:10.1111/j.2044-8309.2011.02061.x

Levenson, J. S., Willis, G. M., & Vicencio, C. P. (2017). Obstacles to help-seeking for sexual offenders: Implications for prevention of sexual abuse. *Journal of Child Sexual Abuse, 26*(2), 99-120. doi:10.1080/10538712.2016.1276116

Levine, L. (2012). Into thin air: The co-construction of shame, recognition, and creativity in an analytic process. *Psychoanalytic Dialogues, 22*(4), 456-471. doi:10.1080/10481885.2012.701140

Lin, P.-Z., Bai, H.-Y., Sun, J.-W., Guo, W., Zhang, H.-H., & Cao, F.-L. (2017). Association between child maltreatment and prospective and retrospective memory in adolescents: The mediatory effect of neurotocism. *Child Abuse & Neglect, 65*, 58-67. doi:10.1016/j.chiabu.2017.01.010

Long, M. (2018). 'We're not monsters... we're just really sad sometimes:' hidden self-injury, stigma and help-seeking. *Health Sociology Review, 27*(1), 89-103. doi:10.1080/14461242.2017.1375862

Maack, D. J., Buchanan, E., & Young, J. (2015). Development and psychometric investigation of an inventory to assess fight, flight, and freeze tendencies: The fight, flight, freeze questionnaire. *Cognitive Behaviour Therapy, 44*(2), 117-127. doi:10.1080/16506073.2014.972443

MacGinley, M., Breckenridge, J., & Mowll, J. (2019). A scoping review of adult survivors' experience of shame following sexual abuse in childhood. *Health and Social Care in the Community, 27*, 1135-1146. doi:10.1111/hsc.12771

Mahtani, S., Melvin, G. A., & Hasking, P. (2018). Shame proneness, shame coping, and functions of nonsuicidal self-injury (NSSI) among emerging adults: A developmental analysis. *Emerging Adulthood, 6*(3), 159-171. doi:10.1177/2167696817711350

Mann, B. (2018). Femininity, shame, and redemption. *Hypatia, 33*(3), 402-417. doi:10.1111/hypa.12432

Masuda, A., Anderson, P. L., & Edmonds, J. (2012). Help-seeking attitudes, mental health stigma, and self-concealment among African-American college students. *Journal of Black Studies, 43*(7), 773-786. doi:10.1177/0021934712445806

Matos, M., & Pinto-Gouveia, J. (2010). Shame as a traumatic memory. *Clinical Psychology and Psychotherapy, 17*, 299-312. doi:10.1002/cpp.659

Matos, M., Pinto-Gouveia, J., Gilbert, P., Duarte, C., & Figueiredo, C. (2015). The other as shamer scale – 2: Development and validation of a short. *Personality and Individual Differences, 74*, 6-11. doi:10.1016/j.paid.2014.09.037

Mayer, C.-H., Viviers, R., & Tonelli, L. (2017). 'The fact that she just looked at me...'-Narrations on shame in South African workplaces. *SA Journal of Industrial Psychology, 43*(0), 1-10. doi:10.4102/sajip.v43i0.1385

McElvaney, R., Greene, S., & Hogan, D. (2012). Containing the secret of child sexual abuse. *Journal of INterpersonal Violence, 27*(6), 1155-1175. doi:10.1177/0886260511424503

Miller, R. S., & Tangney, J. P. (1994). Differentiating embarrassment and shame. *Journal of Social and Clinical Psychology, 13*(3), 273-287. doi:10.1521/jscp.1994.13.3.273

Miner-Rubino, K., Twenge, J. M., & Fredrickson, B. L. (2002). Trait self-objectification in women: Affective and personality correlates. *Journal of Research in Personality, 36*, 147-172. doi:10.1006/jrpe.2001.2343

Misch, A., Over, H., & Carpenter, M. (2016). I won't tell: Young children show loyalty to their group by keeping secrets. *Journal of Experimental Child Psychology, 142*, 96-106. doi:10.1016/j.jecp.2015.09.016

Muris, P., Meesters, C., & van Asseldonk, M. (2018). Shame in me! Self-conscious emotions and big five personality traits and their relations to anxiety disorders symptoms in young, non-clinical adolescents. *Child Psychiatry and Human Development, 49*, 268-278. doi:10.1007/s10578-017-0747-7

Newheiser, A.-K., & Barreto, M. (2014). Hidden costs of hiding stigma: Ironic interpersonal consequences of concealing a stigmatized identity in social interactions. *Journal of Experimental Social Psychology, 52*, 58-70. doi:10.1016/j.jesp.2014.01.002

Niedenthal, P. M., Tangney, J. P., & Gavanski, I. (1994). "If only I weren't" versus "if only I hadn't": Distinguishing shame and guilt in counterfactual thinking. *Journal of Personality and Social Psychology, 67*(4), 585-595. doi:10.1037/0022-3514.67.4.585

Ogle, C. M., Rubin, D. C., & Siegler, I. C. (2014). Changes in neuroticism following trauma exposure. *Journal of Personality, 82*(2), 93-102. doi:10.1111/jopy.12037

Orgad, Y. (2017). On wabi sabi and the aesthetics of family secrets: Reading Haruki Murakami's Kafka on the shore. *Culture & Psychology, 23*(1), 52-73. doi:10.1177/1354067X16650811

Park, C. J. (2016). Chronic shame: A perspective integrating religion. *Journal of Religion & Spirituality in Social Work: Social Thought, 35*(4), 354-376. doi:10.1080/15426432.2016.1227291

Paulus, D. J., Vanwoerden, S., Norton, P. J., & Sharp, C. (2016). From neuroticism to anxiety: Examining unique contributions of three transdiagnostic vulnerability factors. *Personality and Individual Differences, 94*, 38-43. doi:10.1016/j.paid.2016.01.012

Peters, J. R., Eisenlohr-Moul, T. A., Walsh, E. C., & Derefinko, K. J. (2018). Exploring the pathophysiology of emotion-based impulsivity: The roles of the sympathetic nervous system and hostile reactivity. *Psychiatry Research, 267*, 368-375. doi:10.1016/j.psychres.2018.06.013

Platt, M. G., & Freyd, J. J. (2015). Betray me trust, shame on me: Shame, dissociation, fear, and betrayal trauma. *Psychological Trauma: Theory, Research, Practice, and Policy, 7*(4), 398-404. doi:10.1037/tra0000022

Porter, A. C., Zelkowitz, R. L., Gist, D. C., & Cole, D. A. (2019). Self-evaluation and depressive symptoms: A latent variable analysis of self-esteem, shame-proneness, and self-criticism. *Journal of Psychopathology and Behavioral Assessment, 41*, 257-270. doi:10.1007/s10862-019-09734-1

Probyn, E., Bozalek, V., Shefer, T., & Carolissen, R. (2019). Productive faces of shame: An interview with Elspeth Probyn. *Feminism & Psychology, 29*(2), 322-334. doi:10.1177/0959353518811366

Rains, S. A., & Brunner, S. R. (2018). The outcomes of broadcasting self-disclosure using new communication technologies: Responses to disclosure vary across one's social network. *Communications Research, 45*(5), 659-687. doi:10.1177/0093650215598836

Rana, M., Rana, M., Herzberg, P. Y., & Krause, C. (2015). Religious confession and symptom severity: A prospective comparative study. *Journal of Religion and Health, 54*(6), 2142-2154. doi:10.1007/s10943-014-9937-9

Rance, N., Clarke, V., & Moller, N. (2017). The anorexia nervosa experience: Shame, solitude, and salvation. *Counselling and Psychotherapy Research, 17*(2), 127-136. doi:10.1002/capr.12097

Randell, E., Joffer, J., Flacking, R., Starrin, B., & Jerden, L. (2018). Pride, shame and health among adolescents – A cross-sectional survey. *International Journal of Adolescent Medicine and Health, 30*(6), 1-11. doi:10.1515/ijamh-2016-0107

Rebelsky, F. G. (1963). An inquiry into the meanings of confession. *Merrill-Palmer Quarterly of Behavior and Development, 9*(4), 287-294. doi:10.2307/23082935

Reid, R. C., Stein, J. A., & Carpenter, B. N. (2011). Understandign the roles of shame and neuroticism in a patient sample of hypersexual men. *Journal of Nervous and Mental Disease, 199*(4), 263-267. doi:10.1097/NMD.0b013e3182125b96

Rober, P., Walravens, G., & Versteynen, L. (2012). "In search of a tale they can live with": About loss, family secrets, and selective disclosure. *Journal of Marital adn Family Therapy, 38*(3), 529-541. doi:10.1111/j.1752-0606.2011.00237.x

Ruppel, E. K. (2015). Use of communication technologies in romantic relationships: Self-disclosure and the role of relationship development. *Journal of Social and Personal Relationships, 32*(5), 667-686. doi:10.1177/0265407514541075

Ryan-DeDominicis, T. (2020). A case study using shame resilience theory: Walking each other home. *Clinical Social Work Journal,* 1-11. doi:10.1007/s10615-019-00745-9

Saginno, A., Carlucci, L., Sergi, M. R., D'Ambrosio, I., Fairchild, B., Cera, N., & Balsamo, M. (2017). A validation of the psychometric properties of the other as shamer scale- 2. *SAGE Open, 7*(2), 1-10. doi:10.1177/2158244017704241

Schalkwijk, F., Van Someren, E. J., & Wassing, R. (2019). A clinical interpretation of shame regulation in maladaptive perfectionism. *Personality and Individual Differences, 138,* 19-23. doi:10.1016/j.paid.2018.09.001

Scheel, C. N., Eisenbarth, H., & Rentzsch, K. (2020). Assessment of different dimensions of shame proneness: Validation of the SHAME. *Assessment, 27*(8), 1699-1717. doi:10.1177/1073191118820130

Scheff, T. (2014). The ubiquity of hidden shame on modernity. *Cultural Sociology, 8*(2), 129-141. doi:10.1177/1749975513507244

Scheff, T. J. (2001). Shame and community: Social components in depression. *Psychiatry, 64*(3), 212-224. doi:10.1521/psyc.64.3.212.18457

Scheff, T. J. (2003). Shame in self and society. *Symbolic Interaction, 26*(2), 239-262. doi:10.1525/si.2003.26.2.239

Semb, O., Stromsten, L. M., Sundbom, E., Fransson, P., & Henningsson, M. (2011). Distress after a single violent crime: How shame-proneness and event-related shame work together as risk factors for post-victimization symptoms. *Psychological Reports, 109*(1), 3-23. doi:10.2466/02.09.15.16.PR0.109.4.3-23

Shadbolt, C. (2009). Sexuality and shame. *Transactional Analysis Journal, 39*(2), 163-172. doi:10.1177/036215370903900210

Shahar, B., Doron, G., & Szepsenwol, O. (2015). Childhood maltreatment, shame-proneness and self-criticism in social anxiety disorder: A sequential mediational model. *Clinical psychology and psychotherapy, 22*, 570-579. doi:10.1002/cpp.1918

Sharma, A. R., & Tummala-Narra, P. (2014). Psychotherapy with Hindus. In P. S. RIchards, & A. E. Bergin (Eds.), *Handbook of psychotherapy and religious diversity* (Second ed., pp. 321-345). Washington, D.C.: American Psychological Association.

Shaughnessy, M. (2018). Concept inventing: A humanbecoming persective on feeling ashamed. *Nursing Science Quarterly, 31*(2), 111-116. doi:10.1177/0894318418755738

Shaughnessy, M. J. (2018). Integrative literature review on shame. *Nursing Science Quarterly, 31*(1), 86-94. doi:10.1177/0894318417741120

SimplePractice, LLC. (2021). Retrieved from simplepractice: simplepractice.com

Simpson, A. J., Hermann, A. D., Lehtman, M. J., & Fuller, R. C. (2016). Interpersonal trangressions and interest in spiritual activities: The role of narcissism. *Current Psychology, 35*(2), 195-206. doi:10.1007/s12144-015-9393-z

Sklidi, O. (2018). 'Am I a Ceadas child?': Exploring the nature and experience of shame in the psychotherapy of an adolescent boy. *Journal of Child Psychotherapy, 44*(2), 202-220. doi:10.1080/0075417X.2018.1469659

Slepian, M. L., Chun, J. S., & Mason, M. F. (2017). The experience of secrecy. *Journal of Personality and Social Psychology, 113*(1), 1-33. doi:10.1037/pspa0000085

Slepian, M. L., Halevy, N., & Galinsky, A. D. (2019). The solitude of secrecy: Thinking about secrets evokes goal conflict and feelings of fatigue. *Personality and Social Psychology Bulletin, 45*(7), 1129-1151. doi:10.1177/0146167218810770

Slepian, M. L., Kirby, J. N., & Kalokerinos, E. K. (2020). Shame, guilt, and secrets on the mind. *Emotion, 20*(2), 323-328. doi:10.1037/emo0000542.supp

Smith, R., & McElwee, G. (2011). After the fall: Developing a conceptual script-based model of shame in narratives of entrepreneurs in crisis! *International Journal of Sociology and Social Policy, 31*(1/2), 91-109. doi:10.1108/0144333111104823

Son, A. (2018). Inadequate innocence of Korean comfort girls-women: Obliterated dignity and shamed self. *Pastoral Psychology, 67*, 175-194. doi:10.1007/s11089-017-0779-8

Spermon, D., Darlington, Y., & Gibney, P. (2013). Complex posttraumatice stress disorder: Voices of healing. *Qualitative Health Research, 23*(1), 43-53. doi:10.1177/1049732312461451

Squire, C. (2015). Partial Secrets. *Current Anthropolgy, 56*(S12), 201-210. doi:10.1086/683299

Steiner, J. (2015). Seeing and being seen: Shame in the clinical situation. *The International Journal of Psychoanalysis, 96*(6), 1589-1601. doi:10.1111/1745-8315.12419

Stotz, S. J., Elbert, T., Muller, V., & Schauer, M. (2015). The relationship between trauma, shame, and guilt: Findings from a community based study of refugee minors in Germany. *European Journal of Psychotraumatology, 6*(1), 1-10. doi:10.3402/ejpt.v6.25863

Stuewig, J., & McCloskey, L. A. (2005). The relation of child maltreatment to shame and guilt among adolescents: Psychological routes to depression and deliquency. *Child Maltreatment, 10*(4), 324-336. doi:10.1177/1077559505279308

Stuewig, J., Tangney, J. P., Kendall, S., Folk, J. B., Meyer, C. R., & Dearing, R. L. (2015). Children's proneness to shame and guilt predict risky and illegal behaviors in young adulthood. *Child Psychiatry & Human Development, 46*, 217-227. doi:10.1007/s10578-014-0467-1

Stuewig, J., Tangney, J. P., Mashek, D., Forkner, P., & Dearing , R. (2009). The oral emotions, alcohol dependence, and HIV risk behavior in an incarcerated sample. *Substance Use & Misuse, 44*, 449-471. doi:10.1080/10826080802421274

Szentagotai-Tatar, A., Chis, A., Vulturar, R., Dobrean, A., Candea, D. M., & Miu, A. C. (2015). Shame and guilt-proneness in adolescents: Gene-environment interactions. *PLoS ONE, 10*(7), 1-15. doi:10.1371/journal.pone.0134716

Szlyk, H. S., Gulbas, L., & Zayas, L. (2019). "I just kept it to myself": The shaping of Latina suicidality through gendered oppression, silence, and violence. *Family Process*, *58*(3), 778-790. doi:10.1111/famp.12384

Tangney, J. P. (1990). Assessing individual differences in proneness to shame and guilt: Development of the self-conscious affect and attribution inventory. *Journal of Personality and Social Psychology, 39*(1), 102-111. doi:10.1037/0022-3514.59.1.102

Tangney, J. P. (1991). Moral affect: The good, the bad, and the ugly. *Journal of Personality adn Social Psychology, 61*(4), 598-607. doi:10.1037/0022-3514.61.4.598

Tangney, J. P. (1995). Recent advances in the empirical study of shame and guilt. *The American Behavioral Scientist, 38*(8), 1132-1145. doi:10.1177/0002764295038008008

Tangney, J. P. (1996). Conceptual and methodological issues in the assessment of shame and guilt. *Behaviour Research and Therapy, 34*(9), 741-754. doi:10.1016/0005-7967(96)00034-4

Tangney, J. P., Mashek, D., & Stuewig, J. (2005). Shame, guilt, and embarrassment: Will the real emotion please stand up? *Psychological Inquiry, 16*(1), 44-48. Retrieved from https://www.jstor.org/stable/20447260

Tangney, J. P., Miller, R. S., Flicker, L., & Barlow, D. H. (1996). Are shame, guilt, and embarrassment distinct emotions? *Journal of Personality and Social Psychology, 70*(6), 1256-1269. doi:10.1037//0022-3514.70.6.1256

Tangney, J. P., Niedenthal, P. M., Covert, M. V., & Barlow, D. H. (1998). Are shame and guilt related to distinct self-discrepancies? A test of HIggins's (1987) hypotheses. *Journal of Personality and Social Psychology, 75*(1), 256-268. doi:10.1037/0022-3514.75.1.256

Tangney, J. P., Stuewig, J., & Hafez, L. (2011). Shame, guilt, and remorse: Implications for offender populations. *Journal of Forensic Psychiatry & Psychology, 22*(5), 706-723. doi:10.1080/14789949.2011.617541

Tangney, J. P., Stuewig, J., & Martinez, A. G. (2014). Two faces of shame: The roles of shame and guilt in predicting recidivism. *Psychological Science, 25*(3), 799-805. doi:10.1177/0956797613508790

Tangney, J. P., Stuewig, J., & Mashek, D. J. (2007). Moral emotions and moral behavior. *Annual Review of Psychology, 58*(1), 345-372. doi:10.1146/annurev.psych.56.091103.070145

Tangney, J. P., Stuewig, J., Mashek, D., & Hastings, M. (2011). Assessing jail inmates' proneness to shame and guilt. *Criminal Justice and Behavior, 38*(7), 710-734. doi:10.1177/0093854811405762

Tangney, J. P., Wagner, P. E., Hill-Barlow, D., Marschall, D. E., & Gramzow, R. (1996). Relation of shame and guilt to constructive versus destructive responses to anger across the lifespan. *Journal of Personality and Social Psychology, 70*(4), 797-809. doi:10.1037/0022-3514.70.4.797

Tangney, J. P., Wagner, P., & Gramzow, R. (1992). Proneness to shame, proneness to guilt, and psychopathology. *Journal of Abnormal Psychology, 101*(3), 469-478. doi:10.1037/0021-843X.101.3.469

Tangney, J. P., Wagner, P., Fletcher, C., & Gramzow, R. (1992). Shamed into anger? The relation of shame and guilt to anger and self-reported aggression. *Journal of Personality and Social Psychology, 62*(4), 669-675. doi:10.1037/0022-3514.62.4.669

Taylor, S. E., Klein, L. C., Lewis, B. P., Gruenewald, T. L., Gurung, R. A., & Updegraff, J. A. (2000). Biobehavioral responses to stress in females: Tend-and-befriend, not fight-or-flight. *Psychological Review, 107*(3), 411-429. doi:10.1037//0033-295X.107.3.411

Tener, D. (2018). The secret of intrafamilial child sexual abuse: Who keeps it and how? *Journal of Child Sexual Abuse, 27*(1), 1-21. doi:10.1080/10538712.2017.1390715

Tortoriello, G. K., & Hart, W. (2019). Trait interpersonal vulnerability attenuates beneficial effects of constructive criticism on failure responses. *British Journal of Psychology, 110,* 594-613. doi:10.1111/bjop.12356

Tracy, J. L., Cheng, J. T., Robins, R. W., & Trzesniewski, K. H. (2009). Authentic and hubristic pride: The affective core of self-esteem and narcissism. *Self and Identity, 8*(2-3), 196-213. doi:10.1080/15298860802505053

Turner, M. J. (2020). A history of confession of sin: From the early church to modern evangelicalism. *The Reformed Theological Review, 79*(1), 38-63.

Ussher, J. M., Perz, J., Metusela, C., Hawkey, A. J., Morrow, M., Narchal, R., & Estoesta, J. (2017). Negotiating discourses of shame, secrecy, adn silence: Migrant and refugee women's experiences of sexual embodiment. *Archives of Sexual Behavior, 46,* 1901-1921. doi:10.1007/s10508-016-0898-9

van der Merwe, A., & Swartz, L. (2015). Living in two narratives: Psychic splitting in South African survivors of chronic trauma. *South African Journal of Psychology, 45*(3), 361-373. doi:10.1177/0081246315574826

Van Vliet, K. J. (2008). Shame and resilience in adulthood: A grounded theory study. *Journal of Counseling Psychology, 55*(2), 233-245. doi:10.1037/0022-0167.55.2.233

Vangelisti, A. L. (1994). Family secrets: Forms, functions and correlates. *Journal of Social and Personal Relationships, 11*(1), 113-135. doi:10.1177/0265407594111007

Vizin, G., Urban, R., & Unoka, Z. (2016). Shame, trauma, temperament and psychopathology:Construct validity of the experience of shame scale. *Psychiatry Research, 246,* 62-69. doi:10.1016/j.psychres.2016.09.017

Volk, F., Thomas, J., Sosin, L., Jacob, V., & Moen, C. (2016). Religiosity, developmental context, and sexual shame in pornography users: A serial mediation model. *Sexual Addiction & Compulsivity, 23*(2-3), 244-259. doi:10.1080/10720162.2016.1151391

Wang, W., Wang, B., Yang, K., Yang, C., Yuan, W., & Song, S. (2018). When project commitment leads to learning from failure: The roles of perceived shame and personal control. *Frontiers in Psychology, 9*(86), 1-12. doi:10.3389/fpsyg.2018.00086

Wegner, D. M., & Lane, J. D. (1995). From secrecy to psychopathology. In *Emotion, disclosure, and health* (pp. 25-46). Washington, DC: American Psychological Association. doi:10.1037/10182-002

Weingarden, H., Renshaw, K. D., Wilhelm, S., Tangney, J. P., & DiMauro, J. (2016). Anxiety and shame as risk factors for depression, suicidality, and functional impairment in body dysmorphic disorder and obsessive compulsive disorder. *The Journal of Nervous and Mental Disease, 204*(11), 832-839. doi:10.1097/NMD.0000000000000498

Weiss, K. G. (2010). Too ashamed to report: Deconstructing the shame of sexual victimization. *Feminist Criminology, 5*(3), 286-310. doi:10.1177/1557085110376343

Werner, A., & Malterud, K. (2016). Children of parents with alcohol problems performing normality: A qualitative interview study about unmet needs for professional support. *International Journal of Qualitative Studies on Health and Well-being, 11*, 1-11. doi:10.3402/qhw.v11.30673

Wertheim, R., Hasson-Ohayon, I., Mashiach-Eizenberg, M., Pizem, N., Shacham-Shmueli, E., & Goldzweig, G. (2018). Hide and "sick": Self-concealment, shame, and distress in the setting of psycho-oncology. *Palliative and Supportive Care, 16*, 461-469. doi:10.1017/s1478951517000499

Wille, R. (2014). The shame of existing: An extreme form of shame. *The International Journal of Psychoanalysis, 95,* 695-717. doi:10.1111/1745-8315.12208

Wilson, M. (2000). Creativity and shame reduction in sex addiction treatment. *Sexual Addiction and Compulsivity, 7*(4), 229-248. doi:10.1080/10720160008403699

Wismeijer, A. A. (2011). Self-concealers: Do they conceal what we always assumed they do? *Personality and Individual Differences, 51,* 1039-1043. doi:10.1016/j.paid.2011.08.019

Wong, W. C., Holroyd, E., Miu, H. Y., Wong, C. S., Zhao, Y., & Zhang, J. (2017). Secrets, shame, and guilt: HIV disclosure in rural Chinese families from the perspective of caregivers. *Vulnerable Children and Youth Studies, 12*(4), 292-303. doi:10.1080/17450128.2017.1344343

Yalom, I. (1970). *The theory and practice of group-psychotherapy.* New York: Basic Books.

Zarei, M., Momeni, F., & Mohammadkhani, P. (2018). The mediating role of cognitive flexibility, shame and emotion dysregulation between neuroticism and depression. *Iranian Rehabilitation Journal, 16*(1), 61-68. doi:10.29252/NRIP.IRJ.16.1.61

Zerbe, K. (2016). Psychodynamic issues in the treatment of binge eating: Working with shame, secrets, no-entry, and false body defenses. *Clinical Social Work Journal*(44), 8-17. doi:10.1007/s10615-015-0559-9

Zerbe, K. (2019). The secret life of secrets: Deleterious psychosomatic effects on patient and analyst. *Journal of the American Psychoanalytic Association, 67*(1), 185-214. doi:10.1177/0003065119826624

Zhang, J. W., Chen, S., Tomova Shakur, T. K., Bilgin, B., Chai, W. J., Ramis, T., . . . Manukyan, A. (2019). A compassionate self is a true self? Self-compassion promotes subjective

authenticity. *Personality and social psychology Bulletin, 45*(9), 1323-1337. doi:10.1177/0146167218820914

Zhong, J., Wang, A., Qian, M., Zhang, L., Gao, J., Yang, J., . . . Chen, P. (2008). Shame, personality, and social anxiety symptoms in Chinese and American nonclinical samples: A cross-cultural study. *Depression and Anxiety, 25*, 449-460. doi:10.1002/da.20358

Appendix A

Guilt and Shame Proneness Scale (GASP)

Instructions: In this questionnaire you will read about situations that people are likely to encounter in day-to-day life, followed by common reactions to those situations. As you read each scenario, try to imagine yourself in that situation. Then indicate the likelihood that you would react in the way described.

1	2	3	4	5	6	7
Very Unlikely	*Unlikely*	*Slightly Unlikely*	*About 50% Likely*	*Slightly Likely*	*Likely*	*Very Likely*

_____ 1. After realizing that you have received too much change at a store, you decide to keep it becau
uncomfortab
_____ 2. Yo ot
make the ho lihood
that this wou
_____ 3. Yo acher
discovers wh od
that this wou
_____ 4. Aft were
depending o lihood
that you wou
_____ 5. Yo
likelihood th ep
secrets in the
_____ 6. Yo ers it
was your fau feel
incompetent
_____ 7. A f would
stop spendin
_____ 8. Yo ite
themselves i
_____ 9. Yo horse
about breaki
_____ 10. Y lies are
discovered a ink that
you are a de
_____ 11. Y s
aware of it, y ke you
think more c
_____ 12. Y . What
is the likelihood that this would lead you to quit your job?

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INVENTORY

_____ 13. You make a mistake at work and find out a coworker was blamed for the error. Later, your
would feel l
_____ 14. A
colored carp
likelihood th
_____ 15. W
shouting tho
more consid
_____ 16. Y
would feel t

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OF THIS INVENTORY

GASP SCORING: The GASP is scored by averaging the four items in each subscale.
Guilt-Negative-Behavior-Evaluation (NBE): 1, 9, 14, 16
Guilt-Repair: 2, 5, 11, 15
Shame-Negative-Self-Evaluation (NSE): 3, 6, 10, 13
Shame-Withdraw: 4, 7, 8, 12

Cohen, T. R., Wolf, S. T., Panter, A. T., & Insko, C. A. (2011). Introducing the GASP scale: A new measure of guilt and shame proneness. *Journal of Personality and Social Psychology, 100*(5), 947-966. doi:10.1037/a0022641

Yes, you have my permission.

On Wed, Nov 11, 2020, 6:25 PM Gregory, Ann M wrote:

Dr. Cohen,

I am doing a study on shame for my dissertation and would like to use the Guilt and Shame Proneness scale. I wanted to check with you for permission.

Thank you so much,

Ann Gregory

PhD Candidate

Counselor Education and Supervision

Liberty University

Appendix B

The Mini-International Personality Item Pool Scale for Neuroticism (mini-IPIP neuroticism)

Item	Factor		er
1	E		1
2	A		7
3	C		3
4	N		9
5	I	THIS BOX IS HERE	5
6	E	TO PROTECT	6
7	A		2
8	C	THE CONTENT	8
9	N		9
10	I	OF THIS	0
11	E	INVENTORY	1
12	A		2
13	C		3
14	N		9
15	I		0
16	E		6
17	A		2
18	C		8
19	N		9
20	I		0

Note: E = Extraversion; A = Agreeableness; C = Conscientiousness; N = Neuroticism; I = Intellect/Imagination; (R) = Reverse Scored Item. Original item number refers to the corresponding item on the original 50-item IPIP-FFM.

Donnellan, M. B., Oswald, F. L., Baird, B. M., & Lucas, R. E. (2006). The mini-IPIP scales: Tiny-yet-effective measures of the big five factors of personality. *Psychological Assessment, 18*(2), 192-203. doi: 10.1037/1040-3590.18.2.192

Hi Ann,

No permission is needed – feel free to use it! Good luck with your project. –brent donnellan

From: Gregory, Ann M
Sent: Wednesday, November 11, 2020 6:35 PM
To: Donnellan, Brent
Subject: Mini IPIP

Dr. Donnellan,

I am doing a study on shame and the telling of a shame-secret for my dissertation. I am controlling for neuroticism and would like to use the mini-IPIP. I wanted to check with you for permission.

Thank you so much,

Ann Gregory

PhD Candidate

Counselor Education and Supervision

Liberty University

Appendix C

The Self-Concealment Scale (SCS)

Please rate each statement on a scale from 1(strongly disagree) to 5 (strongly agree).

	Strongly Disagree				Strongly agree
1. I hav share	1	2	3	4	5
2. If I sl they’	1	2	3	4	5
3. There keep	1	2	3	4	5
4. Some me.	1	2	3	4	5
5. Wher tend	1	2	3	4	5
6. I’m c I don	1	2	3	4	5
7. Telli wish	1	2	3	4	5
8. I hav lie if	1	2	3	4	5
9. My s with	1	2	3	4	5
10. I hav I nev	1	2	3	4	5

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TO PROTECT

THE CONTENT

OF THIS

INVENTORY

Larson, D. G., & Chastain, R. L. (1990). Self-concealment: Conceptualization, measurement, and health implications. *Journal of Social and Clinical Psychology*, *9*(4), 439-455. doi:10.1521/jscp.1990.9.4.439

Ann--

Yes, you have my permission. Here are some items that might be helpful.

Please share your results when you have them. This is really important work. Shame is the glue that keeps things hidden, as I think Nathanson said. In our review paper we call for more work on shame.

Onward! Dale

On Wed, Nov 11, 2020 at 3:30 PM Gregory, Ann M wrote:

Dr. Larson,

I am doing a study on secrets and shame for my dissertation, and wanted to check with you for permission to use the Self-Concealment Scale.

Thank you so much,

Ann Gregory

PhD Candidate

Counselor Education and Supervision

Liberty University

Appendix D

The Experience of Shame Scale (ESS)

Everybody at times can feel embarrassed, self-conscious, or ashamed. These questions are about such feelings if they have occurred **at any time in the past year**. There are no 'right' or 'wrong' answers. Please indicate the response which applies to you.

	not at all	a little	moderately	very much
1. Have you felt ashamed of any of you	1	2	3	4
2. Hav peo habi				4
3. Hav any				4
4. Hav with				4
5. Hav thin				4
6. Hav you				4
7. Hav pers				4
8. Hav thin				4
9. Hav sort				4
10. Hav do t				4
11. Hav thin				4
12. Hav inab				4
13. Do som				4
14. Hav thin				4
15. Hav thin				4
16. Hav som				4
17. Hav think of you when you said something stupid?				4

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Andrews, B., Qian, M., & Valentine, J. D. (2002). Predicting depressive symptoms with a new measure of shame: The experience of shame scale. *British Journal of Clinical Psychology, 41*, 29-42. doi:10.1348/014466502163778

Ann

I am happy for you to use the Experience of Shame Scale for the purpose of your research dissertation..

Best regards

Bernice Andrews

Bernice Andrews PhD FBPSs

Emeritus Professor of Psychology

Royal Holloway University of London

TW20 0EX

From: Gregory, Ann M
Sent: 11 November 2020 23:47
To: Andrews, Bernice
Subject: [EXT] The Experience of Shame Scale

Dr. Andrews,

I am doing a study on shame and the telling of a shame story for my dissertation and would like to ask your permission to use the Experience of Shame Scale.

Thank you so much,

Ann Gregory

PhD Candidate

Counselor Education and Supervision

Liberty University

Appendix E

The External and Internal Shame Scale

Below are a series of statements about feelings people may usually have, but that might be experienced by each person in a different way. Please read each statement carefully and indicate how often you feel what is described in each item.

		Never			Always
1.	Oth thei				4
2.	I an				4
3.	Oth				4
4.	I an				4
5.	Oth				4
6.	I an				4
7.	Oth of r				4
8.	I an				4

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Ferreira, C., Moura-Ramos, M., Marcela, M., & Galhardo, A. (2020). A new measure to assess external and internal shame: Development, factor structure and psychometric properties of the external and internal shame scale. *Current Psychology*, 1-10. doi:10.1007/s12144-020-00709-0

Dear Ann Gregory,

Thank you for your interest in using the EISS. I am sending you the scale, as well as the paper, as attachment files.

Good luck for your work!

Kind regards,

Ana Galhardo

Clinical Psychologist, PhD
Assistant Professor - ISMT, Coimbra
Associate Researcher - CINEICC, University of Coimbra, Portugal

www.ismt.pt

Largo da Cruz de Celas, nº 1
3000-132 Coimbra
Tel:
Fax:

Appendix F

The Other as Shamer Scale- 2 (OAS-2)

Indicate the frequency (0 = Never, 4 = Almost Always) of your feelings or experiences to the following items:

	Never				Almost Always
1. I fe	0	1	2	3	4
2. Oth					4
3. Peo					4
4. Oth					4
5. I th					4
6. I fe					4
7. Oth					4
8. Oth a person.					4

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Matos, M., Pinto-Gouveia, J., Gilbert, P., Duarte, C., & Figueiredo, C. (2015). The other as shamer scale – 2: Development and validation of a short. *Personality and Individual Differences, 74,* 6-11. doi:10.1016/j.paid.2014.09.037

Dear Ann,

Thank you for your email. You have permission to use the OAS2 in your studies. Best of luck with your work!

Best wishes,

Marcela

--

Marcela Matos, Ph.D.

Clinical Psychologist, Postdoctoral Research Fellow

Universidade de Coimbra I Faculdade de Psicologia e de Ciências da Educação
Centro de Investigação em Neuropsicologia e Intervenção Cognitivo Comportamental I CINEICC
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University of Coimbra I Faculty of Psychology and Educational Sciences
Center for Research in Neuropsychology and Cognitive and Behavioral Intervention I CINEICC
Rua do Colégio Novo I 3000-115 Coimbra I Portugal
https://cineicc.uc.pt

No dia 11/11/2020, às 23:39, Gregory, Ann M escreveu:

Dr. Matos,

I am doing a study on shame and the telling of a shame-secret for my dissertation. I wanted to check with you for permission to use the Other as Shamer Scale-2.

Thank you so much,

Ann Gregory

PhD Candidate

Counselor Education and Supervision

Liberty University

Sent from Mail for Windows 10