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Inquiry into shame: exploring mindfulness, self-compassion, acceptance, and mind-wandering as methods of shame management

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A thesis submitted for the degree of Doctor of Philosophy

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Table of Contents

List of Tables and Figures

List of Appendices

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Declaration

The clinical data (n = 140) in Study 5 were collected by Dr Jeremy Gauntlett-Gilbert and colleagues at the Bath centre for pain service.

Abstract

Shame is a complex emotion and often discussed with reluctance; these feelings are usually incapacitating and unbearable. In this thesis, four studies explored aspects of shame vulnerability and shame management.

First, a cross-sectional study (n = 240) was carried out to assess factors contributing to the experience of shame. This study demonstrated that negative self-judgment and submissive coping strategies accounted for a significant variance in shame above and beyond the effects of recall of adverse childhood experiences, and that negative self-judgment fully mediated the relationship between recall of childhood experiences and shame.

The second study (n = 140 and n = 415) examined the underlying factor structure of a new measure: the Acceptance of Shame and Embarrassment Scale (ASES). Factor analysis in both samples revealed that the ASES had good internal consistency and construct validity.

Thirdly, a cross sectional study (n = 159) considered self-compassion and mindfulness as methods of shame management and demonstrated that mindful and self-compassionate were significantly and negatively correlated with the experience of shame. In addition, this study showed that self-compassion fully mediated the mindfulness-shame relationship.

The final experimental study (n = 120) assessed the effect of shame on mind wandering. Participants were assigned to shame, pride, or control conditions, and mind wandering during a subsequent reading task was measured using retrospective and behavioural methods. Inducing feelings of shame did not have a significant effect on mind wandering.

Overall, these studies suggested that (a) adverse childhood experiences were significantly associated with negative self-judgment and shame, (b) adopting submissive coping strategies is likely to increase the chance of shame vulnerability, (c) the Acceptance of Shame and Embarrassment Scale had promising psychometric properties for assessing acceptance of shame and embarrassment experiences, (d) self-compassion mediated the relationship between mindfulness and shame, and (e) inducing feelings of shame did not have a significant effect on mind wandering.

List of Common Abbreviations

AAQ-II = Acceptance and Action Questionnaire-II

ACT = Acceptance Commitment Therapy

ANOVA = Analysis of Variance

ASES = Acceptance of Shame and Embarrassment Scale

BFNE = Brief Fear of Negative Evaluation Scale

CBT = Cognitive Behavioural Therapy

CoSS = Compass of Shame Scale

CPVI = Chronic Pain Values Inventory

DBT = Dialectical Behaviour Therapy

ESS = Experience of Shame Scale

ISS = Internalized Shame Scale

MBCT = Mindfulness-Based Cognitive Therapy

MBSR = Mindfulness-Based Stress Reduction

OAS = Other as Shamer Scale

PBI= Parental Bonding Instrument

PHLM = Philadelphia Mindfulness Scale

PHQ-9 = Patient Health Questionnaire

RQ = Relationship Questionnaire

SAHP = Social Attention Holding Power

SART = Sustained Attention to Response Task

SCF-SF = Self-Compassion Scale-Short Form

TOSCA = Test of Self-Conscious Affect

VIF = Variance Inflation Factor

Organisation and Content of Thesis

The overarching aim of this thesis is to investigate different aspects of shame vulnerability and shame management. This thesis begins with Chapter 1 discussing the importance of shame. Then, it highlights recent empirical findings in order to define shame and explore its different aspects and characteristics. Furthermore, the chapter briefly introduces the topic of the first empirical study in the thesis. Chapter 1 also identifies differences between shame and similar affective experiences such as guilt and embarrassment and takes a closer look at shame in different cultures and contexts.

Chapter 2 focuses on shame management and shame responses. It starts with a discussion of positive aspects of shame and explores the potential functions of shame. Afterwards, Chapter 2 considers the negative side of shame, pinpointing how shame is positively associated with a wide variety of psychological difficulties. Chapter 2 also examines methods and manners that people often employ to respond to and regulate shame. Finally, the chapter presents new strategies for managing shame which will be focus of the three empirical chapters.

Chapter 3 explores the assessment of shame and how shame can be induced and measured in experimental research. Shame is a difficult emotion to assess, therefore, this chapter more closely considers strengths and weaknesses of the common self-reported measures of shame. In addition, Chapter 3 presents the aims and objectives for the empirical section of the thesis and outlines research questions and primary research hypotheses.

Chapter 4 (Study 1) focuses on factors contributing to shame vulnerability. It specifically examines recall of adverse childhood experiences, adult attachment styles, negative self-judgement, and coping styles. The primary aim of Chapter 4 is to explore the importance of negative childhood experiences in shame vulnerability and to

understand why some individuals are more vulnerable to the experience of shame than others by highlighting contributing factors.

Chapter 5 (Study 2) proposes that acceptance of shame can be considered as a reliable and effective method for managing shame. This chapter will identify the factor structure for a newly devised measure: Acceptance of Shame and Embarrassment Scale. It determines the construct and discriminant validity of this scale and examines how acceptance of shame and embarrassment might be related to health and depression.

Chapter 6 (Study 3) investigates the relationships between shame, self-compassion, mindfulness, and the acceptance of shame and embarrassment. The primary aim of this chapter is to explore a potential mechanism that might underline the mindfulness-shame relationship.

Chapter 7 (Study 4) presents an experimental study exploring the effect of shame on mind-wandering. This chapter proposes that after an experience of shame, individuals engage in mind-wandering in order to manage their feelings of shame. This study specifically examines how shame influences mind-wandering by assessing attention and concentration during a reading task.

Chapter 8 summarises the findings from Studies 1 to 4. It follows up on the implications of these results, reflecting their meanings for the literature on shame and shame management. Chapter 8 further explores the existing challenges and limitations involved in studying and assessing shame. In addition, it highlights important avenues for future research.

CHAPTER 1. Shame

1.1. Introduction

This chapter will introduce the topic of this thesis: shame. Shame is notoriously unpleasant emotion that almost all of us have experienced at least once in our lifetimes. Almost everyone knows what the feeling of shame is like. However, we are reluctant to disclose our shameful experiences. It is often mentioned that shame is a taboo subject (Brown, 2010). Ironically, we are ashamed of our shame. It seems to be much easier to say that "I am angry/sad/nervous" than to say "I am ashamed." Rather than finding it liberating, there is an assumption that talking about shame is demeaning, or is a sign of weakness. Therefore, until recently, there has been a dearth of research, understanding, and knowledge about shame, to the extent that shame and similar emotions, such as guilt, are used interchangeably in the literature.

Helen Block Lewis' (1971) work has renewed an interest in the study of shame. She effectively differentiated shame from guilt by putting an emphasis on the self versus action. She offered a new perspective that has significantly influenced scholarly literature. During the past four decades, her views have been extended and expanded upon by shame theorists such as Tangney and colleagues (Tangney & Fischer, 1995; Tangney & Dearing, 2002), M. Lewis (1992), Gilbert and Andrews (1998), and Tracy and Robins (2007c), to name a few.

Nonetheless, it can still be argued that shame is insufficiently researched in comparison to emotions like sadness, happiness, or fear. Since shame appears to be present in a wide variety of psychological disorders and is associated with mental health problems such as depression, social phobia, and eating disorders, it is necessary to extend our knowledge in this area, and to become well-equipped to deal with shame.

The overarching purpose of this thesis is to investigate shame management and shame vulnerability. In order to do so, this chapter presents an overview of shame, and explores the nature and main features thereof. This chapter has been divided into three sections: understanding of shame, differentiation of shame from similar constructs, and associations between shame, culture, and gender.

The aim of the first section is to take a close look at the theories and research examining what shame is. This section will look at how shame is defined in the literature, what kind of emotion shame is, when shame occurs, its development and parental influence, expressions of shame, and how shame is classified.

The second section will differentiate shame from similar emotions and constructs; this is an important issue because we tend to use guilt when we mean shame in everyday conversations, or we often say: "I felt so ashamed, that was embarrassing." Although shame, guilt, embarrassment, shyness, and humiliation share a degree of similarity, they are separate emotions. From scientific and psychological perspectives, it would be misleading and inconceivable to consider these emotions to be the same. The aim of this section is to clarify what shame is and what shame is not, and to highlight the differences and similarities between shame and related constructs.

The last part of this chapter will look at the cultural differences that might impact any analysis of shame. For example, is shame experienced and viewed differently in individualist cultures versus collectivist cultures? Is shame embedded in culture? Furthermore, this section considers how social groups and group membership can be a source of shame. Finally, the link between shame, gender, and age will be explored. The aim of this section is to extend our understanding of shame by considering the diversity that might exist in the experience in different cultures or different sexes.

1.2. Part One: Understanding of Shame

1.2.1. What Is Shame?

"The feeling you get as a result of doing or thinking something you believe to be bad or immoral. It can also come from a fear of others finding out what you've done."

"Embarrassment or the feeling of being annoyed at yourself. I would describe it as disappointment."

"I would describe shame as an emotion of particular ridicule or a sense of diverging from the social norm, i.e. not fitting into the world, being particularly different from what is socially accepted and exposed as such."

"When you feel as though you have done something bad to someone else you know. When you can't look at someone in the eye."

These are a few examples of how students at the University of Bath, largely unfamiliar with psychology, described shame. Like these students, I also find it very difficult to define shame. From my personal experience, I can say that shame is an overwhelmingly negative emotion. Feelings of shame make me feel insignificant and inferior. When I feel shame, I wish the ground would swallow me up. I wish I could be invisible and not be noticed. According to the Oxford English Dictionary, shame is:

> The painful emotion arising from the consciousness of something dishonouring, ridiculous, or indecorous in one's own conduct or circumstances (or in those of others whose honour or disgrace one regards as one's own), or of being in a situation which offends one's sense of modesty or decency (OED online, December, 2014).

The word shame originated from an older word (skam/skem), which means to cover or to hide (Harper, 2011). This definition may draw particular attention to the secret nature of shame and the desire to disappear or withdraw.

Traditional theoretical accounts have viewed shame as an innate affect that is expressed by lowered eyes and head. In addition, shame has been identified as an essential emotion with adaptive purposes. Shame was responsible for controlling excessive excitement or joy (Tomkins, 1963). According to this view, shame is triggered by a variety of unrelated stimuli, and it is not differentiated from guilt or embarrassment at the level of affect (Harder, 1995; Rahm, Renck, & Ringsberg, 2006). However, it could be argued that interruptions of positive emotions are likely to produce emotions such as sadness, anger, or resentment rather than shame. It is not clear why feelings of shame are evoked in these situations (Gilbert, 1998).

The current shame theorists and the empirical research suggest that shame is one of the so-called *self-conscious* emotions (M. Lewis, 1992), because it mainly involves an evaluation of the self. Shame is believed to be an incapacitating emotion that is accompanied by the feeling of being small, inferior, and of shrinking. The self, as a whole, is devalued and considered to be inadequate, incompetent, and worthless. Shame might also involve the feeling of being exposed, condemned, and ridiculed (Tangney, Stuewig, & Mashek, 2007; Vikan, Hassel, Rugset, Johansen, & Moen, 2010).

Gilbert (2002) stated that shame can be considered as a "multifaceted experience" with different features and components including: a "social or external cognitive component, internal self-evaluative component, emotional component, behavioural component," and "physiological component" (p. 5). *A social or external cognitive component* refers to the idea that shame often occurs in social contexts and evokes thoughts such as "others see me as worthless and inferior". *An internal self-evaluative component* refers to the notion that shame can include negative evaluations of the self and negative thoughts about the self, such as "I am a failure, inadequate, ugly, and worthless." *An emotional component* refers to the idea that feelings and

emotions such as self-disgust, anger, and anxiety may occur or exist when individuals feel shame. *A behavioural component* includes defensive responses, such as a desire to hide, avoid eye contact, engage in submissive behaviour, express anger, or a desire to take revenge that is often associated with shame. *A physiological component* suggests that shame is associated with a stress response, or that it may increase parasympathetic activity. In the following sections, I further explore the nature and characteristics of shame in order to elucidate its meaning and description.

1.2.2. What Kind of Emotion is Shame?

Emotions such as sadness, happiness, fear, anger, and disgust are usually regarded as basic emotions because they are assumed to be biologically primitive, and to have survival and reproductive values (Ortony & Turner, 1990; Tracy & Robins, 2004). For example, it is often mentioned in the literature that fear evokes the fight-or-flight reaction, which is a physiological response to a potential threat or attack, and is essential for the survival of animals and humans. The basic emotions are also thought to be universal and pan-cultural; they are associated with recognisable facial expressions that convey a particular meaning or information in all cultures across the world. Furthermore, basic emotions do not necessarily require higher cognition or thought processes; therefore, they can be experienced by both humans and animals (Ortony & Turner, 1990; Tracy & Robins, 2004).

Unlike basic emotions, shame does not seem to have distinctive universal facial expressions, and is not experienced similarly in different cultures (Edelstein & Shaver, 2007). Emotions such as shame, pride, guilt, embarrassment, envy, empathy, and jealousy are associated with a sense of self and self-awareness; hence, they belong to a family of self-conscious emotions (Gilbert, 2011; M. Lewis, 1992; Tracy & Robins, 2004). To experience shame, individuals need an ability to form self-representations,

internalise external values, and compare and evaluate themselves. Therefore, shame is not experienced in species with lower cognitive abilities and understanding (M. Lewis, 1992; Tracy & Robins, 2004).

Nevertheless, Gruenewald, Dickerson, and Kemeny (2007) considered shame to be a basic emotion. They have argued against the binary classification of emotions (primary versus secondary or basic versus complex). They suggested that it would be more suitable to regard emotions along a continuing axis from basic to more complex. According to these authors, shame fulfils most of the essential criteria for a basic emotion. For instance, they reasoned that although shame does not have a defined facial expression, it can be identified through a mixture of facial and bodily behaviours, such as gaze avoidance and a head down slumped posture. They further acknowledged that there is insufficient evidence to support the notion that shame is expressed or displayed similarly across different cultures; however, they asserted that "shame-like" emotions are present in almost all cultures. Specifically, these kinds of emotions are evoked when there is a feeling that the self is threatened or is positioned as having a lower status (Kemeny, Gruenewald, & Dickerson, 2004). Although no consensus exists in research or theories that focus on emotion classification, the view that shame is a self-conscious emotion predominates in the literature.

1.2.3. The Development of Shame

It is believed that self-conscious emotions, such as shame, guilt, and pride, do not exist at birth (Lagattuta & Thompson, 2007; M. Lewis, 1995, 2000; Tangney & Dearing, 2002). Experiencing these emotions seems to depend on particular cognitive prerequisites (Stipek, 1995). In particular, since the notion of self must be developed, and children do not have a sense of self as autonomous beings until the second year of their lives, self-conscious emotions begin to emerge between the ages of 18 and 24

months (M. Lewis, 2007). Before this age, children experience emotions such as joy and happiness, but not self-evaluative emotions such as shame and pride (Stipek, 1995). By the end of their second year, children recognise themselves in a mirror and start to form thoughts about their physical beings (M. Lewis, 1992).

M. Lewis (1992, 2000) has postulated a model of emotional development in which emotions appearing at birth and requiring little or no cognition are called "primary" or "basic" emotions. The model proposes that, at the age of around 15 to 18 months, the idea of "me" or self-awareness occurs. Around this period, self-conscious non-evaluative emotions such as embarrassment, envy, and empathy, which do not require self-evaluation, emerge. These emotions are based on self-awareness, but not on self-evaluation. M. Lewis (2007) called these emotions *self-conscious exposed emotions*. The model further suggests that around their third birthday, children start to learn about standards, rules, and goals by which they can evaluate their own behaviour. They also begin to make attributions about the self, and decisions about their success or failure. These complex cognitive abilities facilitate the rise of self-conscious evaluative emotions such as pride, shame, and guilt (M. Lewis, 2007).

There is some empirical evidence that indicates that two-year old children are capable of showing signs of guilt and shame. For example, Barrett, Zahn-Waxler, and Cole (1993) found that two-year old children demonstrate shame-relevant behaviour, such as avoidance and hiding, or guilt-like behaviour, such as approach and mending, when they broke the experimenter's (rigged) clown rag doll, which presumably had sentimental value for the experimenter. More importantly, M. Lewis, Alessandri, and Sullivan (1992) demonstrated that three-year old children are cognitively able to evaluate task difficulty and to rate their performance accordingly. In particular, they found that three-year old children, who failed to perform well on an easy task, showed

greater signs of shame (body collapsed, lowered eyes, downward gaze and so on) than did those who failed to perform well on a difficult task. In other words, failure on its own did not evoke a feeling of shame; it might have induced sadness or disappointment in some children, but only those children who failed the easy task experienced shame.

Nevertheless, it is important to point out that the shame or guilt-related behaviours, such as gaze aversion, or the avoidance tendencies that were observed in this experiment are not exclusive to the feeling of shame or guilt (Barrett et al., 1993). It is debatable whether eye gaze aversion or slumped shoulders in young children can be interpreted as early signs of shame. In fact, Ferguson and Stegge (1995) claimed that, while five and six-year old children are aware of shame and guilt and recognise them as negative emotions, they seem unable to describe a situation in which they have felt shame or guilt.

Furthermore, Griffin (1995) contended that children do not experience self-conscious emotions such as shame and pride in an adult form before the age of seven to eight years. For example, when a group of five-year old children were asked to indicate how a child who had violated a social standard and had been judged negatively in front of his classmates felt, the majority of the children stated that the child felt sad, mad or bad, but not ashamed or embarrassed. According to Griffin (1995), understanding social standards, recognising violations, and being aware of a judgmental audience are essential for experiencing shame and guilt, and children do not fully develop these abilities until the age of eight.

Similarly, Leary (2007a) stated that self-conscious emotions are essentially social emotions, and are evoked when an individual is able to imagine him- or herself in others' minds, and to recognise that others form opinions, or judge and evaluate the self. In this regard, Heerey, Keltner, and Capps (2003) demonstrated that children with

autism, who had difficulty recognising and understanding that others form mental states different from their own perspectives, minds, and beliefs (impairment in theory of mind), also had a problem identifying non-verbal expressions of embarrassment and shame in comparison to children without autism. However, their ability to identify non-self-conscious emotions, such as anger, disgust, and contempt, was not significantly different from that of children without autism.

It is perhaps reasonable to conclude that three-year old children show signs of shame, but that sophisticated reasoning about shame and a complete understanding of this complex emotion does not occur until the age of seven or eight. For instance, Olthof, Ferguson, Bloemers, and Deij (2004) found that children seven-years old and older attributed a greater degree of shame to a protagonist who did something wrong that consequently led to negative identity and self-evaluation (such as lying about taking necessary medicine and getting sick as a result), but attributed more guilt to a protagonist who did something wrong that did not lead to unwanted identity, such as sending a family pet away because of the protagonist's allergy. This study showed that seven-year old children are able to appreciate the sophisticated and subtle differences between shame and guilt, which are usually seen in adults (Lagattuta & Thompson, 2007).

1.2.4. Parenting and Shame

Attachment theory (Bowlby, 1983) proposes that forming a bond with others, particularly with a primary caregiver, is essential for children's survival. Based on this theory, children have an innate drive to seek a relationship with a protective adult. More importantly, this theory suggests that the quality of the early relationships between children and their attachment figures leads to the development of Internal Working Models (IWMs), which include mental representations, beliefs, and expectations that

children develop about the self, others, and the relationships between the self and others. This internal working model conceivably determines how the child will interact with others in the future. For example, the infant's experience of sensitive care leads to the development of secure attachment, which in turn encourages the child to see the self positively and to be more agreeable in social encounters. On the other hand, insecure attachment (insensitive and poor primary care) leads to the formation of a negative self-image, which in turn contributes to a lack of confidence and self-doubt (see Thompson, 2006, for a review).

Colman and Thompson (2002) found that, while engaging in problem solving tasks, insecure children seek their mother's help more quickly and often in unnecessary situations, and they express more frustration than do securely attached children. More interestingly, when experiencing failure, securely attached children were confident enough to see and accept their limitations and imperfections effortlessly, while insecure children struggled to acknowledge their weaknesses (Clark & Symons, 2000). Furthermore, Kelley, Brownell, and Campbell (2000) showed that critical and negative maternal attitudes during a challenging task at 24 months were related to the experience of shame and avoidance at 36 months. On the contrary, positive maternal evaluations predicted higher determination and motivation in solving a challenging task.

In general, it seems that children tend to internalise their parents' attitudes towards themselves (Ferguson & Stegge, 1995), which implies that if parents are hostile and critical, children will view themselves in a negative light and criticise themselves harshly (Lagattuta & Thompson, 2007). Bennett, Sullivan, and M. Lewis (2005) argued that harsh parenting, criticism, and physical abuse lead children to believe that they are unwanted and undesirable, which ultimately induces shame. These authors found that physical abuse is related to shame, and that shame partially mediates the relationship

between abuse and behavioural maladjustments. Similarly, Gilbert, Allan, and Goss (1996) found that the memory of being put-down, non-favoured, and belittled by parents during childhood is related to shame-proneness in adulthood.

Moreover, Andrews' research (1995, 1998, 2002) indicated that shame-proneness is likely to stem from the experience of abuse, especially when the abuse lasts for a long time. It seems likely that a multi-dimensional relationship exists between shame and childhood abuse. Abuse (physical, sexual, or verbal) can make individuals feel inferior and small. In other words, abuse of any kind is likely to put victims in a subordinate position and to trigger submissive reactions (Andrews, 2002). It is not uncommon to see that the abused child is stigmatised and blamed by the perpetrator and others in these circumstances, which perhaps adds to the feeling of shame. Abused children may think that there is something wrong with them that attracted the abuser. Even when the abuse is discovered, the child is not relieved. In fact, after the discovery, he or she may experience a higher level of shame (Feiring, Taska, & M. Lewis, 2002). The child may fear how he or she will be perceived or treated in the future. There is also a possibility that the involuntary physiological responses that are experienced during sexual abuse cause further shame. Under these circumstances, victims of sexual abuse blame themselves for unwanted reactions and feel disgusted with themselves (Pettersen, 2009).

Overall, research on attachment and self-image suggests that feelings of shame may arise as a result of dysfunctional child-parent interactions. In particular, rejection by significant others may damage a child's sense of self and self-image, which consequently may cause him or her to be ashamed of the self or hate the self (also see Mills, 2005). We will revisit this issue in Chapter 4, when the first study of this thesis will be presented. A question was raised about factors that may increase the frequency

of shame experiences and shame vulnerability. According to previous research, childhood variables cannot be neglected as they play an important part in the development of shame. In Chapter 4, we will specifically look at parental care, perfectionist parental expectations, peer acceptance, and maternal attitudes towards negative emotions. Furthermore, Chapter 4 will expand upon the previous discussion by examining the potential mechanism that may mediate the relationship between the memory of adverse childhood experiences and shame by focusing on self-judgement and coping methods.

1.2.5. When does Shame Happen?

Some predominant accounts in the literature describe the experience of shame and the root thereof. There are indications that people tend to experience shame when they become aware of the difference between their actual and ideal self-representation, attribute a negative event to the self and evaluate the self negatively, or see themselves as having a lower status. In this part, we look at each of these theories.

1.2.5.1. Actual self versus ideal self-image with regard to shame

Older psychoanalytic approaches argued that shame arises when there is a conflict between the ego (the identity that resembles the real self) and the ego-ideal (the perfect and ideal image to which one aspires). Scholars assumed that guilt was evoked when there was a discrepancy between the ego and the superego; in other words, the conscience, cultural, and moral standards (also see Barrett, 1995; M. Lewis, 1992; Tangney & Dearing, 2002).

Similarly, but concentrating on the self and the difference between self-representations, Higgins (1987) proposed the self-discrepancy theory which focused on inconsistencies or conflicts that may exist between different characteristics of the self. One of the main purposes of this theory was to associate different kinds of emotional

vulnerabilities with different types of incompatible self-beliefs. In order to do so, this theory postulated three dimensions of the self:

1. The actual self, which includes characteristics and attributes that someone has, or that other people think he or she possesses,

2. The ideal self, which refers to characteristics and attributes that someone wishes for or hopes to obtain (wishes, hopes, and aspirations), and

3. The ought self, which involves characteristics or attributes that someone thinks that he or she should have, such as duty, obligations, and responsibilities.

Furthermore, this theory discriminates between two standpoints from which the self can be evaluated:

1. A personal perspective/standpoint (what you believe), and

2. Others' perspectives/standpoints (what significant others believe).

Considering both the self-domains and standpoints six, different self-representations are produced: actual/own, actual/other, ideal/own, ideal/other, ought/own, and ought/other. Actual/own and actual/other are known as self-concepts, particularly actual/own, while ideal/own, ideal/other, ought/own, and ought/other guide or direct individuals, and are known as self-guides.

Broadly speaking, self-discrepancy theory predicts that the difference between the actual self and the ideal self induces dejection-related emotions such as sadness or disappointment because one's desires or wishes have not been fulfilled, while the difference between the actual self and the ought self generates agitation-related emotions such as fear, threat, and restlessness because one has failed to meet obligations and expectations.

It is relevant here that self-discrepancy theory predicts that failure to meet others' expectations (a discrepancy between actual/own and ideal/other) induces feelings of shame, embarrassment, and despondency because these emotions are related to beliefs that someone has lost her or his value or worth in the eyes of others. In contrast, when there is a discrepancy between actual/own versus ought/own, feelings of guilt, self-contempt, and uneasiness will be elicited because one has failed to live up to one's own standards and obligations.

There is some empirical evidence that suggests that self-discrepancies are related to psychological problems. For example, Higgins, Klein, and Strauman (1985) found that differences between actual and ideal representations were related to dejection-related emotions, such as depression, and that discrepancies between actual and ought self-representations were associated with agitation-related emotions, such as anxiety. Similarly, when individuals were asked to write about actual/ideal differences, they reported more sadness, and when they were asked to write about actual/ought discrepancies, they felt more agitated (Higgins, Bond, Klein, & Strauman, 1986).

Nonetheless, the extent to which this theory is accurate in terms of predicting emotional vulnerabilities, such as shame and guilt, is unclear. For instance, Tangney, Niedenthal, Covert, and Barlow (1998) tested Higgins's (1987) hypotheses, and questioned their credibility. Specifically, they asked participants to complete a series of questionnaires, such as the Selves Questionnaire that measures self-discrepancy, and the Test of Self-Conscious Affect (TOSCA), which measures shame and guilt-proneness. Their analyses indicated that not only was the discrepancy between actual/own and ideal/other related to shame-proneness, but also all forms of self-discrepancies. In addition, the association among all types of self-discrepancies were relatively high, which brings the validity of the Selves Questionnaire and the theory into question.

According to the personal accounts of ashamed individuals, Lindsay-Hartz (1984) found that failing to achieve an ideal image is not essential for experiencing shame. Following these interviews, Lindsay-Hartz concluded that the feeling of shame was more closely related to the recognition of a negative ideal (who we would not like to be) rather than to the discrepancy between the actual self and the ideal self (Tangney & Dearing, 2002). Lindsay-Hartz (1984) explained that "what we realize about ourselves when ashamed is that we are who we do not want to be" (p.697). For example, participants mentioned things like "I am fat and ugly" rather than "I failed to be pretty" and "I am bad and evil" rather than "I am not as good as I want to be" (Lindsay-Hartz, de Rivera, & Mascolo, 1995, p.227); or "I realized that I was a crook and a thief, and I didn't want to be" (Lindsay-Hartz, 1984, p.697). This difference is not merely semantic. In fact, the participants claimed that the difference was critical for understanding their feelings (Gilbert, 1998).

1.2.5.2. Cognitive attributes and shame

The way shame is defined in cognitive-attributional theories over the last three decades has been very popular. These theories explain how and when shame is evoked. Specifically, they indicate that shame has a cognitive, as well as an affective element (M. Lewis, 2003; Dearing & Tangney, 2002; Tracy & Robins, 2007b). Prominently, M. Lewis (1992) argued that shame is not elicited in response to a specific situation, but that its generation merely depends on an individual's interpretation of a negative event. Thus, an event that causes shame in one person may cause guilt in another (M. Lewis, 1992; Tangney & Dearing, 2002). In other words, shame is distinguished from similar self-conscious emotions on the basis of an attribution pattern.

According to attribution theories (Weiner, 1985), when explaining reasons for our (and others') actions, we consider three dimensions:

1. Locus: whether an action is caused by an actor (internal) or by a situation (external),

2. Stability: whether actions or causes are fixed (stable) or not (unstable),and

3. Controllability: whether individuals have control over some causes (controllable) or do not (uncontrollable).

As reported by the cognitive-attributional theory of shame, elicitation of shame is associated with internal, stable, and uncontrollable attributions (M. Lewis, 1992, 2003; Mills, 2005). For example, attributing failure in an exam to uncontrollable factors such as low ability is likely to induce shame rather than any other emotions (Brown & Weiner, 1984; Weiner, 1985).

Tangney, Wagner, and Gramzow (1992) investigated the association between shame-proneness, psychopathology, and attribution style. Examining several samples of undergraduate students, these authors found that the tendency to make internal, stable, and global attributions regarding negative incidents was highly and positively associated with proneness to shame. Specifically, participants who stated that they tended to hide after making a mistake at work (shame-prone individuals) were also inclined to attribute someone's hostility to their own personal characteristics, an indication of stable and global attribution (Tangney & Dearing, 2002). More importantly, the results of this study demonstrated that individuals' affective styles (shame-proneness and guilt-proneness) explained a significant variance in depression over and above the variance explained by attribution style. The findings from the regression analysis indicated that, although shame-proneness and attribution style are significantly correlated, they are not the same constructs. After controlling for the effect of attributional style, shame explained an additional 8-15% variance in depression (Tangney & Dearing, 2002).

Encouraged by cognitive-attributional and appraisal theories, Tracy and Robins (2004, 2007b) proposed the appraisal-based model of self-conscious emotions. According to this model, when encountering a situation, the first evaluative step is to see whether the situation "is relevant to survival" goals (Tracy & Robins, 2007b, p. 9). If the event is considered pertinent to survival goals, it will induce one of the basic emotions. However, if the circumstance is not relevant to survival goals, it will not evoke any basic emotions.

In the next step, the model suggests that individuals will consider whether the event is relevant for the self. If a situation is meaningful for the self and focuses on the self, related self-representations might be activated explicitly or implicitly, which in turn leads to self-evaluation. Self-representations may include the actual self, the ideal self or the 'ought' self. They may also include private aspects of the self or of the public self. As indicated by this theory, only after the activation of self-representations are self-conscious emotions generated (Tracy & Robins, 2007b).

Once self-representations are activated, events can be evaluated to see whether they are important for identity goals, such as: "Does it matter for who I am or would like to be?" (Tracy & Robins, 2007b, p.10). According to the model, only when self-representations are considered important for identity goals can self-conscious emotions be evoked. However, if there are no identity concerns, no self-conscious emotions will be generated.

The next aspect involves identity-goal congruence. This step governs the valence of emotions. If the event is consistent with one's goals, it elicits positive emotions, whereas if the event is not consistent with one's identity goals, it elicits negative emotions.

Individuals are then motivated to identify the cause of the event. By using a series of evaluations, individuals determine whether the event has an internal or external cause. If an individual makes an internal attribution for the event, self-conscious emotions result. For example, if someone makes a negative internal attribution regarding failure in an exam, he or she is likely to feel shame or guilt. However, if he or she makes a positive attribution, feelings of pride will be elicited. External attributions evoke basic emotions such as anger.

Furthermore, according to this model, in order to distinguish between self-conscious emotions (shame, guilt, embarrassment, and pride), it is essential to consider other causal attributions such as stability (stable and invariant), controllability (controllable vs. uncontrollable) and globality (the individual as a whole or some aspect of the person). The model predicts that shame is evoked by internal, uncontrollable, stable, and global attributions, while guilt is elicited by internal, controllable, unstable, and specific (not global) attributions. Embarrassment can occur only when individuals pay attention to the public self and when public self-representations are activated. Internal attributions are sufficient for embarrassment to occur. No complex cognitive ability or further attributions are needed to evoke embarrassment.

In support of this theory, Tracy and Robins (2006) conducted a series of studies. In one of these studies, they asked participants to indicate how they felt about their current grade point average. They then asked a trained analyst to code the contents of the participants' responses and determine whether the participants thought the grades that they had received depended on internal causes, such as ability, or on external causes, such as effort. In addition, the level of controllability that the participants thought they had over a situation was determined. It was found that internal attributions were associated with feelings of guilt and shame. Furthermore, students who attributed

their low grades to their abilities (an internal, stable, and uncontrollable cause) were more likely to express shame, while those students who attributed their low grades to their effort (an internal, unstable, controllable cause) were more likely to feel guilt.

Considering attributions in shame from a different perspective, Yi and Baumgartner (2011) asked participants to recall a recent experience of impulse buying, and then indicate how they felt after buying that item. It was found that impulsive shoppers who attributed the outcome to stable and uncontrollable aspects (for example, "my impulse buying reflects my weak self", p.459) were more likely to feel shame than those who attributed the outcome to unstable and controllable aspects (for example, "I got temporarily carried away by a discount", p.459). According to the authors, encouraging impulse buyers to attribute their impulse shopping to situational and short-term factors, instead of to fixed and global elements, may induce guilt rather than feelings of shame which, in turn, may help individuals to use problem-focused strategies rather than avoidance-based methods to cope with their feelings.

1.2.5.3. Rank, status, dominance, and shame

Social ranking theory (Gilbert & McGuire, 1998; Gilbert, 2000) proposes that shame arises as a result of one's perception of one's social status/rank. In social situations, people compete with each other for acceptance, approval, and attractiveness. People want to be desired, chosen, and valued, rather than being avoided or rejected. According to this theory, shame results when one views oneself as a being of relatively low social rank or in an unwanted subordinate position. For example, someone may see him/herself as having personal attributes (body-shape, size), personality characteristics (boring and dishonest), or as engaged in behaviour (stealing and lying) that others will find unattractive or unacceptable. This person may think that he or she is flawed, inadequate, and inferior. In addition, the said person may become vulnerable to

criticism and social put-downs (Gilbert & Miles, 2000), or act submissively (Gilbert, 2000). Therefore, according to this theory, those who are in low status positions, for whatever reasons, are more prone to experiencing shame. Empirical findings corroborate that shame is highly correlated with feelings of inferiority/submissiveness (Birchwood et al., 2006). For example, Gilbert (2000) found that those participants who scored highly for three measures of shame also rated their relative social rank as low on a social comparison scale (e.g., "In relation to others I feel inferior", p.179), but had higher scores on the submissive behaviour scale (e.g.,"I agreed I was wrong even though I knew I wasn't," p.179). In other words, feelings of shame were significantly associated with the perceptions of low social rank and expressions of submissive actions.

In the next chapter, submissive behaviours will be discussed further, and I will explore how they may have positive functions in relation to the experience of shame. For now, however, it is important to note that whether we focus on the issue of rank, status, or dominance regarding shame, or whether we believe that shame, like most negative emotions, involves a comparison of the self to the perfect image (or becoming someone who we would not like to be), or whether we consider that shame arises as a result of negative attribution styles, we conclude that the experience of shame involves a negative self-image. Even in cognitive-attributional theories of shame, if one does not have a negative self-image, why does a person attribute a negative event to the self? Negative self-image seems to fertilise and make it possible for shame to occur and grow or vice versa. In Table 1.1, we see how the conceptualisation of shame has evolved or changed over the years. The notion that shame is a self-related emotion and highly negative is evident in most of these theories.

Table 1.1

Conceptualisation of Shame from Different Perspectives

Conceptualisation of shame	Proposed by these theorists
Becoming exposed and self-conscious, related to physical/body performances such as toilet training	For example, Erik Erikson (1950)
Differences between the ego and the ego-ideal	For example, Piers and Singer (1953)
A primitive innate affect. It occurs when there is disturbance/interruption or an abrupt end to excitement or joy	For example, Tomkin (1963); Kaufman (1996); Nathanson (1994)
The self is considered bad; a discrepancy between actual/own and ideal/other	For example, H.B. Lewis (1971); Higgins (1987)
Making internal, stable, and uncontrollable attribution, attributing a negative incident to the self	For example, M. Lewis (1992); Tracy & Robins (2004)
Realisation of low status/rank, feeling inferior and submissive	For example, Gilbert (2000)

1.2.6. Expression and Body Responses in Shame

The most commonly identified non-verbal expressions of shame include gaze aversion, a downward head, slumped shoulders, and a collapsed posture (Keltner & Buswell, 1996; Keltner & Harker, 1998). Of these, body movements such as drooping shoulders and a slumped posture seem to be important indicators in the recognition of shame. This might be because shame does not have unique or exclusive facial expressions (Ferguson & Stegge, 1995). For instance, gaze aversion, downward head movements, and blushing can also occur when someone feels shy or is embarrassed (Crozier, 2014).

As a result, observers tend to be less accurate in identifying non-verbal expressions of shame in comparison to basic emotions (Keltner & Buswell, 1996). For example, the level of accuracy for recognising emotions such as anger or disgust is

above 80%, while the level of accuracy for identifying shame is about 50-60% (Keltner & Harker, 1998). Supposedly, the level of accuracy could be lower depending on the comparison emotions. It is difficult to imagine how individuals in the state of shame could be differentiated from those who have been humiliated, for example. Thus, identifying and recognising shame based body language might be complex and challenging.

Looking at bodily responses, when experiencing shame, the indicators include blushing (Crozier, 2004, 2014), increased body temperature, and sweating. In fact, these responses are very similar and associated with physiological arousal responses that occur with anxiety and stress (Gilbert, 1998, 2002).

Dickerson and colleagues (Dickerson, Gruenewald, & Kemeny, 2004; Grunewald et al., 2007) posited that shame evokes a series of psychological and physiological responses, such as an increase in cytokine activity and cortisol. More specifically, these researchers stated that "events that threaten the social self elicit activation of the hypothalamic-pituitary-adrenal (HPA) and proinflammatory immune systems, leading to the release of the HPA hormone cortisol and inflammatory cytokines" (Gruenewald et al., 2007, p. 74).

Recent research confirms a link between shame (and other negative self-evaluative states) and increased levels of cortisol and proinflammatory cytokine activity. For example, in one study, participants who were induced to experience self-blame and threats to their social self by writing about their personal experiences, not only experienced a higher level of shame in comparison to other negative emotions, they also showed a heightened level of proinflammatory cytokine (Dickerson, Kemeny, Aziz, Kim, & Fahey, 2004). Similarly, Dickerson, Gable, Irwin, Aziz, and Kemeny (2009) found that female participants who were asked to give a speech or perform a

math test in front of an evaluative audience (a social evaluative threat) showed an increase in proinflammatory cytokine in comparison to those who performed the tasks without the presence of an evaluative audience. Furthermore, M. Lewis and Ramsay (2002) demonstrated that four-year old children, who expressed signs of shame and evaluative embarrassment after failing a colour-matching task in a laboratory, also had a higher cortisol response.

Moreover, empirical evidence indicates that experiencing low social status may affirm a continuous threat to the social self (a chronic experience of shame), which in turn may forecast health problems. In this regard, Dickerson, Gruenewald, et al. (2004) found that HIV patients who were stigmatised and rejected because of their sexual orientation died on average two years before those who were not stigmatised. However, HIV patients who experienced other negative emotions such as anger, anxiety, or sadness did not experience a CD4 T-Cell decline over seven years (Gruenewald et al., 2007). To put it differently, shame seems to be the only negative emotion that predicts health outcomes in people who have been shunned and rejected.

1.2.7. Classification for Shame

In this part, in order to better understand the impact of shame, it is important to look at the ways shame has been classified in the scholarly literature, namely state shame, chronic (trait) shame, shame-proneness, internal shame, and external shame.

1.2.7.1. State shame, chronic (trait) shame, and shame-proneness

Although often neglected, state shame can be differentiated from trait shame. In general, at the state level, emotions produce momentary reactions to emotion-inducing events that do not have long-lasting effects. They may evoke particular thoughts or motivate specific behaviours but, after some time, their effect will subside and individuals can function normally. At the trait level, however, emotions are experienced

frequently and have severe impacts on life functions and adaptability (Ferguson & Stegge, 1995).

Correspondingly, state shame refers to a transient feeling of shame in response to a particular situation (Goss, Gilbert, & Allan, 1994). At the state level, shame may regulate social interaction, and increase humility or conformity (Ferguson & Stegge, 1995). In retrospective studies of shame, participants are often asked to recall or describe a personal episode of the state of shame versus the state of guilt (Tangney, 1992). The experience of shame is often accompanied by a feeling of being self-conscious, exposed or inferior, lacking power, feeling inhibited, and results in a faster heartbeat, muscle tensing, and being hot or flushed (Turner, 2014; Wallbott & Scherer, 1989; Wicker, Payne, & Morgan, 1983). Although the experience of shame is unpleasant and people often try to avoid it, state shame is not an indicator of an emotional disorder. On the contrary, inability to experience shame is often unacceptable and, to some extent, a sign of immorality (Tantam, 1998).

Trait shame (chronic) shame refers to a frequent or constant feeling of shame. Trait shame may be a state of being rather than an emotional state (Tantam, 1998). At the trait level, an individual's identity is pervaded by a sense of worthlessness, inadequacy, and helplessness (Ferguson & Stegge, 1995). Some shame theorists, such as Tangney and her colleagues, believe that a corresponding trait or disposition for state shame is shame-proneness, which is defined as a propensity to experience shame in response to a range of negative situations (Tangney, 1996). In particular, Tangney (1996) contended that shame-prone individuals (as opposed to guilt-prone individuals) experience shame more easily when they are in a specific negative situation.

Harper (2011) suggested that trait shame may arise because one is frequently suppressed or put down. In this situation, the said person may internalise the feeling of

shame, and shame becomes part of his/her identity and disposition. Similarly, Tantam (1998) stated that frequent reminders of one's faults and awareness of such faults may lead to the development of trait shame.

Unsurprisingly, trait shame and shame-proneness are associated with a wide variety of psychological symptoms. For example, trait shame or shame-proneness often have stronger associations with psychological problems such as depression and anxiety than does state shame (Allan, Gilbert, & Goss, 1994; Rusch et al., 2007).

Literature regarding shame focuses heavily on dispositional shame (Leeming & Boyle, 2002). Some researchers concentrate on shame-proneness (being susceptible to the experience of shame in response to particular situations), some pay more attention to global shame (feeling shame frequently, irrespective of particular situations), and some focus on trait shame in a specific domain such as feeling shame about physical appearance, ethnicity, and education (Andrews, 1998).

State shame is usually examined when shame is induced in experimental studies or when participants are asked to recall a personal shame-inducing episode. However, it should be noted that there is no strict boundary between state shame and trait shame. A person who is prone to the experience of shame and high in trait shame is also more likely to experience shame in response to a specific shame-inducing situation (state shame).

1.2.7.2. Internal and external shame

Gilbert (1998, 2000, 2003) differentiated between "feeling shame" and "being shamed". He suggested that when an individual feels shame about his/her own attributes, this is internal shame (feeling shame); this emerges when an individual evaluates and judges the self negatively and sees the self negatively. According to Gilbert (1998), individuals may also feel shame because others see and judge them

negatively. This is known as external shame, and occurs when one thinks that, in the minds of others, he/she will be rejected or attacked. In other words, an individual feels shame because others have a negative image of the self and he/she sees the self through their eyes. For example, someone may not reveal his or her sexual orientation to colleagues or family members because he/she is afraid of negative judgement or unfair treatment. The said person does not feel shame internally per se; however, external situations may lead him/her to feel ashamed (Gilbert, 1998). The idea that shame is experienced as a result of others' image of the self resembles Cooley's (1902, p.183) concept of the "looking-glass self," which refers to the notion that people evaluate themselves as they believe others see them (see also Scheff, 2000). In this regard, it is worth pointing out that individuals usually evaluate themselves not only based on how others *really* view them, but also based on how they *think* others see or evaluate them (Hogg & Vaughan, 2008; Shrauger & Schoeneman, 1979). It is possible to not feel shame even if others consider the self negatively; however, it is unlikely that one will not feel shame when the self is evaluated negatively by the self (Gilbert, 2000). In other words, external shame does not lead to internal shame necessarily, while internal shame can have a great impact on feelings of external shame.

1.3. Part Two: Shame and Other Constructs

People in the general population often have difficulty in distinguishing shame from similar emotions and constructs, such as guilt and embarrassment (Tangney & Dearing, 2002). It is the case that the terms shame and guilt are used interchangeably. However, research has documented that feeling shame is very different from feeling guilt, embarrassment, or shyness, and has different consequences. In order to understand what feelings of shame entail, it is necessary to examine the difference between shame and other similar constructs.

1.3.1. Shame and Guilt

The distinction between shame and guilt has been highly influenced by the work of psychoanalyst Helen. B. Lewis (1971). After examining clinical cases, she concluded that a fundamental difference between shame and guilt lies in the role of the self. In shame, the focus of evaluation is on the self (e.g., I was a bad person), while the focus of evaluation in guilt is on behaviour (e.g., my action was bad or I did a bad thing). Pursuing H. B. Lewis' line of work, Tangney and colleagues (see Tangney & Dearing, 2002) have provided evidence for the dissimilarities between shame and guilt over the past three decades. Some of the strongest support for this notion comes from a series of studies conducted by Niedenthal, Tangney, and Gavanski (1994). In these studies, participants were asked to recall a personal experience of shame/guilt (Study 1c), or to put themselves in situations that are shame/guilt-inducing (Studies 1a and 1b). They were then asked to produce counterfactuals in order to change the problematic situations. It is interesting that, regarding experiences of shame, participants were inclined to undo aspects of themselves ("if only I weren't"), while in guilt experiences they tended to undo specific behaviour ("if only I hadn't). This is one of the main

reasons why the feeling of guilt is regarded as a less critical and harmful emotion than that of shame.

Furthermore, it is a common belief that there is a difference between the action tendencies of shame and guilt. Shame seems to be associated with avoidance-related tendencies, such as avoiding shame-eliciting situations, withdrawing from others or hiding. Guilt, on the other hand, is related to approach tendencies, such as approaching others and trying to repair the damage done, for example by apologising. Guilt may encourage a change in actions (Sheikh & Janoff-Bulman, 2010; Yi & Baumgartner, 2011).

As noted, in shame, the focus is on the self, whereas in guilt, individuals are able to focus on the wellbeing of others (Joireman, 2004). This is why guilt has been associated with perspective-taking and empathy towards others, while in shame the preoccupation with the self is at odds with the other-oriented nature of empathy (Parker & Thomas, 2009). Shame-prone individuals tend to be self-absorbed and oblivious to others' needs or requests (Tangney & Dearing, 2002). It could be assumed that shame, especially chronic shame and shame-proneness, makes interpersonal encounters difficult not because ashamed individuals do not feel empathy, but because they are too self-conscious to show their true emotions and vulnerabilities. They find social situations threatening and potentially shaming; hence, they avoid them as much as possible.

Conventionally, shame is viewed as a public emotion and guilt as a private emotion. The experience of shame results from public exposure. In other words, individuals feel shame when their transgression has been seen and revealed publicly. In this line of thought, Smith, Webster, Parrott, and Eyre (2002) found that when participants' failings were seen by others, they felt a stronger sense of shame than they

did of guilt. More specifically, this research (Studies 1 and 2) demonstrated that, in hypothetical shame and guilt-related situations, when a transgression occurred in public and an antagonist was exposed, participants assumed that the antagonist would feel more shame than when a transgression occurred in private. However, with regard to guilt, the public versus private situation did not matter. Participants assumed that the antagonist would feel the same level of guilt in public as well as in private.

The notion that shame is a public emotion is to some extent in harmony with Gilbert's (1998, 2000) view of shame, which suggests that shame is related to social ranking. When there is no audience, social ranking and status are essentially meaningless (Kim, Thibodeau, & Jorgensen, 2011). Nevertheless, support for the public versus private nature of shame/guilt is contradictory. For instance, Tangney, Miller, Flicker, and Barlow (1996) asked participants to recall personal experiences of shame, guilt, and embarrassment. Their findings indicated that shame is not a more public emotion than is guilt. According to their analyses, both shame and guilt occurred mainly and equally in public. However, 10.4% of the participants' guilt experiences and 18.2% of their shame experiences happened in private. The literature suggests that shame is a relatively individualised emotion and does not have unique triggers. The common view is that the same situation can induce shame in one person and guilt in another. It depends on how the role of self is interpreted, not whether the situation takes place publicly or privately (Parker & Thomas, 2009). Nevertheless, it should be mentioned that shamed individuals feel exposed. Although shame probably does not require an actual audience or witness, often the thought of how one's shortcomings will appear to others is salient in the experience of shame (Tangney & Dearing, 2002). The fear of negative evaluation is present in the experience of shame. This is perhaps why shame is often assumed to be a more public/social emotion than is guilt.

1.3.2. Shame and Embarrassment

Some scholars believe that shame and embarrassment are very similar (see Crozier, 2014, for a review). They argue that the only difference between these two emotions is their level of intensity. Embarrassment is believed to be a milder form of state shame (M. Lewis, 1995, 1998).

M. Lewis (1998, 2000) suggested that there are two types of embarrassment. The first type is less intense than shame. It occurs when an individual fails to meet personal goals that are not crucial for the identity of that person. For example, if driving is strongly related to one's core identity, failing at it may evoke a feeling of shame. However, if driving is not particularly relevant for that person, failing at it may be embarrassing rather than shaming. Secondly, people sometimes become embarrassed purely because of their presence being acknowledged. This is known as "exposure embarrassment." For instance, being complimented or praised for something in front of large audience may induce feelings of embarrassment.

Surprisingly, Tangney, Miller, et al. (1996) found that shame and embarrassment have less in common than do embarrassment and guilt. Embarrassed people believed that they were victims of situations. They even found embarrassing situations funny and amusing to some extent, rather than painful and intense. Embarrassing situations seemed to be more accidental (people said they felt awkward).

In cognitive-attributional theories, embarrassment is considered either non-evaluative (M. Lewis, 2003) or less cognition-dependent (Tracy & Robins, 2004). It happens when attention is focused on the public self. It requires attributions to internal causes, but does not command any further attributions, and can occur in response to stable or unstable and controllable or uncontrollable causes (Tracy & Robins, 2006, 2007b).

Furthermore, Keltner and Buswell (1996) claimed that embarrassment is associated more with the violation of conventions, whereas shame is related more to personal failure. These authors found that the most common antecedents of embarrassment were physical pitfalls, cognitive shortcomings (such as forgetting a name), loss of control over the body (vomiting), and shortcomings in physical appearance, such as walking around with toilet paper stuck to one's shoe.

Nonetheless, Sabini, Garvey, and Hall (2001) argued that tripping or falling, for instance, are not violations of convention, but can be viewed as a personal failure. They argued that if someone's real weakness is revealed, he /she is likely to feel shame. If from one's own standpoint no real flaw is revealed, but other people think that such a flaw has been revealed, that person may feel embarrassment or anger. It depends on whether or not it is sensible for the audience to believe that such a flaw exists.

After examining the literature, Crozier (2014) found that shame is usually differentiated from embarrassment according to the following criteria: intensity (shame is more intense than embarrassment); duration (shame lasts longer); self (shame is related to negative self-evaluation and a flawed self); breaking social rules (shame is related to a breach of fundamental rules); morality (shame is associated with morality); audience (need for an audience in embarrassment); physiological differences (blushing is associated with embarrassment); uncertainty (after embarrassment, individuals feel confused); and non-verbal expression (laughter in embarrassment). However, after critically considering the proposed distinctions, Crozier (2014) concluded that no consensus exists in the literature regarding the differences between shame and embarrassment. For example, while some researchers believe that laughter occurs after embarrassment, others argue that laughter follows shame in order to reduce its impact.

1.3.3. Shame and Low Self-esteem

Theoretically, shame and self-esteem are different (Tangney & Dearing, 2002). Self-esteem is mostly considered as a self-evaluative construct. Shame, however, is usually regarded as an emotion that has cognitive elements (Blum, 2008). Furthermore, self-esteem is a general evaluation of the self, whereas shame is likely to be a negative evaluation of the self in relation to a specific situation (Andrews, 1998; Tangney, 1996). Andrews (1998) has suggested that negative self-evaluation may be an essential part of shame, but that it is not sufficient as a definition of shame.

Nevertheless, Gilbert (1998) argued that the way in which self-esteem is defined in the self-esteem literature is very similar to how shame-proneness is described. Along this line, Brown and Marshall (2001) found that self-esteem and self-conscious emotions, such as shame and pride, are associated. Specifically, individuals with high self-esteem tended to experience pride, while those with low self-esteem were inclined to feel shame (Brown & Marshall, 2001). This may also indicate that the negative feelings reported by people with low self-esteem are usually feelings of shame (Tracy & Robins, 2004).

Tangney and Dearing (2002) reported a modest correlation between shame-proneness and self-esteem ($r = -.42$). They stipulated that a bidirectional link exists between self-esteem and shame. Tangney and Dearing also postulated that individuals who are shame-prone do not necessarily have low self-esteem, or vice versa. According to their argument, it is possible to have high self-esteem but also to be shame-prone. For instance, one may have a positive image of the self (as worthy and likable), while still being shame-prone. One may easily experience shame when there is failure or a negative incident. Similarly, these authors suggested that it is possible to have low self-esteem but not to feel shame in response to transgressions or failures.

1.3.4. Shame and Shyness

Mosher and White (1981) distinguished shame from shyness and stated that the experience of shame in real life situations is more intense and unpleasant than shyness, and they argued that it is not acceptable to use shyness and shame interchangeably. Shyness seems to be a non-evaluative emotion. It is more closely related to fear than to self-evaluation. Therefore, no cognitive complexities are needed to feel shy. Shy people become apprehensive and uncomfortable in social situations. Shyness is likely to be biologically given, as it has been observed in three-month old infants, while shame appears at around the age of 18 months (Blum, 2008; M. Lewis, 2000). However, it is debatable to what extent shyness can be considered as a non-evaluative emotion. At times, self-evaluation and evaluation of situations are likely to be present when individuals experience shyness.

1.3.5. Shame and Humiliation

Humiliation includes a sense of being ridiculed, scorned, or degraded by others (Klein, 1991). Humiliated individuals do not feel responsible for a negative event. They blame others or situations, not themselves, for their profound loss of dignity. They probably attribute the source of the event to external causes rather than to internal causes. Humiliated people think that they are victims of situations (Tantam, 1998). In order to feel humiliation, a victim, a humiliator, and an observer are usually required (Klein, 1991). The victim is powerless, while the humiliator is in power. Shame is more connected with feelings of the self about the self, while people who feel humiliated think that they do not deserve to be humiliated and treated in such a way. For example, a person who has cheated on his or her spouse might feel shame, while the person who has been cheated on is most likely to feel humiliated (Klein, 1991).

The important thing to remember when we look at all the above distinctions is that these emotions can occur simultaneously. For instance, a person who has cheated on his/her spouse might feel guilt as well as shame, and we often hear statements such as "that was so humiliating, I feel so embarrassed" in day-to-day conversation. Thus, it is vital to acknowledge that the difference between emotions can be easily blurred. In addition, there is a possibility that what we feel at the first instance (primary emotion) can change or be substituted with another emotion very quickly (secondary emotion). Therefore, distinguishing these emotions in some situations might be complex. A summary of these differences is presented in the following figure.
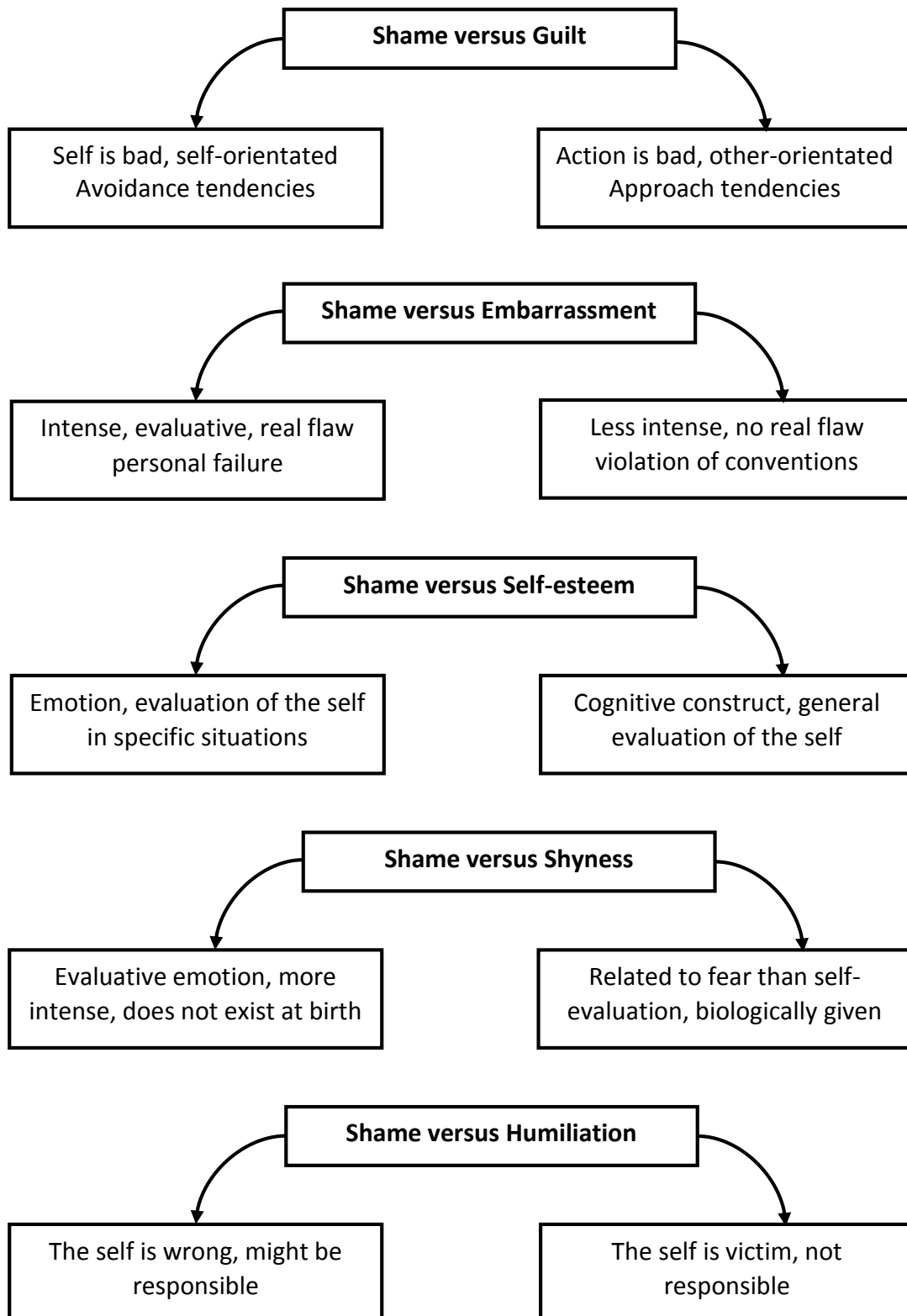
Figure 1.1. Differences between shame and similar constructs

1.4. Part Three: Shame, Culture, and Demographic Variables

This section will look at how shame is experienced in different cultures, whether it can be vicarious, and consider the effect of demographic variables such as age and gender on shame.

1.4.1. Cultural Differences in Shame

Wallbott and Scherer (1995) demonstrated that shame is experienced differently in collectivist cultures, such as Mexico, Venezuela, India, Brazil, and Chile, and in individualist cultures like Sweden, Norway, Finland, New Zealand, and the United States. In comparison to individualistic cultures, the experience of shame in collectivist cultures was reported as having a shorter duration and a less negative effect on self-esteem, as being less immoral and being followed by laughing or smiling (Wallbott & Scherer, 1995).

This seems to be due to the idea that, in a collectivist culture, the self is interdependent and people tend to see themselves in relation to others (Kitayama, Markus, & Matsumoto, 1995). Therefore, in many collectivist cultures, shame is more likely to be determined by social roles rather than by personal failure (Crystal, Parrott, Okazaki, & Watanabe, 2001). In these cultures, shame is no longer an individual experience, but is associated with cultural values and standards, and conforming to the cultural rules is essential for avoiding feelings of shame (Greenwald & Harder, 1998). Those who do not behave according to the cultural values or conventional norms are not only shamed, but also bring shame to their communities. Hence, in order to restore the social image and to claim lost "honour," those who tarnish the social reputation and violate the social rules are usually punished harshly (Cohen, Vandello, & Rantilla, 1998). For instance, honour killings or similar accounts demonstrate that the

perpetrators, who are often members of a family or social group, take drastic measures in order to save the social image and family reputation (Lindisfarne, 1998).

Unsurprisingly, individuals in collectivist cultures are more likely to experience shame when they are around others, because they are more attuned to the presence of others (Wong & Tsai, 2007). Moreover, the distinction between shame and guilt is less clear in collectivist cultures than it is in individualistic cultures (but also see Wallbott & Scherer, 1995, for an opposing view).

Although the experience of shame is unlikely to be positive (Edelstein & Shaver, 2007), in many collectivist cultures shame is considered to be constructive, adaptive, informational, and motivational. For instance, 43.5% of Indian students viewed shame as more similar to happiness than to anger, while the majority of American students believed that shame and anger are more similar. In fact, only 6% of Americans thought that shame and happiness share some similarities (Rozin, 2003). The Indian students believed that shame and happiness are similar, because they consider both of these emotions as socially effective and constructive, while the Americans viewed shame and anger as similar because they are both negative (Rozin, 2003). In a similar manner, Chinese parents are more likely to implement shame strategies in dealing with their children than are American parents, because they believe that shaming methods can be rehabilitating (Wong & Tsai, 2007).

Furthermore, Fischer, Manstead, and Rodriguez Mosquera (1999) demonstrated that individuals from an honour-based culture such as Spanish viewed shame more positively than did participants from an individualist culture (Dutch). For instance, when describing their experiences of shame, Spanish participants focused more on other people and their relationship with them, whereas Dutch participants focused more on

their own personal experiences and feelings of self-failure (Rodriguez Mosquera, Manstead, & Fischer, 2000).

Culture also affects how individuals respond to the experience of shame. For example, the experience of shame for Filipino salespeople, who come from an interdependent-oriented culture, is associated with social involvement and an attempt to rebuild social contacts with customers, while Dutch salespersons, who belong to an independent-oriented culture, tend to use defensive mechanisms such as avoiding conversations with consumers in order to protect their self-image after experiencing shame (Bagozzi, Verbeke, & Gavino, 2003).

1.4.2. Shame in a Group Context

There is a great likelihood that individuals experience chronic shame as a result of their membership of a specific group. For example, ethnic minorities, immigrants, or those with an alternative lifestyle may feel ashamed because of their membership in low-status or stigmatised groups (Greenwald & Harder, 1998). In this regard, Keltner and Harker (1998) argued that even observers tend to assign feelings of shame to women or African Americans, who stereotypically belong to low-status groups.

In addition, people are blamed and stigmatised for the negative behaviour of their in-group. For example, family members of people with mental or drug/alcohol problems experience significant stigma and shame (Corrigan, Watson, & Miller, 2006). Our social groups are a very important part of our identity, so the actions or status of our in-group has implications for the self. In particular, negative behaviour on the part of our group's members may damage our self-image, threaten our social identity, and negatively affect our social standing (Lickel, Schmader, & Spanovic, 2007; Schmader & Lickel, 2006).

Johns, Schmader, and Lickel (2005) demonstrated that Americans who identify strongly with their nationality reported feeling shame when other Americans showed prejudice towards out-groups (for example, people of Middle Eastern descent, after the September 11th attacks). Nonetheless, individuals are likely to feel shame in response to an in-group's behaviour if they feel that the person's action is relevant to them and they share an identity with that particular group and with the wrongdoer (Lickel, Schmader, Curtis, Scarnie, & Ames, 2005). For example, German participants reported that they would experience a significant amount of shame in regard to the holocaust and treatment of the Jews in front of out-groups (such as in front of a foreigner or a Jewish person) but not when they were with their in-group (with other Germans) or alone (Dresler-Hawke & Liu, 2006).

In addition, studies suggest that, after vicarious shame, some participants are motivated to distance themselves from the shameful events (Lickel et al., 2005), while others may engage in activities in order to restore the damaged group's image (Lickel et al., 2007). It is interesting that, as Gunn and Wilson (2011) demonstrated, group affirmation assists individuals to express shame over the mistreatment of out-groups, which may in turn facilitate reparatory attitudes and actions. For example, in their study, Canadians who were asked to choose the most important value for Canadians and to indicate why this value was important to them and why they had selected this particular value (group affirmation condition), expressed greater shame over the mistreatment of and injustice towards Aboriginals, and they showed a greater tendency towards compensatory actions.

1.4.3. Shame and Demographic Characteristics

Research has shown that shame decreases from adolescence to middle age, and then increases into old age. In addition, wealthy individuals report feeling less shame

than do less privileged individuals (Orth, Robins, & Soto, 2010). In fact, the experience

of shame is very common among poor and working class individuals (Power, Cole, &

Fredrickson, 2010). They may feel shame merely because of being poor, or because of

being stigmatised for being poor. Social class also triggers shame, even for those who

are educated and have a high status in society, but who emerge from a working class

background (Brown, 2007).

Furthermore, women report more shame than men (M. Lewis, 1992; Orth et al.,

2010). It sometimes seems that, regardless of gender, those individuals with a feminine

gender role feel a higher level of shame than do those with a masculine gender role

(Benetti-McQuoid & Bursik, 2005). Gross and Hansen (2000) proposed that investment

in relatedness, which refers to valuing close personal relationships with others, to be

connected, loved and cared for, mediates the relationship between gender and shame.

They found that after controlling for relatedness, the effect of gender on shame

disappeared.

Women are socialised differently from men (M. Lewis, 1992). For instance,

Brown (2012) asserted that her qualitative work on shame and vulnerability implicated

that one of the main triggers of shame for women is their appearance, while for men it

is their weakness/power. Men do not want to be viewed as weak or "girly". This is

exactly what culture imposes and the media promotes an extensive focus on women's

appearance and men's masculinity.

Objectification theory proposes that self-objectification, seeing oneself as an

object and putting a high value on one's appearance, increases the feeling of shame

about one's body (Grabe, Hyde, & Lindberg, 2007; Tiggemann & Boundy, 2008). Even

a compliment about one's appearance increases body shame among those who are high

in self-objectification (Tiggemann & Boundy, 2008). Specifically, in the current

atmosphere in which culture is highly appearance-oriented, sexual objectification often targets and affects women more than it does men, forces girls and women to see themselves as objects, and to evaluate their value based on their physical attributes or appearance (Roberts & Goldenberg, 2007). In media and culture, women's appearance has a far greater value than other characteristics (Sanftner & Tantillo, 2011), and since the idealised appearance and body are impossible to attain, and standards are extremely narrow and rigorous (young, slim, white and so on), women are more prone to experience bodily shame than men, and often tend to be judged and treated negatively in social situations, such as at school and at work, merely because of their appearance, even though this is irrelevant to their qualifications, experience, and performance (Roberts & Goldenberg, 2007).

Thus, it can be said that culture and society put a lot of pressure on women with regard to their appearance, age, and body. As a result, it is not unreasonable to assume that these extra pressures contribute to the development of poor self-image, shame, and self-esteem. For example, a recent report in England indicated that 18% of girls aged 10 to 13 were unhappy with their appearance, in comparison to 9% of boys (Lusher, 2014). More importantly, this survey found that the way in which girls think about their appearance and looks was perhaps a main contributor to the reduced wellbeing and lower life satisfaction that was seen in girls.

1.5. Summary

This chapter introduced the concept of shame and explored its characteristics and nature. The first section argued that shame is one of the self-conscious emotions; it starts to emerge around 18-24 months. In shame, there is a feeling of inadequacy, unworthiness, and inferiority. Shame can occur when someone makes internal, stable, uncontrollable, and global attributions for a negative incident or when they feel they

have a lower status in relation to others. In the second section, there was analysis of the differences between shame and similar constructs and how shame can be distinguished from guilt, embarrassment, self-esteem, shyness, and humiliation. In the last section, I described how shame is perceived in collectivist and individualist cultures. Previous research indicates that shame can be vicarious and elicited as a result of particular group membership. Women and people from underprivileged backgrounds, minorities, and working class people are more prone to experience shame.

Furthermore, this chapter briefly introduced the first topic for the empirical part of this thesis. As mentioned, the first aim of this thesis is to investigate elements that might contribute to the frequency of shame and shame vulnerability. This chapter demonstrated that adverse childhood experiences can foster shame vulnerability. Therefore, the first empirical chapter of the thesis will consider negative childhood experiences as important factors in the development and maintenance of shame vulnerability. In addition to identified factors such as parenting styles, Chapter 4 will assess maternal attitudes towards expressing negative emotions, perfectionist parental expectations, and peer acceptance. The purpose is to extend the literature by focusing on these variables and also identifying a potential mechanism that may influence the association between adverse childhood experiences and shame.

The next chapter will look at other aspects of shame that are particularly important for the empirical chapters of the thesis. Specifically, next chapter focuses on the positive and negative sides of shame and consider how shame can be managed.

Chapter 2. Positive and Negative Aspects of Shame and Shame Management

2.1. Introduction

The aim of this chapter is to discuss the literature on shame management and shame responses, and to highlight unaddressed issues in this area that will be the focus of the empirical chapters later in this thesis. This chapter is divided into four sections: the positive side of shame, the negative side of shame, emotion management and shame management, and new perspectives on shame management.

The first section provides information about the positive impact that shame has on our lives and actions. As mentioned in the previous chapter, shame is an extremely unpleasant emotion. However, shame may have a positive function. For example, feelings of shame may regulate behaviours and act as a warning sign. Theories and research findings examining the functions of shame will be summarised in this section.

The second section will look at the negative aspect of shame and how it can be destructive and problematic for psychological well-being. There is a growing body of evidence associating shame, depression, and social anxiety. The literature in this field will be briefly considered.

In the third section, the methods and manner by which people respond to and manage shame will be outlined. In order to classify and categorise shame management strategies, the literature concerning both emotion regulation and coping will be examined. In particular, by drawing on Gross' (1988) model of emotion regulation and the literature on coping, this section will identify existing shame management methods and responses.

The last section will introduce new approaches and methods that can be used to regulate shame and to deal with it effectively. For instance, in recent years, self-compassion has been recognised as an antidote to shame. In this section, I will examine

how self-compassion, mindfulness, acceptance, and mind-wandering might be related to shame and can be used to manage it. The aim of this section is to briefly introduce topics and ideas that will be the focus of the empirical chapters.

2.2. Part One: The Positive Side of Shame (Function of Shame)

According to the evolutionary perspective, emotions have evolved to facilitate the survival and reproduction of humans and animals. In particular, emotions assist individuals tackle difficulties and challenges in the physical and social worlds. Emotions also modify internal or external responses according to physical threats, and enhance the adaptation of individuals to their environments (Goetz & Keltner, 2007; Leary, 2007a). Thus, regardless of their valence (positive or negative), emotions are instructive and adaptive. A number of potentially positive characteristics of shame have been proposed. For instance, shame acts as a warning signal, may regulate social behaviour, and may have appeasement functions.

Gilbert (1998, 2003) proposed that humans have developed an ability to estimate their social attractiveness, which he called Social Attention Holding Power (SAHP). According to this theory, humans are able to track of their worthiness by calculating their social attention holding power (Gilbert, 2003, 2007). SAHP monitors the extent to which others appreciate and respect an individual, and whether he or she stimulates positive feelings in them (Gilbert, 2003).

Humans seek love and acceptance from others (Gilbert & McGuire, 1998). This is essential for their survival. Being loved or attractive heightens one's social status and guarantees access to scarce resources. Therefore, it is important for humans to keep track of their attractiveness and social rank. According to Gilbert and McGuire (1998) and Gilbert (2003), shame arises when there is a threat to the social self. Specifically, shame is associated with conflicts of power and status between superiors and inferiors

(Goss et al., 1994). Shame infers that the level of one's social attractiveness has substantially decreased, or that one is no longer accepted or liked in the minds (real or imagined) of others. Shame also indicates to individuals that, because they are no longer accepted or loved, it is better for them to hide, escape, or display non-verbal signals of shame. Shame may implicitly advise individuals which thoughts or behaviours should be kept hidden and which should be revealed to avoid rejection (Leary, 2007a).

As with Gilbert and McGuire (1998), Dickerson, Gruenewald, et al. (2004) proposed the social preservation theory, which suggests that shame (evaluative negative emotion) is experienced when an individual's positive social image or social esteem is threatened. These authors contended that shame has evolved in order to facilitate and maintain social encounters; it directs an individual's behaviours and actions in the appropriate direction, and informs people about how to behave and what to do in order not to be ostracised.

The basis of social attention holding power (Gilbert & McGuire, 1998) and social preservation (Dickerson, Gruenewald, et al., 2004) theories are not new. Indeed, they are very similar to what Leary and colleagues posited as the sociometer model of self-esteem (Leary, Tambor, Terdal, & Downs, 1995; Gilbert, 2007). This model proposes that self-esteem works as an interpersonal monitor. It measures an individual's social desirability and acceptance, and subsequently alerts individuals when there is a possibility that they might be socially rejected or excluded. In consonance with this model, individuals are motivated to increase their value and to avoid social exclusion.

Barrett's (1995) functionalist developmental model of shame posited that shame is not fundamentally a negative emotion. According to Barrett (1995), if shame is experienced at appropriate levels, it helps individuals to learn about social rules and

standards. Barrett speculated that shame facilitates the development of self-awareness and meta-awareness; it particularly encourages children to pay attention to the self and to see how the self is viewed by others. Consequently, this increases an individual's knowledge about the self; it causes one to step back from the self as an agent and to evaluate the self as an object, which in turn may assist individuals to avoid mistakes. Shame may even help individuals to evolve as people. In other words, experiencing shame makes it more difficult to do wrong, which is likely to increase one's acceptance and self-esteem in future encounters.

All self-conscious emotions, not just shame, seem to play an important role in regulating social behaviours. In particular, patients with damage to the orbitofrontal cortex, which is the centre of self-regulatory control, show a deficit in self-conscious emotions, as well as impairment in the regulation of social behaviours (Beer, Heerey, Keltner, Scabini, & Knight, 2003). For instance, Beer et al. (2003) demonstrated that orbitofrontal patients were more embarrassed when there was no reason to be, or they became more proud than a control group when they were successful at solving a task, or they showed inappropriately intimate and hostile gestures.

Moreover, Tracy and Robins (2007a) suggested that the function of shame and guilt is to regulate actions. Shame or guilt indicates that one is breaking social rules, and that it is preferable to stop the action. However, in shame because the entire self is questioned, the message is likely to be very harsh and severe (e.g., stop acting like that, you are incompetent or failure). For this reason, shame is less effective in changing behaviours or regulating actions (M. Lewis, 2003). Indeed, in the field of criminology, it is believed that shaming should be re-integrative, thus focusing more on behaviour (good person but bad actions) rather than stigmatising (attacking the character of a bad person) in order to rehabilitate offenders (Harris & Maruna, 2005).

Furthermore, the non-verbal communicative behaviours of shame, such as avoidance of eye contact, slumped shoulders, a downward movement of the head, and a sagging posture are likely to have an appeasement function (Keltner & Harker, 1998). The non-verbal expressions of shame signal submissiveness, which may increase sympathy or liking, facilitate forgiveness, and reduce the damage to one's social standing (Tracy & Robin, 2007a; Van Vliet, 2008). For example, Power et al. (2010) found that participants were more likely to donate money in response to an advertisement where a woman was expressing shame rather than anger about being poor. In addition, Giner-Sorolla, Kamau, and Castano (2010) demonstrated that the expression of shame made an apology for an assault look more sincere, and reduced the level of insult to some extent. In some cases, being submissive or showing submissive signals makes an individual feel safe, because showing or indicating a positive self-image, while others constantly criticise the self, can create conflict and confrontation (Gilbert, 2007). Therefore, holding a negative self-image can be used as a defence mechanism, which is probably one reason why treating shame can be extremely difficult as people are afraid and unwilling to let the negative self-image fade (Gilbert, 2007).

Although shame may help individuals to avoid social exclusion by increasing their conformity (Greenwald & Harder, 1998), shame that is felt continuously and for a long time is unlikely to have any adaptive function. In such situations, individuals see the self as incompetent and inferior. Consequently, they may feel powerless and weak, leading them to believe they are unable to take action and alter their status.

In addition, it is questionable whether a feeling of shame can be beneficial if it arises from stable characteristics that are not easily changed or regulated. For example, one may feel shame for being physically unattractive or poor, having a disability, or

even having a different skin colour. These characteristics are relatively stable and unalterable, and the feeling of shame is likely to lead to social avoidance and withdrawal. As Lindsay-Hartz et al. (1995) eloquently asserted:

> Shame may be regarded as a maladaptive choice of emotion when it involves supporting unattainable or unrealistic ideals (such as the idea of having a different skin colour or sexual orientation, or the ideal of having unflawed parents). Shame may also be maladaptive when a person accepts the view of others that a particular way of being is unacceptable when it need not be viewed that way (e.g., viewing a racial characteristic or disability as lowly or terrible). (p.297)

Tangney et al. (2007) firmly believed that, contrary to popular belief, shame-proneness does not increase morality when compared to guilt-proneness. In fact, shame-prone individuals are less concerned about others' well-being or problems (Tangney & Dearing, 2002), and their focus and actions are mainly self-orientated (Joireman, 2004). Specifically, previous research has demonstrated a positive association between shame-proneness and personal distress, but a negative (or insignificant) relationship between shame-proneness and other-orientated empathy (Tangney & Dearing, 2002). As noted earlier, this might be due to the painful nature of shame, which makes it difficult for individuals to focus on others, and to desire to flee instead of making amends after the experience of shame (Tangney et al., 2007).

The next section will consider the negative aspect of shame. Not only is chronic shame distressing and uncomfortable, but it has also been linked to a number of psychological problems.

2.3. Part Two: The Negative Side of Shame

Researchers over the past few decades have consistently shown that proneness to shame and chronic shame are related to a wide variety of psychological problems. For example, shame has been associated with substance abuse (Dearing, Stuewig, & Tangney, 2005), lower self-esteem (Brown & Marshall, 2001), the severity of PTSD symptoms (Leskela, Dieperink, & Thuras, 2002), a higher level of rumination and personal distress (Joireman, 2004), lower empathy (Dennison & Stewart, 2006), an inability to generate effective solutions (Covert, Tangney, Maddux, & Heleno, 2003), borderline personality disorder (Rusch et al., 2007), and aggression (Stuewig, Tangney, Heigel, Harty, & McCloskey, 2010). However, the main focus of scholarship has been on relationships between shame-proneness or chronic shame and a number of specific psychological problems, which will be reviewed here.

2.3.1. Shame and Depression

Shame is strongly linked to depression in the literature (Kim et al., 2011; Orth, Berking, & Burkhardt, 2006). Indeed, some believe that shame plays an important role in the onset and course of depression (Andrews, Qian, & Valentine, 2002). Even in adolescents, shame-proneness is a significant predictor of depressive symptoms, both concurrently and over the course of a year (De Rubeis & Hollenstein, 2009). It seems that the relationship between external shame and depression is stronger than is the relationship between internal shame and depression (Kim et al., 2011). Although the attributional styles in shame and depression are very similar, such as making internal, stable, and global attributions for negative events, shame-proneness accounts for a considerable amount of the variance in depression after controlling for attributional style (Tangney, Wagner, & Gramzow, 1992). M. Lewis (1995) suggested that sadness or, in its severe form, depression, is a defensive reaction to the experience of shame. He

argued that shame is an extremely intense and to some extent unbearable emotion and individuals try to substitute it with more manageable and less intense emotions such as sadness or anger. However, if sadness is constantly substituted for shame, it becomes more detrimental and severe, leading to depression (De Rubies & Hollenstein, 2009).

However, it can be equally argued that shame is such a painful experience that it may make people more vulnerable to a variety of psychological problems, such as depression (Tangney et al., 1992). As Andrews et al. (2002) demonstrated, shame is likely to play a causal role in the development of depression. In particular, bodily shame mediates the relationship between childhood abuse and depression (Andrews, 1995). Feeling shame about one's body can appear after early abuse and before the start of depressive symptoms; this may indicate that feeling shame about one's body plays a causal role in depression (Andrews, 1995, 1998, 2002). There is also a possibility that the high degree of association between shame and depression is due to their similar symptoms and common indictors rather than a cause and effect relationship.

2.3.2. Shame and Social Anxiety

Shame-proneness is highly correlated with social anxiety (Lutwak & Ferrari, 1997a). In fact, Gilbert (2000) found that shame was not associated with depression after controlling for social anxiety but continued to be related to social anxiety after controlling for depression. Nevertheless, Gilbert stated that shame is not the same as social anxiety. He claimed that "shame is a much broader concept than social anxiety" (Gilbert, 2000, p. 186), and that shame measures do not do justice to it. Indeed, the focus of social anxiety can be narrow (e.g. concern that other people will see that they are anxious), whereas shame implies a global negative self-evaluation. Shame is significantly correlated with a fear of negative evaluation, a feeling of helplessness, and inferiority (Gilbert, Pehl, & Allan, 1994). Like those with social anxiety disorder,

shame-prone individuals seem to feel anxious in interpersonal situations and worry about negative evaluations from others (Lutwak & Ferrari, 1997a).

One difference between chronic shame and social anxiety is that anxiety may decrease as one moves away from problematic social situations, while a sense of shame may increase or remain unchanged due to constant rumination about one's negative self-image (Gilbert, Pehl, & Allan, 1994). However, people with social anxiety also ruminate a great deal, and there may be occasions when avoidance-based strategies can be used to reduce feelings of shame, as well as social anxiety. It could be argued that social anxiety and the associated avoidance behaviours are driven by a fear of experiencing the shame that arises from negative evaluations by others; therefore, these emotions – shame and anxiety – are very alike. While a socially anxious individual is fearful of the truth of a negative self-evaluation, a person experiencing shame has accepted that the negative evaluation of the self is valid (K. Rimes, personal communication, May 2015).

2.3.3. Shame, Body, Disordered Eating, and Eating Disorders

Physical appearance is a strong predictor of feelings of shame (M. Lewis, 1998; Gilbert & Miles, 2002). Individuals fear that they may be rejected by or evoke feelings of disgust in others because of their appearance and bodies (Roberts & Goldenberg, 2007). Some examples of bodily features that induce shame include: disfigurements such as acne (Kellet, 2002; Kent & Thompson, 2002), psoriasis (Miles, 2002), and scarring from burn injuries (Coughlan & Clarke, 2002).

Individuals with a physical disfigurement may feel shame because they believe they are unattractive (internal shame). They may feel shame because they think others evaluate and consider them to be unattractive (external shame), or they may feel shame because they have been ridiculed, ostracised, rejected, or called ugly due to their

physical attributes (Coughlan & Clarke, 2002). In these situations, it is also possible to feel shame about the feeling of shame (secondary emotion). For example, people may strongly condemn lookism. Intellectually, they may abhor media attitudes towards appearance (Brown, 2007). They may strongly believe that focusing on appearance is shallow and superficial. However, they may lack the ability to control their emotions and feelings of shame when looking in a mirror or seeing their own photograph, and subsequently feel shame about their own attitudes towards their appearance (Brown, 2007).

It is significant that research has revealed higher scores on shame measures for women with eating pathologies than for the general population (Rortveit, Astrom, & Severinsson, 2010); those women who were in remission from eating disorders showed a lower level of shame and scored lower on shame scales than did those who still suffered from eating disorders (Troop, Allan, Serpell, & Treasure, 2008). Moreover, internal and external shame tends to be associated with anorexia and bulimia. It would seem that feeling shame about one's body encourages food restriction and subsequent weight loss and, in extreme cases, anorexia and bulimia (Troop et al., 2008). In addition, some individuals who feel shame engage in disordered eating and binge eating in order to numb or ease the feelings of shame (Goss & Gilbert, 2002).

2.3.4. Shame and Narcissism

Some clinical theses presume that narcissistic behaviours and attitudes are defence mechanisms against the experience of shame (H.B. Lewis, 1971; Wright, O'Leary, & Balkin, 1989). It appears that people use a wide variety of behaviours and attitudes to protect the self against shame. Features of narcissism, such as grandiosity or an excessive need for undivided attention, are thought to prevent feelings of shame. It is believed that shame is sometimes bypassed (H.B. Lewis, 1971): a state where the self

does not feel or experience shame consciously. In other words, shame is not acknowledged (Blum, 2008) but is experienced in other forms, such as anger or narcissism (M. Lewis, 1992). There is a possibility that individuals will repress feelings of shame and regard the self highly (Wright et al., 1989).

To examine the association between shame and narcissism, Gramzow and Tangney (1992) carried out research to measure shame and guilt proneness, as well as narcissistic personality disorder. Their study demonstrated that shame-proneness was negatively associated with adaptive aspects of narcissism, such as leadership and self-absorption. However, pathological aspects of narcissism or covert narcissism, such as the exploitative aspect, were positively related to shame-proneness (Tangney & Dearing, 2002). Similarly, Bosson and Prewitt-Freilino (2007) demonstrated that participants who had a higher score for shame also had a higher score for covert narcissism. According to these authors, the difference between implicit and explicit self-esteem contributes to the development of covert narcissistic tendencies identified with low self-esteem, neurotic inclinations, and shame.

Thomaes, Stegge, and Olthof (2007) further examined the relationship between narcissism and the externalisation of shame in pre-adolescent children. They found that children who had a higher score on the narcissism scale – in other words, they answered positively to items such as "without me, our class would be much less fun" and "I am a very special person" (p.565) – tended to respond aggressively to situations that were shame-inducing, such as when someone criticised their taste in music. It is likely that children with a high score for narcissism will find shame-provoking incidents highly unbearable, and will try to respond aggressively in order to maintain their desired self-image (Thomaes et al. 2007).

More recently, Ritter et al. (2013) explored implicit and explicit shame in patients with narcissistic personality disorder. Implicit shame was measured using an implicit association test (see Rusch et al., 2007), and explicit shame was assessed by self-reporting measures of shame (the Test of Self-Conscious Affect and the Experiential Shame Scale). Their findings indicated that patients with narcissistic personality disorder had a higher score on the explicit measures of shame (state shame and shame-proneness) than did the non-patient control group. Furthermore, in the implicit association test, the narcissistic patients associated the self with shame more than with anxiety.

In conclusion, the association between shame and psychological problems has received increasing attention in the literature. The strong correlations between shame, depression, and social anxiety may indicate that the individual response to and management of shame can influence, mediate, and moderate psychological and physiological maladjustments. In this regard, an important question is why some people are able to bounce back and manage shame effectively, while the morale of others is destroyed and shattered by the experience of shame. For instance, why do some individuals with a disability, skin problem, or body-image issue feel constant shame and are emotionally paralysed, while others with the same problems are able to function successfully? To cultivate resilience to shame and overcome the painful feeling of shame and function effectively, it is necessary to study shame management methods.

2.4. Part Three: Managing Emotions and Shame

The purpose of this section is to identify the methods people often employ in order to address shame. However, the literature that examines shame management and regulation is relatively disorganised and scattered. To integrate different components of the shame management literature, it is necessary to step back and see how emotions are

generally managed, and how people tend to cope with negative experiences. A comprehensive review of emotion regulation and coping strategies is beyond the scope this chapter. The intention is to provide a succinct review of the identified emotion regulation methods, focusing primarily on Gross' (1998) model of emotion regulation, in order to offer a clear structure for categorising methods and strategies in the shame management literature.

2.4.1. Coping and Emotion Regulation

The most commonly cited definition of coping has been offered by Lazarus and Folkman (1984), who described coping as "constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p.141). Other theorists have offered similar but different definitions of coping. For example, Skinner and Wellborn (1994) defined coping as "how people regulate their behaviour, emotion, and orientation under conditions of psychological stress" (p.112), while Compas, Connor-Smith, Saltzman, Thomsen, and Wadsworth (2001) described coping as involving "conscious volitional efforts to regulate emotion, cognition, behaviour, physiology, and the environment in response to stressful events or circumstances" (p. 89).

Therefore, coping strategies can be considered as the methods and ways whereby individuals regulate their emotions, behaviour, and physiology when they are under stress or in an adverse situation (Compas et al., 2001; Skinner &Wellborn, 1994; Skinner & Zimmer-Gembeck, 2007).

Notably, Gross (1998) regarded emotion regulation as:

> The process by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions. Emotion regulatory processes may be automatic or controlled, conscious or unconscious,

and may have their effects at one or more points in the emotion generative

process. (p. 275)

The majority of studies on emotion regulation attempt to distinguish adaptive emotion

regulation strategies from maladaptive ones, and to examine how these maladaptive

methods influence psychopathology.

As seen above, emotion regulation and coping are highly affiliated, but are

considered distinct constructs (Folkman & Moskowitz, 2004; Gross & Thompson,

2007). It is believed that coping strategies tend to concentrate on reducing negative

emotions, while emotion regulation methods focus on both negative and positive

emotions. Furthermore, coping strategies, such as coping and dealing with the death of

a partner may work over a longer period of time than emotion regulation strategies. In

addition, emotion regulation involves both conscious and unconscious processes, while

some theorists (Folkman & Moskowitz, 2004) believe that coping strategies should not

include volitional and involuntary responses. Another important distinction is that

coping methods (if we exclude proactive or preventive coping) are utilised after the

onset of emotion or stress, while emotion regulation can occur before the initiation of

emotions (Folkman & Moskowitz, 2004; Gross & Thompson, 2007).

In fact, according to Gross and Thompson (2007), the phrase "emotion

regulation" is more appropriate to describe "how emotions are regulated (regulation of

emotions)" rather than it does "how emotions regulate something else, such as thoughts,

physiology, or behaviour (regulation by emotions)" (p.9). Nonetheless, in this thesis, in

order to identify the methods individuals use to manage their emotions and,

consequently, shame, it is more constructive to look at both emotion regulation and

coping methods in order to understand how they have been grouped and classified, and

whether the same methods can be applied to shame management strategies.

2.4.2. Classifying Ways of Coping

Looking at the literature on coping, it is clear that people use a wide variety of methods to cope with and manage their feelings and adverse life events. Skinner, Edge, Altman, and Sherwood (2003) identified 400 ways of coping. Suppression, seeking social support, acceptance, religion (prayer), humour, denial, mental or behavioural disengagement, planning, the use of drugs and alcohol, fantasising, and many other forms of behaviour are considered ways of coping. The extreme diversity of coping responses makes it challenging to classify and group coping strategies. However, the following strategies are often cited in the literature.

Problem-focused versus emotion-focused coping: Problem-focused coping requires paying particular attention to the cause of the stress and taking action in order to eliminate or evade the stressor, such as making plans or finding other solutions; emotion-focused coping involves concentrating on the emotion caused by the stressor and attempting to manage or resolve the associated emotion by seeking help or engaging in wishful thinking, for example. These two methods are not completely distinct. Managing emotion helps individuals to focus on the problem, and taking action and resolving the problem reduces negative feelings associated with the stressor (Carver & Connor-Smith, 2010; Lazarus & Folkman, 1984).

Engagement versus disengagement: Engagement, or approach coping, is composed of behaviours or responses oriented towards the threat, such as seeking social support or engaging in problem solving. By contrast, in disengagement, or avoidance coping, individuals respond by to moving away from the stressor, such as denial or fantasising (Carver & Connor-Smith, 2010; Roth & Cohen, 1986).

Primary versus secondary control: The goal of primary control is to change the stressor and associated emotions through (for example) problem solving or emotion

regulation. Secondary control attempts to adapt or adjust to the stressful environment via acceptance or cognitive reconstruction (Morling & Evered, 2006; Skinner et al., 2003). In general, problem-focused coping, engagement coping, and primary and secondary control are regarded more positively, because they usually predict better physical and psychological outcomes than do emotion-focused and disengagement coping methods (Connor-Smith & Flachsbart, 2007).

2.4.3. Regulation of Emotions According to Gross' Process Model

Gross (1998) developed a process model of emotion regulation that proposes five groups of strategies for emotion regulation: situation selection, situation modification, attention deployment, cognitive change, and response modulation.

2.4.3.1. Situation selection

Situation selection is the first strategy in this model. It refers to approaching (or avoiding) situations, certain people, or objects that maximise (or minimise) the probability of desirable (or undesirable) emotions. Examples include watching a funny film before an exam to reduce apprehension or a shy person avoiding a social situation in order to control anxiety (Gross, 1998; Gross & Thompson 2007). Avoiding versus approaching is a classic example of situation selection. Although avoidance can obstruct the emergence of emotion early on, it can be a highly maladaptive emotion-regulation strategy (Sheppes & Gross, 2012). Accurately weighing without bias short-term benefits against long-term costs is an essential element of effective situation selection (Gross, 1998; Gross & Thompson 2007; Sheppes & Gross, 2012). In addition, there is a high probability that individuals will overestimate or underestimate the effect of a given situation, which can be considered a serious barrier to effective situation selection.

2.4.3.2. Situation modification

After selecting a potentially emotion-inducing situation, individuals may still attempt to change or modify the situation in order to alter its emotional significance (Gross & Thompson, 2007). Similar efforts have previously been identified as problem-focused coping or primary control in the coping literature (Gross, 1998). Situation modification focuses on changing one's external (physical) world in order to regulate emotions. For example, an anxious student may decide to use a verbatim transcript during a presentation or check a podium a few days before a presentation in order to reduce his or her anxiety (Sheppes & Gross, 2012), or a couple may take a break during a heated argument in order to manage their anger.

2.4.3.3. Attention deployment

Attention deployment is an internal emotion regulation process and includes strategies to manage one's emotions through attention. Instead of changing one's external environment or situation, emotion is regulated by using attention deployment. Distraction, concentration, and rumination are examples of attention deployment (Sheppes & Gross, 2012).

For instance, distraction can include activities such as looking away from an emotional stimulus (Gross, 1998), or engaging in tasks such as reading a book or watching television in order to minimise the effect of emotion. Use of distraction strategies seems to be effortless but short-lived (Larsen & Prizmic, 2004). They are likely to have short-term benefits but long-term costs (Sheppes & Gross, 2012).

2.4.3.4. Cognitive change

Even after the use of situation selection, situation modification, and attention deployment, a response to emotions can be regulated through cognition. Cognitive change refers to redefining or transforming the meaning of a potentially emotion-

inducing situation in order to reduce its emotional impact. A common example of cognitive change is downward social comparison (Gross & Thompson, 2007), which means comparing oneself with those in less favourable positions (Suls, Martin, & Wheeler, 2002). This comparison is likely to enhance an individual's affective state.

A well-known example of cognitive change is reappraisal. This form of cognitive change refers to the reconstruction and re-evaluation of an emotion-eliciting situation to minimise negative feeling and emotional impact (Gross, 2002). In general, the ability to find benefits or see the "silver lining" in adverse situations has been linked to psychological and physical health (Tennen & Affleck, 2002). For example, Davis, Nolen-Hoeksema, and Larson (1998) demonstrated that participants who could find something positive in the loss of a loved one, such as finding strength in the face of the loss or a new life perspective, were less distressed and better adjusted 13 months after the loss.

In addition, Gross and John (2003) found that individuals who habitually tend to use reappraisal strategies were in better health than those who used suppression. Additional evidence for the advantage of reappraisal comes from experimental studies; for example, participants who were instructed to watch a film about an arm amputation objectively (focusing on technical aspects rather than getting caught up in the emotional aspect) experienced a lower level of disgust compared with participants who were in the control group and were instructed to just watch the film (Gross, 1998).

2.4.3.5. Response modulation

According to the process model of emotion regulation, all of the previous emotion regulation strategies, namely situation selection, situation modification, attention deployment, and cognitive appraisal, occur before the onset of an emotional response. These regulation methods are referred to as *antecedent-focused* strategies.

Nonetheless, the model suggests that emotions can be regulated after they have been initiated, which is referred to as *response-focused* strategy. Response-focused regulation includes response modulation which involves attempts that target physiological, experiential, or behavioural expressions of emotional responses directly. For example, alcohol, drugs, food, relaxation and exercise can be used to temper physiological, experiential and behavioural responses to negative emotions (Gross & Thompson, 2007). In addition, individuals may try to suppress their emotional response (Richards & Gross, 2002), or they may allow themselves to experience their emotions without trying to control them (Sheppes & Gross, 2012). Previous studies indicate that efforts to inhibit emotional thoughts and experiences may have negative effects (Wegner, 1994), or that attempts to suppress emotional expression may promote maladjustments (Gross & Thompson, 2007).

In general, antecedent-focused strategies are efficacious in regulating emotion; early interventions are successful, while response-focused strategies that target later stages and occur after the generation of response tendencies are less successful (Gross, 2002; Sheppes & Gross, 2011). However, some techniques such as muscle relaxation or controlled breathing used to regulate emotional responses are beneficial, while some antecedent-focused strategies such as rumination are believed to be highly flawed (Koole, van Dillan, & Sheppes, 2011).

2.4.4. Shame Management and Shame Responses

There is no shortage of claims about how shame might be managed; however, relatively little empirical evidence is available concerning how people tend to address shame: the available information is very scattered. In the discussion below, I will start with Brown's (2010) distinction between shame responses – that people tend to respond to shame by moving away, moving towards, or moving against it. Next by drawing on

Gross' (1998) model and common classifications in the coping literature, I will discuss
attention-based shame management methods, cognitive-reappraisal strategies, and other
methods that people employ when encountering shame.

2.4.4.1. Moving away (avoidance, withdrawal, and concealment)

As mentioned in the literature on coping and emotion regulation, the methods of
engagement versus disengagement or avoidance versus approach (situation selection)
are recognised as common means for dealing with emotions. According to the shame-
management model (Nathanson, 1992), avoidance and withdrawal are the two main
strategies for dealing with shame; this model is based on the idea that each person
develops a series of schemas or scripts for managing shame according to his or her
previous personal experiences (Nathanson, 1992).

Previous studies on shame also indicate that shame activates avoidance-based
responses and motivations, such as a desire to disappear, hide or withdraw (Behrendt &
Ben-Ari, 2012; Tangney, 1995; Yi & Kanetkar, 2011). For example, Yi and
Baumgartner (2011) found that participants who felt shame after engaging in impulse
shopping and responded positively to items such as "felt like I was a bad person" or
"felt like others would judge me," (p.462) were also more likely to report the use of
avoidance-related coping methods such as: mental disengagement ("I slept more than
usual or went to bed earlier after this impulse buying occasion", p.466) than were
participants who felt guilt.

As noted in the previous chapter, shame is mainly distinguished from guilt on
the basis of different action tendencies. Shame motivates individuals to avoid, escape or
withdraw, while guilt facilitates approach or reparative tendencies (Lindsay-Hartz,
1984; Lindsay-Hartz et al., 1995; Tangney & Dearing, 2002; Wicker et al., 1983).
Strong support for this differentiation comes from autobiographical accounts of shame

and guilt demonstrating that individuals in a state of shame report a stronger desire to hide or withdraw than do those who have experienced guilt (Tangney, Miller et al., 1996; Wicker et al., 1983). In addition, avoidance-based strategies such as avoiding eye contact and dismissive body language are considered markers of shame, while engagement and contrite displays are believed to convey guilt-proneness (Barrett, 1995; Barrett et al., 1993).

Research also indicates that people are often reluctant to describe shameful experiences (Lindsay-Hartz, 1984; Tangney, 1992). However, if they do describe them, they usually have an urge to leave or escape from the situation (Lindsay-Hartz et al., 1995). Because the experience of shame is extremely painful and intense, people who feel ashamed try to distance or physically remove themselves from shame-inducing situations in order to manage their feelings and avoid further negative emotions (Tangney, 1995; Tangney et al., 2007). In particular, they may want to avoid further observation or negative evaluations (Fischer & Tangney, 1995).

2.4.4.2. Moving towards (approach and self-enhancement)

Despite the empirical support for the shame-avoidance association, de Hooge, Zeelenberg, and Breugelmans (2010; 2011) challenged the relationship between shame and avoidance/withdrawal tendencies. They argued that the majority of studies that have established a relationship between shame and avoidance tendencies have focused on chronic shame rather than on state shame. They suggested that ashamed individuals try to repair a devalued self after experiencing shame rather than escaping from the situation.

According to this view, the experience of shame challenges the positive view of the self. The main focus of shame is a devalued self, and because people are motivated to have a positive self-view, ashamed individuals try to amend the devalued self and

enhance their self-esteem. Nonetheless, if restoring the devalued self becomes impossible or too risky for those experiencing chronic shame (for example), or if the ashamed individuals know that attempting to restore the self may cause further failure, self-enhancing motives become less apparent. In these situations, ashamed individuals are more likely to escape from the situations or avoid them (de Hooge et al., 2011).

Specifically, de Hooge, Breugelmans, and Zeelenberg (2008) demonstrated that endogenous shame inspired individuals to engage in prosocial activities, while exogenous shame did not motivate such behaviour. The influence of shame is endogenous when it is relevant to the task at hand and is part of goal pursuit, while the influence of shame is considered exogenous when it is irrelevant to the decision at hand and is not part of current goal pursuit. For instance, in their experiment, participants were more generous towards a partner who had witnessed shame and who was aware of the shame-evoking situation than towards a partner who was not aware of the situation.

Similar findings have been reported by Behrendt and Ben-Ari (2012), who examined personal experiences of shame. Their analyses of the narrative accounts of ashamed individuals indicated that more than 50% of the participants in the shame condition coped with shame through engaging in competitive behaviour. It may be that these individuals were motivated to restore the damaged self by engaging in competitive behaviour and consequently winning and showing their competence. Gilbert (1998) further speculated that behaviour such as apologising or helping others might be engaged in in order to heal feelings of shame. According to the author, there are rituals in some cultures that ashamed individuals can participate in to eliminate their experience of shame.

At the same time, some researchers (see Silfver, 2007) have contended that the state of shame may not be associated with a particular style of coping (approach or

avoidance), while shame-proneness or chronic shame is more strongly linked to avoidance and withdrawal coping strategies. It could also be said that, in chronic shame, that avoidance might operate prior to the shame experience, as with social anxiety, while in the state of shame, avoidance-based strategies such as withdrawal or hiding may occur after the experience of shame; ashamed individuals may avoid further contact rather than using avoidance-based strategies pre-emptively. For instance, if someone constantly feels ashamed about her/his appearance or body, that person may avoid attending social situations (situation selection) or looking in the mirror to manage feelings of shame pre-emptively. However, if someone feels ashamed (state shame) after a bad presentation, that person may immediately leave the situation and hide from other people. The ashamed person in the second scenario may also form negative beliefs about giving presentations and therefore avoid them in future.

2.4.4.3. Moving against (shame and anger)

The literature on shame indicates a very strong association between shame and anger. To cope with the experience of shame, ashamed individuals may "strike back" or blame others and behave aggressively (Tangney, Wagner, Fletcher, & Gramzow, 1992). Directing anger towards others may temper negative feelings towards the self and consequently reduce feelings of shame or invalidate the state of negative self-evaluation. Anger is likely to indicate authority and command rather than weakness and submissiveness. Anger, rather than shame, may assist individuals to promote their social status by signalling power (Gilbert, 1998).

According to the shame-management model (Nathanson, 1992), individuals may cope with shame by attacking the self or attacking others. Attacking the self occurs, when the shame message is accepted and an individual experiences self-directed anger. In this case, the person feels negatively about the self and criticises it. On the other

hand, attacking others occurs when the shame message does not appear legitimate and an individual makes another person feel bad and ashamed.

Correspondingly, Schoenleber and Berenbaum (2012) proposed two aggression-related regulation methods that can be used to manage shame. The first is other-directed aggression (aggression towards others), and the second is self-directed aggression (aggression towards the self). Other-directed aggression consists of physical aggression, verbal aggression, relational aggression (excluding others socially or spreading rumours about others), passive-relational aggression (preventing others from attaining their goals explicitly or implicitly), and ruminative retribution (persistent hostile thoughts towards others or imagining harming others). Self-directed aggression involves explicit self-deprecation (disparaging oneself in front of others) and physical self-harm. However, Schoenleber and Berenbaum (2012) have not provided any empirical evidence for these suggestions, and research has yet to establish links between these associations.

As noted earlier, some shame theorists (H. B., Lewis, 1971; M. Lewis, 1992) believe that shame may not be fully acknowledged or experienced. However, it is unlikely that shame disappears, although it might recede from consciousness. According to this view, unacknowledged shame might be substituted with anger. M. Lewis (1992) further speculated that criminal activities in some parts of the United States may be related to the fact that the residents of these areas are continuously ashamed because they are often poor, black, and disadvantaged.

Aside from the strong theoretical link between shame and anger, empirical and correlational studies have also corroborated a positive association between shame and anger (Tangney, Wagner, Fletcher et al., 1992; Tangney, Wagner, Hill-Barlow, Marschall, & Gramzow, 1996). More importantly, Stuewig et al. (2010) demonstrated that the relationship between shame and anger is not direct; it is mediated by the

externalisation of blame. In other words, shame-prone individuals who blamed others (externalisation of blame) were more likely to show verbal and physical aggression towards others.

Furthermore, Thomaes, Stegge, Othhof, Bushman, and Nezlek (2011) found that the experience of shame made children aggressive. In their experimental study, children were asked to compete in an online game against an opponent. The participants were unaware that the game was rigged: there was no opponent. The study was designed in such a way that all of the children failed at the task; however, only those who felt ashamed after their failure expressed anger. In other studies, Thomaes and colleagues (Thomaes, Bushman, Stegge, & Olthof, 2008; Thomaes et al., 2007) revealed that children who had a positive but fragile self-regard (a high degree of narcissism) responded more aggressively towards others in response to shame-inducing situations. In addition, on days when the children experienced shame, their classmates observed increased anger in them (Thomaes et al., 2011), which demonstrates a solid link between anger and shame. Overall, it seems due to the painful and disruptive quality of shame, ashamed individuals are inclined to externalise blame and show anger instead of shame which, in turn, may protect their egos and self-images.

2.4.4.4. Attention-based strategies and shame

Attention deployment (Sheppes & Gross, 2011) might be applied in order to regulate shame. For example, Schoenleber and Berenbaum (2012) proposed that people may move their attention away from their flaws or weaknesses (misdirection) in order to escape or reduce feelings of shame. Furthermore, drawing on her clinical work, Ekstromer (2002) stated that it is very common for children who feel shame to fantasise about being someone else. For example, she mentioned Jenny, a six-year old girl who felt shame as a result of having bowel problems and wished to be a different girl,

Sophie, a girl who did not have bowel problems. It would appear that Jenny engaged in fantasy in order to minimise the painful feeling of shame.

Although associations between attention-related strategies and shame are under-researched, Tracy and Robins (2007a) applied the process model of self-conscious emotions (Tracy & Robins, 2004) in order to explain how self-conscious emotions such as shame might be regulated. They argued that ashamed individuals may try to change their focus of attention; in particular, they may divert their attention from the self to the external world. According to this proposal, the regulation of attention halts the elicitation of self-conscious emotions because it prevents the activation of self-representations. As was noted in Chapter One, Tracy and Robins (2007b) argued that self-representations are an essential part of shame elicitation.

Rumination is another attention-oriented strategy that may be relevant to the experience of shame. Rumination refers to a tendency to focus and concentrate on negative emotion and distress in a passive and repetitive fashion (Nolen-Hoeksema & Corte, 2004; Watkins, 2008). For example, individuals may focus on thoughts such as "I feel so down and blue. Will I ever snap out of this?" or "What's wrong with me that I feel this way?" (Nolen-Hoeksema & Corte, 2004, p .411). A tendency to engage in rumination is associated with elevated symptoms of depression and anxiety (Nolen-Hoeksema & Corte, 2004; Nolen-Hoeksema, Parker, & Larson, 1994).

Notably, ashamed individuals tend to engage in self-rumination. For example, Joireman (2004) found that shame-prone individuals responded positively to items such as "I often play back over in my mind how I acted in a past situation" or "I spent a great deal of time thinking back over my embarrassing or disappointing moments" (p. 227). In addition, Joireman's (2004) study demonstrated that self-rumination mediates the relationship between shame and personal distress. In a similar manner, Orth, et al.

(2006) found that event-related shame evokes rumination which leads to depression. In their study, feelings of shame after separation and family breakup were associated with rumination about the breakup: ("any reminder of the breakup brought back feelings about it" and "I thought about the breakup when I didn't mean to", p.1611) and rumination mediated the relationship between shame and depression.

2.4.4.5. Cognitive change, reappraisal, and shame

Tracy and Robins (2007a) contended that a useful strategy for regulating self-conscious emotions such as shame could be reappraisal of the emotion inducing incident. Specifically, individuals may start to re-evaluate an incident as being irrelevant to their goals. For example, they may make light of the incident, or question its validity or importance. Furthermore, individuals may consider the emotion-eliciting event to be inconsistent with their identity goals. For example, "a failing student could shift her hierarchy of self-representation, reconceptualising her ideal self so that failing an exam becomes congruent with goals for a different identity – that of being a fun-loving Bohemian who is not overly focused on studying and achievement" (Tracy & Robins, 2007a, p. 195)

Furthermore, according to Tracy and Robins (2007a), it is possible for one to re-evaluate casual attributions rather than altering one's ideal self. The authors indicated that *self-serving attributional bias* (Campbell & Sedikides, 1999) is likely to be utilised in order to prevent feelings of shame and guilt, and to enhance feelings of pride; one can change and attribute the cause of the incident from internal to external. It is important to note that attributing the cause of the event from internal to external may prevent the elicitation of any self-conscious emotions. Altering the cause of an event from internal to external may elicit emotions such as anger, which might be less self-demeaning and negative than shame.

Moreover, individuals may reattribute the stability, controllability or globality of the incident. In these circumstances, the elicitation of shame is prevented. For example, considering the cause of the incident to be internal, but unstable and controllable, elicits feelings of guilt rather than shame. To my knowledge, there is no empirical support for the majority of these theses. However, there is a great possibility that individuals engage in these activities unconsciously, which makes them very difficult to assess and study.

2.4.4.6. Response modulation and shame

Alcohol, drugs, food, relaxation, and exercise might be used to temper physiological, experiential, and behavioural responses to shame (Gross & Thompson, 2007). In addition, individuals may try to suppress their feelings of shame (Richards & Gross, 2000). Some researchers (Harper, 2011; Dearing et al., 2005; Tangney & Dearing, 2002) proposed that shame-prone individuals often abuse food, drugs, and alcohol, most likely in an attempt to numb painful feelings of shame. However, the relationship between shame and food, or between shame and alcohol, might be bi-lateral. Using alcohol or consuming food without limits is likely to induce shame as well. A vicious cycle between shame and excessive use of food or substances can then develop (Goss & Gilbert, 2002).

An important point regarding all of the above categories (see Figure 2.1) is that they overlap in key places. For example, mental disengagement might be considered as an avoidance-based strategy as well as an attention-based method. Therefore, these categories do not have strict boundaries. However, using classification groups can increase the understanding of shame management methods.

 In order to get a clearer picture about shame management, four important issues need further exploration:

1. Whether these methods occur prior to the experience of shame or afterwards,

2. Which methods are most effective,

3. Are these methods employed consciously or unconsciously, and

4. Do these methods depend on the context of emotional elicitation?

These issues will be briefly considered in the following sections.

2.4.4.7. Proactive coping and shame

Proactive or preventative coping methods refer to strategies that are used in advance in order to prevent the induction of negative emotions or stressors. These strategies are believed to be more effective in regulating emotions because early inventions are usually more constructive than later regulations (Sheppes & Gross, 2011).

Schoenleber and Berenbaum (2012) recognised methods that can be used pre-emptively to block the elicitation of shame. According to these authors, preventive shame regulation includes achievement sabotage (obstructing chances of performance or progress), dependence (over-reliance on others in order to avoid taking responsibility and consequently reducing the chances of failure), fantasy (fantasising about achieving ideal outcomes instead of focusing on reality), interpersonal avoidance (avoiding social contact and relationships), and perfectionist behaviour (setting extremely high standards).

Although the associations between shame and these methods have not been empirically examined, it can equally be argued that some of these strategies – such as fantasising or interpersonal avoidance – can be used both prior to and after the experience of shame. In fact, a wide variety of coping methods can be used pre-

emptively, as well as during and after the post-shame experience. For example, relaxation methods can be used after the initiation of emotional response in order to regulate physiological indicators of anxiety after exams, and someone may use the same techniques before exams. In this way, he/she prevents anxiety or panic attacks. The only advantage of one approach is that using relaxation techniques before the exam is more effective because it helps the anxious student to focus on his/her exam rather than to feel anxious.

2.4.4.8. Short-term versus long-term emotional regulation

According to the process model of emotion regulation (Gross, 1998) avoidance, which is a situation selection strategy, occurs early and before any emotion processing; people either approach or avoid a situation that may trigger emotion. Avoidance might be very effective in the short-term, but at the cost of long-term benefits. Similarly, distraction, which is another early selection strategy, provides short-term comfort but often causes long-term maladjustments (Sheppes & Gross, 2011). By either avoiding a situation or using a distraction strategy, individuals fail to properly identify their emotion and its potential negative consequences or to take the necessary action to resolve the emotion. However, as Sheppes and Gross (2011) stated, engaging in or focusing on emotion is not always constructive. In fact, ruminating over emotional incidents can be detrimental in a variety of ways (Watkins, 2008).

One of the challenges of managing emotions is that negative feelings may encourage individuals to seek immediate pleasure which, in turn, disrupts emotion regulation. In particular, Baumeister (2002) and Baumeister, Zell, and Tice (2007) have suggested that negative moods prevent individuals from self-regulation and interrupt the pursuit of distant goals. Individuals may act impulsively under stressful conditions in order to repair their negative moods. For example, distressed or sad individuals tend to

make unhealthy choices, such as eating unhealthy food or consuming high levels of alcohol. In a similar vein, research has demonstrated that sad individuals tend to procrastinate about studying for an upcoming test and to engage in activities such as playing video games or reading newspapers if they believe these activities will help them feel better (Baumeister et al., 2007).

There is also some indirect evidence suggesting that shame-prone individuals fail to regulate their emotions effectively and engage in risky behaviour. For example, Tangney and Dearing (2002) reported a longitudinal study indicating that individuals who tended to be shame-prone in the fifth grade (10-11 years old) had a higher rate of drug use when they were young adults (18-19 years old). Therefore, there may be some association between shame-proneness and a tendency to prefer short-term solutions, which makes shame management challenging and taxing.

2.4.4.9. Non-conscious emotional regulation and shame

Fitzsimons and Bargh (2004) concluded that habits such as nail biting or smoking cigarettes, which are often used to diminish anxiety, can be considered an automatic emotion-regulation strategy. Furthermore, Westen and Blagov (2007) stated that operant conditioning, such as social avoidance and unconscious strategies (the externalising of blame) can be considered implicit emotional regulation on some occasions.

It is possible that emotion-regulation strategies evolve and become automated as a result of extensive use (Davidson, 1998), or they might be used habitually without any higher-order processing (Koole et al., 2011). In addition, defence mechanisms such as denial or projection will, in response to negative emotions, work without awareness and consciousness (Loewenstein, 2007). Therefore, it is reasonable to conclude that shame can be regulated automatically and without awareness or higher-order processing. As

noted, ashamed individuals often show anger without recalling or acknowledging the experience of shame. Indeed, narcissistic individuals attempt to cover their vulnerabilities, self-doubt, and shame unconsciously. Furthermore, denial and repression have been reported in relation to the experience of shame in clinical works (M. Lewis, 1992). However, it is impossible to measure the presence of repressed shame, denied shame, or bypassed shame explicitly.

2.4.4.10. Habitual versus contextual coping

Another significant question is whether responding to emotional experiences depends more on the context in which the emotion occurs or on the characteristics of the individuals who are dealing with the emotion. Folkman and Moskowitz (2004) thought coping was a process that depended on the nature of the stressful environment. In other words, coping is situational and context dependent. It is affected by the event type, the controllability of the situation, and resources. However, some researchers believe coping responses can also be influenced by habitual traits (Carver, Scheier, & Weintraub, 1989; Moos & Holahan, 2003). For example, an avoidant person is more likely to use disengagement strategies in response to a wide variety of emotional situations (Carver et al., 1989). In support of this idea, it has been found that the personality traits of extraversion, conscientiousness, and openness are associated with dispositional problem-solving and engagement as coping strategies, while neuroticism is correlated with wishful thinking, withdrawal, and disengagement as coping strategies (Carver & Connor-Smith, 2010; Connor-Smith & Flachsbart, 2007).

John and Gross (2007) also asserted that personality variables such as conscientiousness, extraversion, and neuroticism influence how individuals regulate their emotions. They argued that highly conscientious individuals tend to be very mindful of situations they encounter (situation selection). They prefer not to choose

emotionally charged situations. However, if they encounter emotionally intense situations, they are able to modify them (situation modification) or divert their attention away from the situations (attention deployment). By contrast, extroverted individuals, who usually tend to approach social situations, are less likely to be selective about the situations they encounter; they may have problems regulating their emotions in this regard. Neurotic individuals demonstrate less ability or success in regulating their emotions because they believe their emotions cannot be controlled or regulated. In fact, they do not even make an attempt to use any of the emotion-regulation strategies.

There is certainly no shortage of disagreement in this area. It might be that both situational factors and individual characteristics interact with each other to determine how people respond to emotion-evoking situations. However, because contextual situations and factors are variable and unstable, they are more laborious to detect and predict.

2.5. New Methods for Managing Shame

Reflecting on the above literature, it is evident that, with the exception of a few strategies for shame management such as cognitive reappraisal, the majority of the strategies, including avoidance, concealment, and anger, are fundamentally destructive or unhelpful in the longer-term. These negative strategies are unlikely to resolve feelings of shame effectively. In fact, they may contribute to the feelings of shame. For instance, it is common knowledge that avoidance-based strategies, considered by many theorists to be predominant responses to shame, paralyse social functions and erase personal opportunities and growth. Avoidance could also lead to further feelings of unworthiness, loneliness, and isolation. Cognitive reappraisal and traditional cognitive-based treatment (cognitive-behavioural therapy) are valid methods for treating depression and social phobias; it can be argued that they are constructive in dealing

with shame by challenging negative self-image and thoughts. Nonetheless, these well-established methods do not typically focus on shame directly or measure it as an outcome, and even if they do, they might not be productive for all individuals. Therefore, there is a strong need to recognise, identify, and investigate new methods for managing with shame. Over the last few years, researchers have developed new constructs and methods. The following sections, propose a few mechanisms that can be implemented for managing shame; the empirical chapters of this thesis will test these ideas. One of the strategies that has been identified and which has great potential for dealing with shame is self-compassion.

2.5.1. Self-compassion and Shame

This thesis investigates self-compassion as a method for regulating shame. Broadly speaking, self-compassion refers to being kind, supportive, and compassionate towards oneself when experiencing personal suffering and pain (Neff, 2003a). Being self-compassionate protects individuals against negative emotions and anxiety (Allen & Leary, 2010).

Previous studies have demonstrated that self-compassion is significantly and negatively associated with depression (Neff, 2003a), anxiety (Neff, Hsieh, & Dejitterat, 2005), and neuroticism (Neff, 2009), while it is positively and significantly correlated with happiness and a positive affect (Neff, Kirkpatrick, & Rude, 2007). For example, Adams and Leary (2007) found that inducing self-compassion regulates the eating behaviour of restrictive eaters. By the same token, Leary, Tate, Adams, Allen, and Hancock (2007) conducted a series of studies and found that self-compassion lessens the effect of negative experiences and emotions. Specifically, in one of these studies, participants were assigned to one of the following conditions:

1. Self-compassion induction: Participants were asked to write about a negative event from their past compassionately by focusing on common humanity (everyone may experience that), showing kindness towards the self, and trying to write it in a non-judgmental manner;

2. Self-esteem induction: Participants were asked to describe a negative personal experience, but to focus on their positive characteristics;

3. Writing control: Participants were asked to write about a negative personal experience and explore their feelings about that event; or

4. Control: participants were asked to write about a negative experience.

The study revealed that participants in the self-compassion condition experienced a lower level of negative affect compared with the participants in other conditions. These participants also accepted more responsibility for the event, rather than blaming others.

Interesting results were found by Kelly, Zuroff, and Shapira (2009) when studying shame. They reported that acne sufferers who engaged in self-compassion exercises, such as visualising a compassionate and accepting image and writing a self-compassionate letter to themselves, showed a reduced level of shame experiences. Indeed, their level of shame decreased to normal levels, which is testimony to the efficaciousness of self-compassion. It seems that writing about a difficult and uncomfortable experience in a compassionate manner by expressing kindness and understanding towards the self, increases self-soothing tendencies and self-esteem (Imrie & Troop, 2012).

Paralleling Kelly et al.'s (2009) findings, Gilbert and Procter (2006) demonstrated that evoking compassionate images in the mind and writing compassionate letters to oneself (generating feelings of compassion and warmth) reduced the level of self-threat and shame in clinical patients. Furthermore, Ferreira,

Pinto-Gouveia, and Duarte (2013) found that self-compassion mediated the relationship between external shame and body dissatisfaction in a sample of women from the general population as well as in those with an eating disorder.

The associations between self-compassion and shame will be discussed more thoroughly in Chapter 6. For now, it is important to note that empirical evidence and previous research have indicated that self-compassion may be a highly valuable resource for dealing with shame. In this thesis, it is investigated as an effective coping method.

2.5.2. Mindfulness and Shame

A new approach has recently emerged in psychology that emphasises the importance of changing the context of emotional experiences rather than their content (Cash & Whittingham, 2010). In particular, studies on mindfulness provide a new perspective on emotional regulation. Mindfulness, which refers to paying attention to emotions, thoughts, or inner experiences at the present moment without judgment (Kabat-Zinn, 2005), can be viewed as a mode of emotional regulation (Brown & Ryan, 2003).

In Gross' (1998) model of emotional regulation, mindfulness can be considered a subcategory of attention deployment (Sheppes & Gross, 2012), because it is an attention-based strategy. In fact, in an attempt to define mindfulness, Bishop et al. (2004) proposed a two-component model. The first element is an ability to direct attention to the present moment and to focus on the present moment's activities. The second component of mindfulness refers to being open and receptive towards internal and external experiences, and accepting the present moment's experiences with openness.

We will revisit mindfulness and how it might be related to shame in more detail in Chapter 6. However, it is important to note that, by focusing on the present moment, mindfulness encourages individuals to experience every emotion and thought (positive or negative) instead of becoming preoccupied with the past or future. By focusing on an attitude of acceptance, mindfulness embraces emotions and thoughts without trying to alter them, which contrasts with cognitive change and reappraisal methods mentioned in the previous section. It can be said that mindfulness regulates emotions without actually directly regulating them. Through mindfulness, a new relationship occurs with negative emotions. Individuals step back and observe their thoughts and feelings without engaging in evaluation and judgement. As a result, in the mindfulness mode of processing, negative emotions tend to be experienced and perceived less negatively. Experiences are observed as experiences without any implications or connotations, including for the self (Bishop et al., 2004; Brown & Ryan, 2003; Erisman & Roemer, 2010).

Because of the lack of scholarship on shame management, we have very little information about the association between shame and mindfulness. It is reasonable to assume mindfulness would be effective for managing shame. However, there is little knowledge of the mechanism that would explain why this would occur. Considering the need for further research to explore the relationships between shame and mindfulness and the potential underlying mechanism, the current thesis attempts to understand how shame and mindfulness might be related. Exploring this idea makes a contribution to existing knowledge.

2.5.3. Acceptance and Shame

Acceptance is an essential element of both self-compassion and mindfulness. Acceptance and, ultimately, self-acceptance might be a reason these methods are

effective in dealing with negative emotions. In fact, the notion of acceptance is incorporated in mindfulness-based therapies such as Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn et al., 1992) and Mindfulness-Based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2002). More importantly, research in suppression literature indicates that efforts to inhibit emotional thoughts and experiences have a paradoxical effect (Wegner, 1994). For instance, when people attempt to suppress their thoughts and feelings, the frequency of unwanted thoughts and emotions seems to increase (Wegner, Schneider, Carter, & White, 1987). In addition, suppression can be counter-productive. Emotional suppression appears to impair performance in memory tasks (Richards & Gross, 1999). It may consume attentional resources and impair subsequent performance (Richards, 2004). Furthermore, habitual suppression has been negatively associated with health and psychological well-being (Gross & John, 2003).

By contrast, acceptance is a basis for change. Acknowledging and accepting the experience of shame is the first step towards resolving it (Dearing & Tangney, 2011). During therapy little progress can be made without acceptance (Dearing & Tangney, 2011). Hayes, Strosahl, and Wilson (1999) are also proponents of acceptance, and they believe that it positively affects well-being. The concept of acceptance and how it can be constructive will be discussed more thoroughly in Chapter 5. Overall, acceptance is considered favourably in the literature and is an alternative to suppression or even reappraisal.

Gauntlett-Gilbert and Rimes (2012) devised a new measure: the Acceptance of Shame and Embarrassment Scale (ASES). This scale aims to measure an individual's inclination to accept experiences of shame and embarrassment. This thesis will attempt to psychometrically validate the ASES measure, and to examine how the acceptance of

shame and embarrassment might be associated with depression and health. Currently, there is no self-report measure that assesses the acceptance of shame. Nevertheless, acceptance seems to be a constructive strategy to deal with shame, and it may have different consequences for physical and psychological well-being than avoidance. The development of this measure may promote research on acceptance-based strategies in relation to shame and make an original contribution to the literature.

2.5.4. Mind-wandering and Shame

This thesis will also examine the effect of shame on mind-wandering. As noted earlier, the literature suggests that being present and focusing on the present moment, which is an essential element of mindfulness, is beneficial for well-being and regulating negative emotions. This can be contrasted with mind-wandering where the mind is no longer focused on the present moment.

It can be argued that different elements of mindfulness, such as acceptance, passive observation, and awareness of the present moment, resemble approach coping (Erisman & Roemer, 2010), while engaging in mind-wandering reflects avoidance coping. Although mind-wandering is an attention-based strategy, the aim of mind-wandering or wishful thinking is also to avoid thinking about the shameful incident. Therefore, it is possible that individuals engage in mind-wandering after the experience of shame to numb their feelings of shame. Mind-wandering and its relationship to shame will be further discussed in Chapter 7. For now it is sufficient to note that mind-wandering is one of many responses to shame, which may be less helpful than mindfulness. Figure 2.1 summarises and visualises the methods people may use to manage their shame. Some of these methods can be used both before and after the experience of shame.
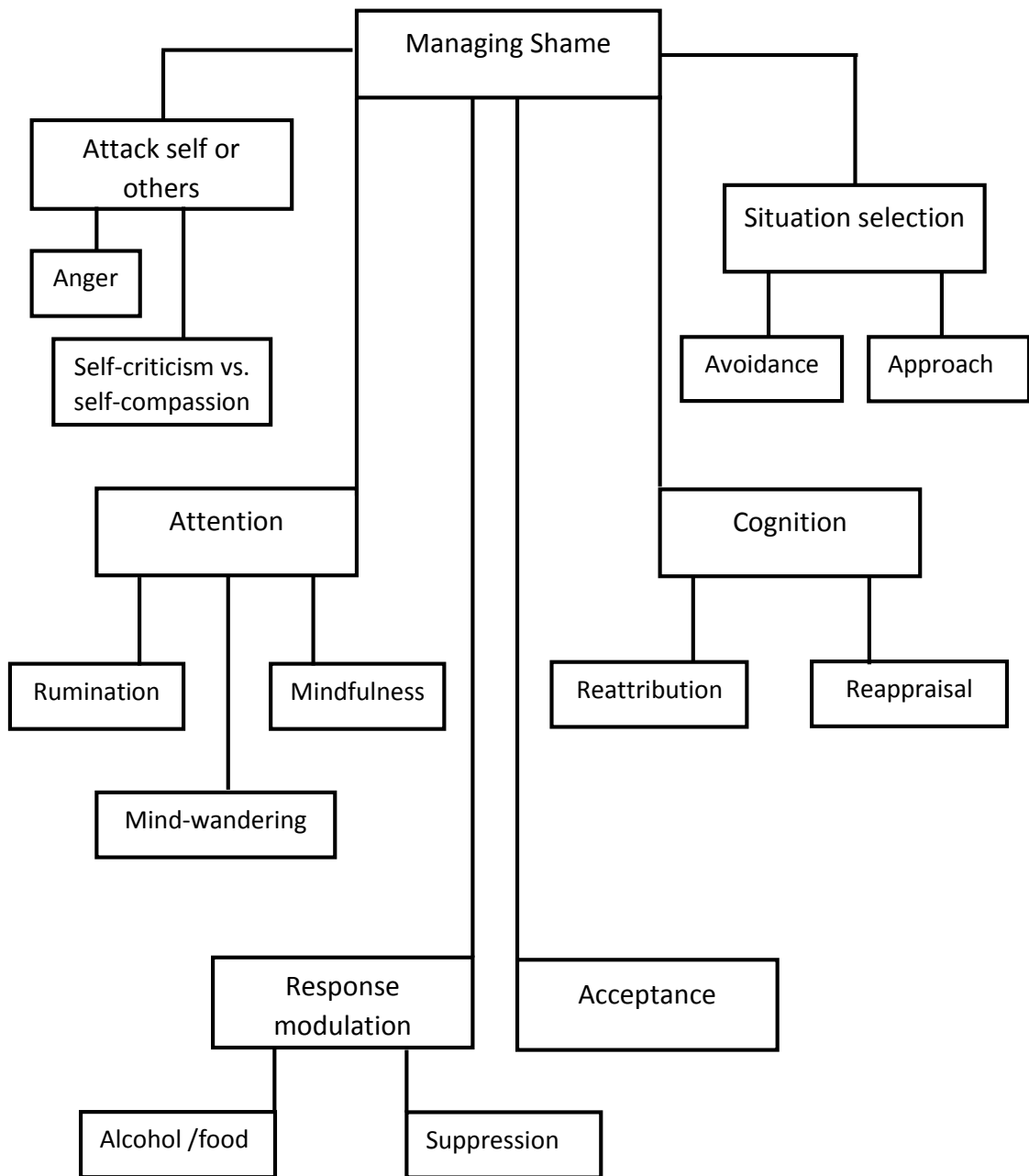
Figure 2.1. Summary of shame management methods

2.6. Summary

This chapter outlined the positive and negative aspects of shame. Shame has an appeasement function and regulates social and interpersonal behaviours. Nevertheless, if shame is experienced frequently, it may influence psychological maladjustment. Shame has been associated with a wide variety of psychological problems such as depression, social anxiety, and eating disorders. Therefore, in order to reduce the impact of shame and to function successfully, shame must to be managed effectively. Drawing from the literature on emotion regulation and coping, I identified the methods which regulate shame.

Studies that examine shame management and shame responses largely focus on a broad classification of coping strategies such as avoidance versus approach. As discussed above, there are countless theoretical models explaining how shame is addressed by individuals; however, there are few empirical (correlational and experimental) studies that pursue this line of inquiry. As a result, there is a tremendous gap between the theoretical models and the empirical research on coping with shame. For example, self-distraction, denial, wishful thinking, or mind-wandering can be considered to be different forms of disengagement strategy. Theoretically these methods have been used to address the experience of shame (Schoenleber & Berenbaum, 2012). However, they have not been validated empirically. This is an important matter that cannot be neglected. Ignoring finer or narrower categories of shame regulation in favour of broader classifications can be scientifically misleading. It cannot be assumed that all forms of disengagement strategies have similar consequences. For example, the use of withdrawal or avoidance strategies after the experience of shame may cause depression (Schoenleber & Berenbaum, 2012), while engaging in self-distraction or wishful thinking may generate positive feelings, at least

in the short-term. Therefore, one aim of the thesis is to contribute to the literature on shame regulation by bridging the gap between theoretical assumptions and empirical studies on shame management. The thesis argues that self-compassion, mindfulness, acceptance, and mind-wandering can all be considered methods of shame management. The question discussed in this chapter is whether these mechanisms are related to shame. The following chapter will look at how shame is assessed, and will introduce the aims and objectives of the empirical work in the thesis.

CHAPTER 3. Measuring Shame and the Empirical Studies of Thesis

3.1. Introduction

The purpose of this chapter is to: (a) present an overview of approaches that are used to measure and induce shame in the laboratory and (b) to introduce the aims and objectives of the empirical studies within this thesis. The methodological approaches, measurements, samples, and the rationale behind each empirical study will be discussed within their respective chapters.

Shame is a complex emotion and challenging to assess. The means by which shame is assessed in the literature is not without its limitations and should be addressed. This thesis takes a quantitative approach towards studying shame; therefore, it is important to present an overview of how shame is measured. In addition, understanding shame scales will assist to form a definition of shame in empirical research. Therefore, in the first section of this chapter, a brief overview of shame assessment instruments is provided. The second section will outline the aims and objectives of the empirical work in the thesis.

3.2. Shame Assessment

3.2.1. How Shame is Currently Measured

Across the literature, a number of instruments have been used to assess shame and other self-conscious emotions. A complete review of these measures is beyond the scope of the current chapter; nonetheless, several of these measures have been employed in repeated empirical studies for the purposes of assessing shame (for a complete review, see Robins, Noftle, & Tracy, 2007; Tangney & Dearing, 2002). Please note, however, that while most studies measure shame by means of a self-report scale, some studies (M. Lewis, 1992; Randles & Tracy, 2013) have relied on coding non-verbal expressions for the assessment of shame.

The most widely used self-report measure of shame is Tangney, Wagner, and Gramzow's (1989) Test of Self-Conscious Affect (TOSCA). The TOSCA is a scenario-based measure, the current version (TOSCA-3; Tangney, Dearing, Wagner, & Gramzow, 2000) consists of 16 scenarios, 11 of them negative and 5 positive. The TOSCA measures shame-proneness, the readiness to feel/experience shame, rather than an actual emotional state (Xuereb, Ireland, & Davis, 2009). In addition to shame-proneness, the TOSCA-3 measures guilt-proneness, externalisation, pride in one's self, pride in one's behaviour, and detachment. It includes sets of responses, each representing a different affective tendency. For example, respondents are asked to consider the following hypothetical situation and to rate their responses on a 5-point Likert scale (1 = *Not likely*, 5 = *Very likely*):

"You make plans to meet a friend for lunch. At 5 o'clock, you realize you stood your friend up."

1. You would think: "I am inconsiderate."

2. You would think: "Well, my friend will understand."

3. You would think you should make it up to your friend as soon as possible.

4. You would think: "My boss distracted me just before lunch."

In this scenario, response (1) measures shame-proneness, (2) measures detachment, (3) measures guilt-proneness, and (4) measures externalisation. Scale scores are the sum of the responses to relevant items (e.g., the score for the shame scale equals the respondent's answer to the shame-related items).

In light of the TOSCA's having a Cronbach's alpha of .77 for shame and .78 for guilt (Robins et al., 2007), it is considered a relatively reliable measure. Scores on the TOSCA shame scale are strongly correlated with scores on other measures of shame

(Andrews et al., 2002), thereby implying that the TOSCA does indeed measure a similar shame construct.

However, the TOSCA has been criticised for its limitations. First, the TOSCA is not domain-specific (Andrews et al., 2002), and therefore, does not measure shame in unique contexts, such as feeling shame as result of having a particular attribute (e.g., bodily shame). Secondly, Dost and Yagmurlu (2008) have argued that the TOSCA provides moral dilemmas for respondents rather than actually measuring affective experiences. Specifically, Leeming and Boyle (2004) questioned the scenario-based measure of shame, questioning its validity across age, socioeconomic background, and culture.

Thirdly, the TOSCA's guilt measure seems to assess a desire to make amends rather than feelings of guilt, whereas the TOSCA's shame scale emphasises negative feelings about one's self as well as a willingness to hide after a wrongdoing. Consequently, the TOSCA is concerned with the adaptive components of guilt and the maladaptive elements of shame (Silfver, Helkamen, Lonnquist, & Verkasalo, 2008). However, it is thought that guilt, especially chronic guilt, can be as maladaptive as shame (Dost & Yagmurlu, 2008). It might also be argued that the TOSCA's shame scale is biased towards items referring to negative self-esteem. Luyten, Fontaine, and Corveleyn (2002) conducted principal component analyses on the shame and guilt scales of TOSCA. They found that items significantly loaded on the shame factor were concerned with negative self-esteem. In addition, the findings indicated that negative self-esteem items in the TOSCA, such as feelings of incompetence and inadequacy account for the significant relationship between the TOSCA and psychological maladjustment. This is contrary to what Tangney (1996) claimed – that shame is, as measured by the TOSCA, is different from negative self-esteem.

Another instrument that is widely used for measuring shame is the Internalized

Shame Scale (ISS) (Cook, 1994). The ISS aims to measure chronic shame that has been

internalised and transformed one's personal identity. This measure is contained in a

series of negative statements identified from Cook's clinical work and practice that

demonstrate the painful nature of shame (Leeming & Boyle, 2004). Respondents are

asked to rate the frequency of statements, such as: "I see myself as being very small and

insignificant" and "I feel like I am never quite good enough." The ISS is employed

chiefly in clinical research (Robins et al., 2007). Similar to the TOSCA, this scale does

not use the word "shame" directly in its items. Although the ISS has good internal

consistency and psychometric properties, it has been criticised for its considerable

overlap with self-esteem measures (Tangney, 1996) and depression (Allan et al., 1994).

Tangney (1996) argued that items, such as: "I feel like I am never quite good enough"

or "compared to other people, I feel like I somehow never measure up," used in the ISS

to assess shame, are not sufficiently discriminant from items that used to measure self-

esteem. In addition, the correlation between the ISS and measures of self-esteem is

considerably high, sometimes around -.81 or -.88 (Tangney & Dearing, 2002).

Therefore, the discriminant validity of this measure is doubtful.

The Other as Shamer Scale (OAS) (Allan et al., 1994) was adapted from Cook's

(1998) ISS to measure external shame instead of internal shame. The OAS is comprised

of items such as: "Other people see me as small and insignificant" and "I feel other

people see me as not good enough"; and the scale discerns how others judge the self.

Nonetheless, scores on this measure are highly correlated with scores on the ISS ($r =$

.81) (Goss et al., 1994).

Another common method for assessing shame is the adjective-based checklist

(e.g., Hoblitzelle, 1987; Mosher & White, 1981). Respondents are given a list of shame-

related adjectives (e.g., ashamed, humiliated, and mortified) and asked to indicate if they feel these emotions right now (i.e., state shame) or in general (i.e., trait shame). However, because other terms such as "embarrassment" and "humiliation" are used to assess shame, determining the discriminate validity of these measures is difficult (Tangney & Dearing, 2002). In addition, some versions of these measures are significantly reliant on participants' language proficiency or the ability to differentiate between similar emotions such as guilt and shame (Tangney, 1996). These disadvantages can reduce the level of accuracy and validity of these kinds of measures (Tangney & Dearing, 2002).

The Experience of Shame Scale, developed by Andrews et al. (2002), is based on a series of selected questions that have been used for measuring shame during interviews with participants (Andrews & Hunter, 1997). For example, in an interview participants were asked: "Is there anything else about yourself that you have felt ashamed of?"; their verbal descriptions were recorded and rated by researchers (e.g., Andrews & Hunter, 1997, p.376).

Unlike the TOSCA, which is based on hypothetical transgressions, and the ISS, which relies on a global self-evaluation, the Experience of Shame Scale asks direct questions about three specific areas where individuals may feel shame (i.e., personal characteristics, behaviour, and body). More specifically, character shame includes "shame of personal habits," "manner with others," "sort of person (you are)," and "personal ability" (Andrews et al., 2002, p. 32). Behavioural shame includes "shame about doing something wrong," "saying something stupid," and "failure in competitive situations" (Andrews et al., 2002, p. 32). Bodily shame involves questions about the body. For each aspect of shame, respondents are asked to indicate whether they have experienced a particular kind of shame, whether they have worried about others

opinions of them, and if they have attempted to conceal or cover up the shame-related areas (Andrews et al., 2002). Example questions include: "Have you felt ashamed of any of your personal habits?" and "Have you worried about what other people think of your personal habits?" Questions are answered on a 4-point scale ranging from 1 (*not at all*) to 4 (*very much*).

The Experience of Shame Scale uses the word "shame" in its items, which can be valuable. Asking explicit questions about shame heightens the face validity of the measurement tool. In addition, by using the word "shame", we can eliminate any pre-conceived notions an author of a scale might possess. For example, if the author believes that shame is incapacitating, when developing a scale, he or she includes items that assess negative essence of shame. Without asking direct questions, any definition of shame would be ultimately determined by the author of the scale's conception of shame. However, a scale in which the word "shame" is used does not need shame to be defined. Instead, the respondents are empowered to decide for themselves what shame means and to indicate whether they have experienced shame.

The Experience of Shame Scale will be used throughout the multiple empirical studies forming this thesis to assess shame. The Experience of Shame Scale has been demonstrated to possess good psychometric properties (Cronbach's alpha = .90) (Andrews et al., 2002) and is regarded favourably in the literature (Leeming & Boyle, 2004). However, it should be noted that the Experience of Shame Scale and the TOSCA are significantly correlated ($r = .60$), suggesting that the use of the TOSCA might produce similar results.

The measures previously described relate to trait shame or shame-proneness. State shame is scarcely measured in cross-sectional studies. The principle measure of state shame is the State Shame and Guilt Scale (SSGS) (Tangney & Dearing, 2002). An

example of an SSGS question item is, "I want to sink into the floor and disappear at this moment." Alternatively, a shame-related adjective checklist can also be used to measure state shame.

3.2.2. How State Shame is Induced in Vitro

There are two major problems with inducing shame in the laboratory. First, it is difficult to devise an experimental design that is both ethical and will induce shame in all of the participants. Second, the experience of shame depends on the interpretation of the events and specifically role of the self (M. Lewis, 1992). Therefore, it requires idiosyncratic elicitors (Tracy & Robins, 2004). In fact, only a handful of studies have induced shame in the lab. These studies have mainly used one of the following methods:

1. *Imagining shame*. Respondents are asked to imagine that they are giving a presentation to a group and everything goes completely wrong. For example, they stumble over their words, their intended meaning is unclear, and by the end, it is clear that nobody understood what they were trying to say (e.g., de Hooge et al., 2008). In this case, the extent to which respondents can imagine the situation and experience feelings of shame is questionable.

2. *Failure feedback paradigm*. Respondents are asked to perform a task (e.g., taking an ability test) for which they will receive bogus negative feedback in public about their performance. This method has been used in many studies to affect self-esteem or induce negative emotion. However, it is not clear that this procedure induces shame rather than related states such as sadness or disappointment. Whether shame is a dominant emotion or whether it can be distinguished from other negative emotions is debatable. Although sometimes the negative feedback is given publicly, shame is not necessarily

a public emotion (see Chapter 1). Some studies (e.g., M. Lewis et al., 1992; Thomaes et al., 2011) applied the easy task failure paradigm, in which respondents are asked to perform an easy task versus a difficult task. M. Lewis et al. (1992) suggested that failing at an easy task is likely to induce shame, while failing at a difficult task may only cause sadness or disappointment rather than shame.

3. *Autobiographical recall procedure* (see Yang, Yang, & Chiou, 2010). In this method, respondents are asked to recall a personal experience when they felt a strong sense of shame. Although this method is widely used for evoking emotion, the extent to which individuals can induce feelings of shame by remembering a shameful account is debatable. In addition, some may describe an embarrassing or guilt-related event rather than a shameful event. Typically, it is difficult for lay people to differentiate between embarrassment, guilt, and shame (Tracy & Robins, 2006).

Overall, much of the empirical work on shame has examined shame dispositions, namely, shame-proneness, and trait shame. Shame, in these studies, is often assessed using the Tests of Self-Conscious Affect and the ISS, both of which have been criticised for being highly correlated with self-esteem measures. In the current project, it was decided to employ the Experience of Shame Scale, which contains the word "shame" and to ask direct questions about experiencing shame. In terms of methods to induce shame, there are not many viable options available, which reflects the complexity of issue. We will consider this matter further in the Chapter 7 of this thesis.

3.3. Aims and Objectives

As mentioned in the preceding chapter self-compassion, mindfulness, acceptance, and mind-wandering are considered shame managing methods in this research project. One goal of the thesis is to assess how these mechanisms might be related to shame and how they might potentially assist with shame management; another aim of this thesis to assess factors that might contribute to shame vulnerabilities. These objectives are addressed through a series of four studies.

In the first chapter, I briefly noted that parenting and a child's environment could influence feelings of shame. This variable will be further examined in the thesis. The first study (Chapter 4) employs a cross-sectional design and assesses adverse childhood experiences, attachment style, negative self-judgement, and shame-coping styles in order to determine factors contributing to shame vulnerability. In addition, this study tests a mediation model in which adverse childhood experiences affect negative self-judgement, which, in turn, influences shame. This study tests the following primary hypotheses:

1. Adverse childhood experiences are significantly related to negative self-judgement, and negative self-judgement mediates the association between negative childhood experiences and shame.

2. Shame has a greater association with submissive coping styles in comparison to adverse childhood experiences.

In the second study (Chapter 5), data from two different samples will be used to conduct factor analysis on draft items for the proposal scale of the acceptance of shame and embarrassment. The aim is to identify the underlying factors of this scale and validate this newly designed assessment tool. In addition, this study will examine how

this scale might be related or predict depression and health outcomes. The study tries to establish:

1. Whether the acceptance of shame and embarrassment scale is valid?

2. If scores on this scale predict quality of life and depression?

The third study (Chapter 6) employs a cross-sectional design and measures the associations between mindfulness, self-compassion, the acceptance of shame and embarrassment, and shame. The primary of aim of this study is to determine whether mindfulness is related to shame and if so, how and why this works. The study proposes a potential mechanism for the mindfulness-shame association. This study tests the hypotheses that:

1. Mindfulness, self-compassion, and the acceptance of shame and embarrassment are positively associated but these measures are negatively correlated with shame.

2. Mindfulness affects self-compassion, which, in turn, influences shame. In other words, self-compassion mediates the relationship between mindfulness and shame.

The last study (Chapter 7) is designed to induce shame (or pride) in the laboratory and measure the extent to which participants may engage in mind-wandering afterwards. It is proposed that mind-wandering can be considered a method for shame management. Therefore, the primary hypothesis is:

1. The level of mind-wandering in the shame condition is different from the level of mind-wandering in the pride and control conditions.

As noted, experimental studies in shame literature are rare due to a few reasons. First, inducing shame through experiment is a complex process for ethical reasons; in addition, this kind of induction is susceptible to factors such as authenticity and demand

characteristics. Second, chronic or trait shame is more likely to be maladaptive or relate to psychological disorders than state shame. However, studying both trait shame and state shame are valuable and can add to our understanding of shame. In the thesis, study 1 and 3 particularly focus on trait shame and are cross-sectional, while study 4 focuses on state shame and has an experimental design.

In summary, the primary purposes of this thesis are to: (a) examine the association between adverse childhood experiences, negative self-judgement, shame, and coping methods; (b) validate a newly devised measure of acceptance of shame and embarrassment; (c) determine the association between mindfulness, self-compassion, and shame; and finally, (d) consider the effect of shame in mind-wandering. In order to visualise these premises, the following research model has been developed (Figure 3.1). In the next four chapters, empirical studies will be conducted to examine these issues.
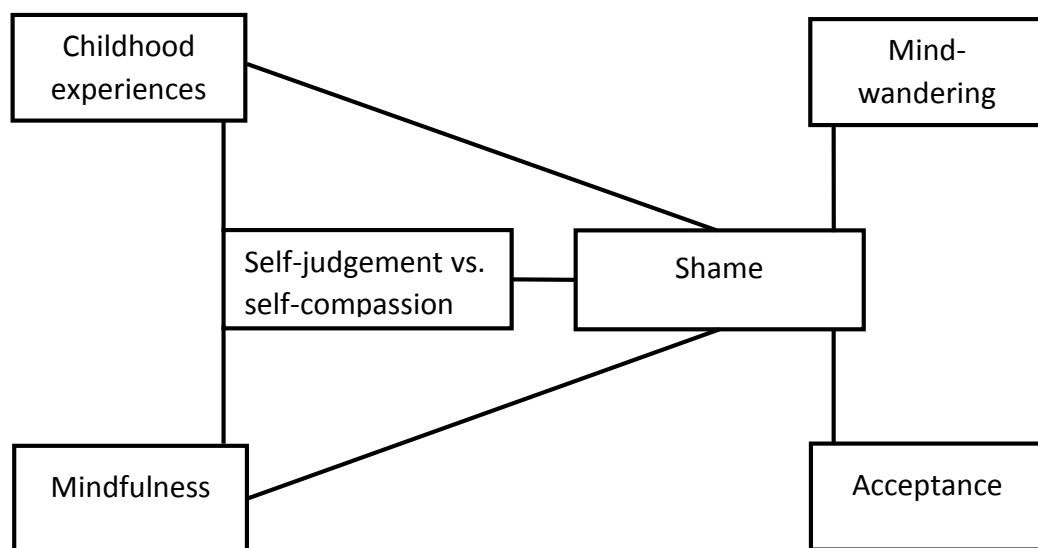
Figure 3.1. Research model for this thesis

Chapter 4. Factors Contributing to Shame Vulnerability: Adverse Childhood Variables and Submissive Coping Strategies

4.1. Abstract

It is well established that some individuals are more vulnerable to the experience of shame. This study explores factors that may contribute to shame vulnerability. The study employed a cross-sectional design. Two hundred and forty participants completed self-reporting assessments of parental care and expectations, childhood experiences of emotion, peer acceptance during childhood, attachment styles, negative self-judgement, and shame-coping styles. Self-judgement and submissive coping strategies (i.e., Attack Self and Withdraw) explained a significant variance in shame well beyond adverse childhood experiences and attachment styles. In addition, self-judgement fully mediated the relationship between childhood experiences and shame. The study indicates that clinical interventions targeting self-judgement and submissive coping strategies are likely to be beneficial to help individuals that are highly vulnerable to shame.

4.2. Introduction

Theories in shame indicate that self-devaluation (Gilbert, 1998; M. Lewis, 2003; Tangney & Dearing, 2002) and negative self-judgement are hallmarks of shame. Tangney (1996), in particular, stated that shame emerges from a negative evaluation of the self in response to a particular situation (Tangney, 1996). Notably, there is a dispositional tendency to experience shame; that is, some individuals are more susceptible than others to experiencing shame in response to a range of situations (Leeming & Boyle, 2004; Tantam, 1998).

Over the years, researchers have tried to determine which factors affect shame vulnerability. An early adverse family environment is one obvious potential contributory factor (Pulakos, 1996). Rejection or abandonment during childhood seems to play a key role (Mills, 2005). In Lutwak and Ferrari's (1997b) study, individuals who believed their parents were neglectful, controlling, and cold reported a higher level of shame. Moreover, recall of early childhood put downs (Gilbert et al., 1996), sexual abuse (Andrews, 1998), and emotional abuse (Hoglund & Nicholas, 1995) were often related to shame-proneness and shame vulnerability. Indeed, in a longitudinal study, Stuewig and McCloskey (2005) found that a punitive parenting style (i.e. physical and verbal abuse) in childhood was associated with shame-proneness.

A shame-prone identity may emerge from a parent's response to a child's negative feelings. If parents respond with criticism or lack of understanding or warmth, the child may conclude that negative feelings are an unacceptable sign of weakness which results in negative evaluation by others. As a result, they may experience shame and negative feelings. Rimes and Chalder (2010) suggested that beliefs about the unacceptability of experiencing or expressing negative emotions might contribute to the development of a range of clinical problems. In fact, such an orientation may result in

counter-productive attempts to suppress negative emotions or avoid help from others when distressed.

Attachment theories propose that the quality of the early relationship between the caregiver and the child leads to the formation of different cognitive schemas about one's worth, acceptance, and competence (Ravitz, Maunder, Hunter, Sthankiya, & Lancee, 2010). In the literature, four patterns of attachment style have been recognised (Bartholomew & Horowitz, 1991):

1. Secure style (the self and others are considered positively): As adults, individuals with a secure attachment style are able to trust others. They have high self-esteem and enjoy intimate relationships.

2. Anxious–preoccupied style (the self is considered negatively, but others are believed to be positive): Individuals with an anxious attachment style seek approval and intimacy from others. They have high levels of worry and doubt about themselves and their abilities in intimate relationships.

3. Dismissive–avoidant style (individuals have a positive view of the self, but a negative view of others): These individuals have problems with close relationships. They tend to invest little emotion in relationships and are reluctant to be close to others.

4. Fearful–avoidant style (both the self and others are considered negatively): They have mixed feelings about relationships in general. On the one hand, they would like to be in close relationships, but on the other hand, they seek less intimacy and deny their feelings.

Adult attachment styles are associated with childhood attachment styles; both are influenced by early childhood interactions. Gross and Hassen (2000) examined the associations between attachment styles and shame in a retrospective study. They

revealed there were lower levels of shame among securely attached adults and that shame was positively and significantly associated with fearful and anxious attachment styles. However, shame was not related to a dismissive attachment style. As predicted by the shame literature, individuals who had a positive view of themselves (secure attachment) reported lower level of shame.

In addition to adverse parental experiences, peer rejection as opposed to peer acceptance may contribute to the development of negative self-evaluation and shame vulnerability. Peer rejection is a risk factor for a wide variety of psychological problems (e.g., Bagwell, Newcomb, & Bukowski, 1998; Deater-Deckard, 2001; Parker, Rubin, Price, & DeRosier, 1995). For instance, being rejected or bullied at school led to depressive symptoms and poor self-esteem in the bullying victims at age 23 (Olweus, 1993). The rejection of peers may lead individuals to think they are unlovable, unacceptable, and unattractive, which, in turn, makes them more vulnerable to experiencing shame in adulthood.

It is a common belief that individuals judge and treat themselves in the same manner as others have judged or treated them. Therefore, a history of rejection and adverse childhood experiences may lead to the development of negative self-judgement and subsequently shame. The link between parental rejection and self-criticism has been well established (e.g., Blatt & Homann, 1992; Koestner, Zuroff, & Powers, 1991). Specifically, cold parental behaviour cultivates self-criticism tendencies in individuals (Thompson & Zuroff, 1999). The current study tests the hypothesis that, in addition to negative parental experiences, peer rejection during childhood increases the level of negative self-judgement and shame. Negative childhood experiences have a significant effect on shame vulnerability through negative self-judgement.

At the same time, the maintenance of shame vulnerability may also depend on the manner in which individuals respond or react to their shameful experiences. Drawing from Nathanson's (1992) model of shame management, Elison, Lennon, and Pulos (2006) devised the Compass of Shame Scale. Based on this model, there are four cognitive styles used for coping with shame: (a) Attack Self—an individual feels anger or contempt towards the self and criticises the self in response to the experience of shame; (b) Withdrawal—after experiencing shame, the individual tries to withdraw from the situation, in order to limit damage to the self; (c) Attack Other—the shame message does not seem legitimate, and the individual tries to make someone else feel bad, thereby externalising the feeling of shame; and (d) Avoidance—the shame message is not accepted or justified (denied), and an individual tries to change the situation to something neutral or positive. In this situation, the feeling of shame is not acknowledged or experienced consciously (Elison, Lennon et al., 2006; Patridge, Wann, & Elison, 2010).

According to this model, Attack Self and Withdrawal are relatively negative strategies when compared to Avoidance; a refusal to accept a shame message may imply higher self-worth and/ or active attempts to improve the situation (Elison, Lennon et al., 2006). Indeed, Attack Self and Withdrawal have the highest association with low self-esteem (Yelsma, Brown, & Elison, 2002), fear of shame and embarrassment (Elison & Patridge, 2012), internalised shame (Elison, Pulos, & Lennon, 2006), and psychological problems (Elison, Lennon et al., 2006). It is reasonable to assume that taking a submissive stance—by attacking oneself or withdrawing from situations—is more likely to contribute to the maintenance of shame vulnerability than blaming others. In general, individuals who behave submissively are more prone to psychological problems (Gilbert, Cheung, Grandfield, Campey, & Irons, 2003). These

individuals tend to submit to their own self-attacks and subsequently are unable to protect themselves against self-criticism (Whelton & Greenberg, 2005).

The purpose of the current study is to investigate factors that lead to shame vulnerability and its maintenance such as recall of parental care, parental expectation, childhood experiences of emotion, peer acceptance, attachment styles, negative self-judgement, and coping styles. These variables have not been examined in a single study. Therefore, the current analysis provides an opportunity to determine the unique contributions of these factors to shame vulnerability.

To set the context, it was posited that: (a) there is a positive relationship between current experiences of shame and perfectionist parental expectation, childhood experiences of rejection (i.e., peer rejection and parental control), and perceptions of maternal views about the unacceptability of negative emotions; (b) current shame experiences are negatively associated with secure attachment, but positively associated with fearful and anxious attachment styles. (Based on previous results, it was assumed that there is no relationship between shame and the dismissive style of attachment); (c) shame is positively associated with negative self-judgement; (d) shame has a stronger relationship with Attack Self and Withdrawal coping styles than with Avoidance; and, finally, (e) negative self-judgement mediates the relationship between adverse childhood experiences and shame.

4.3. Method

4.3.1. Participants

Two hundred and forty people (194 females, 43 males, 3 undeclared, $M_{age} =$ 27.79, $SD = 10.91$) participated in this study. The sample included undergraduate students (57.1%), postgraduate students (10.4%), and people who were working full-time (21.3%), as well as other community members (11.3%). The participants were

from the United Kingdom (25.8%), the United States (41.3%), Canada (2.9%), and other countries (29.6%).

4.3.2. Procedures

The Ethics Committee of the Department of Psychology at the University of Bath approved this study (Reference number: 13-023). Participants were recruited via online advertisements. Information about the study was provided on academic psychology sites and the University of Bath home webpage. All the materials were made available online, and the participants were provided with a web address to participate in the study. After reading the information page and consent form, participants who wished to continue were instructed to complete a series of self-report scales (see Appendix A).

4.3.3. Measures

Parental Bonding Instrument (PBI) (Parker, Tupling, & Brown, 1979). This 25-item scale was used to measure parental care. The participants were asked to indicate how they remembered their parents during their first 16 years. This scale consists of two subscales: Care (12 items) and Control (13 items). The Care items measure parental affection and warmth and are contrasted with coldness and rejection. The Control items measure overprotection and are contrasted with psychological autonomy and independence. This scale is completed for both mothers and fathers separately. Sample items: My mother/father "Spoke to me in a warm and friendly voice" and "Tried to control everything I did." Each of these items is rated on a 4-point scale (0 = *Very unlike,* 3 = *Very like*). Higher scores indicate higher "Care" and higher "Control". This scale has good reliability and validity. In this sample, alpha for Mother-Care was .95, for Father-Care .95, for Mother-Control .90, and for Father-Control .90. As with previous studies (e.g., Suchman, McMahon, Zhang, Mayes, & Luthar, 2006;

Warner & Atkinson, 1988), mother-care and father-care ($r = .42$) were averaged. Similarly, mother-control and father-control care ($r = .55$) were averaged. A composite score was then derived for each parent by subtracting the Control score from the Care score.

Childhood Experiences of Emotions (Rimes & Chalder, 2010). The Beliefs about Emotion Scale has 12 items and measures beliefs about expressing and experiencing negative emotions. In the current study, this was adapted so that the respondents were asked to think about their mother or main caregiver when they were growing up and indicate what message they got from them about their own negative thoughts and feelings. Sample item: "As a child, I got the impression from my mother or main caregiver that it is a sign of weakness if I have miserable thoughts." Each item is rated on a 7-point scale (1 = *totally disagree*, 7 = *totally agree*). Higher scores indicate a negative attitude towards expressing negative emotions. The Beliefs about Emotion Scale demonstrated a high internal consistency of .91 (Rimes & Chalder, 2010). In this sample, alpha was .95.

Parental Expectations subscale (Frost, Marten, Lahart, & Rosenblate, 1990). The 5-item subscale of the Multidimensional Perfectionism Scale (MPS) assesses parental expectations in relation to high standards. Sample item: "My parents set very high standards for me." In this study, items were rated on a 5-point scale (1 = *strongly disagree*, 5 = *strongly agree*). Higher scores indicate higher parental expectation. The reported Cronbach' alpha for this subscale is .84 (Frost et al., 1990). In this sample, alpha was .90.

Peer acceptance (Butler, Doherty, & Potter, 2007). This 4-item measure is developed to assess the overall level of acceptance or popularity. Sample items: "While I was growing up most kids I knew liked me." Items were rated on a 5-point scale (1 =

strongly disagree, 5 = *strongly agree*). Higher scores indicate a higher level of acceptance. The Cronbach's alpha for this measure is .80 (Butler et al., 2007). In this sample, alpha was .83.

The Relationships Questionnaire (RQ) (Bartholomew& Horowitz, 1991). This single item questionnaire consists of four short paragraphs, each describing an attachment style (i.e., Secure, Fearful, Anxious, or Dismissive). In order to minimise order effects, participants are first instructed to choose which statements best describe their relationship styles. Then, they are asked to rate each of the attachment styles to indicate how well each description corresponds to their general relationship style, on a 7-point scale (1 = *disagree strongly*, 7 = *agree strongly*).

Self-judgement subscale (Neff, 2003a). This is a subscale of the Self-Compassion scale. It consists of five items. Sample item: "I'm disapproving and judgmental about my own flaws and inadequacies." Each of these items is rated on a 5-point scale (1 = *almost never*, 5 = *almost always*), a higher score indicating a higher negative self-judgement. The internal consistency value for this subscale has been estimated as .88 (Neff, 2003a). In this sample, alpha was .89.

The Compass of Shame Scale (CoSS) (Elison, Lennon, et al., 2006). This scale is designed to assess the use of the four shame-coping styles (i.e., Attack Self, Withdrawal, Attack Other, and Avoidance) described by Nathanson (1992). It consists of 12 shame-inducing situations (e.g., "When an activity makes me feel like my strength or skill is inferior") or variations of shame emotions (e.g., "When I feel humiliated"). Each situation is followed by four responses, representing the four shame-coping styles: Attack Self (e.g., "I get mad at myself for not being good enough"); Withdrawal (e.g., "I withdraw from the activity"); Attack Other (e.g., "I get irritated with other people"); and Avoidance (e.g., "I act as if it isn't so").The participants were

instructed to respond to all four items for each scenario and indicate the frequency with which they reacted in these situations (1 = *Never,* 5 = *Almost Always*). The reported Cronbach's alphas for these components—Attach Self, .91; Withdrawal, .89; Attack Other, .85; and Avoidance, .74—were acceptable (Elison et al., 2006). In this sample, alpha for Attack Self was .91, for Withdrawal .89, for Attack Other .87 and for Avoidance .74.

The Experience of Shame Scale (ESS) (Andrews et al., 2002). This scale consists of 25 items. Each item asks direct questions about the frequency of three types of shame (i.e., characterological shame, behavioural shame, and bodily shame) encountered during the past year. For each type of shame, items reflect experiential, cognitive or behavioural dimensions. Sample items: *"Have you felt ashamed of any of your personal habits?"* Responses are made on a 4-point scale (1 = *Not at all,* 4 = *Very much*), with a higher score indicating a higher level of shame. The internal consistency for this scale has been reported as .92 (Robins et al., 2007). In this sample, alpha was .95.

4.4. Results

Mean and standard deviations for all variables are presented in Table 4.1. The data were screened for normality of distribution. Preliminary analysis revealed a relatively normal distributed sample. Skewness values ranged from -0.32 to 0.37 and kurtosis values ranged from -1.07 to -0.31.

Moreover, the effects of the demographic variables, age, and gender, were examined. Age was significantly correlated with shame ($r = -.14$), self-judgement ($r = -.13$), and anxious attachment ($r = -.24$). Gender was significantly correlated with shame ($r = -.15$). Therefore, the effect of age and gender will be controlled in the regression analysis.

Table 4.1

Means and Standard Deviations for Shame, Coping Styles, Self-judgement, Childhood Variables, and Attachment Styles

	Mean	**SD**
Shame	63.09	16.70
Attack Self	41.92	9.02
Withdrawal	39.68	9.00
Attack Other	29.20	8.09
Avoidance	33.60	6.25
Self-judgement	18.10	4.53
Maternal attitudes towards emotions	50.71	18.54
Parental care	7.51	28.04
Peer acceptance	11.43	3.97
Parental expectations	15.46	5.29
Secure attachment	3.58	1.82
Fearful attachment	4.51	1.87
Anxious attachment	3.54	1.97
Dismissive attachment	3.72	1.87

Note. SD = Standard deviation.

4.4.1. Correlation Analysis

The Pearson product moment correlation coefficients (two-tailed) for all of the variables are given in Table 4.2. As illustrated in the table, shame vulnerability was significantly correlated with all variables with the exception of the avoidance coping style, the dismissive attachment styles, and parental expectations. The strongest associations were between shame and Attack Self ($r = .72$), shame and Withdrawal ($r = .68$), and shame and self-judgement ($r = .68$). The associations between shame and childhood variables were significant but modest (.21 to .30). Similarly, shame and secure, fearful, and anxious attachment styles were moderately correlated. Contrary to the hypothesis, shame was not associated with perfectionist parental expectations ($r = .04$). However, those who scored high in the parental expectations scale reported higher score on the childhood experiences of negative emotions (i.e., it was unacceptable for them to express negative emotions in childhood). In addition, individuals who had a higher score on perfectionist parental expectations score more highly on the Avoidance coping scale (e.g., "I exaggerate my accomplishments" and "I pretend I don't care") and the dismissive-avoidant attachment style.

Table 4.2

Pearson's Correlations between Shame, Childhood Variables, Attachment Styles, Negative Self-judgement, and Coping Methods

	1	2	3	4	5	6	7	8	9	10	11	12	13
1.Shame													
2.Attack self	.72**												
3.Withdrawl	.68**	.74**											
4.Attack other	.30**	.35**	.43**										
5.Avoidance	.09	.16**	.21**	.34**									
6.Emotion	.21**	.23**	.28**	.23**	.30**								
7.Self-judgement	.68**	.76**	.62**	.25**	.12	.29**							
8.Parental care	-.30**	-.23**	-.30**	-.28**	-.12	-.52**	-.27**						
9.Peer acceptance	-.29**	-.31**	-.32**	-.17**	-.03	-.18**	-.29**	.33**					
10.Secure attachment	-.29**	-.26**	-.33**	-.21**	-.05	-.25**	-.22**	.27**	.30**				
11.Fearful attachment	.30**	.22**	.25**	.08	.03	.26**	.31**	-.22**	-.20**	-.39**			
12.Anxious attachment	.20**	.26**	.23**	.27**	.04	.09	.29**	-.09	.14*	-.07	.16*		
13.Dismissive	-.01	-.01	.08	-.06	.21**	.13*	.03	-.01	-.13*	-.19**	.17*	-.18**	
14.Parental expectation	.04	.11	.07	.03	.17**	.24**	.11	-.12	-.06	-.05	.04	.17**	-.03

Note. Emotion= Maternal attitudes toward emotions (*p<.05, **p<.01).

4.4.2. Regression Analysis

To explore the relative contribution of childhood variables, attachment styles, self-judgement, and coping styles to shame, a hierarchical regression was conducted. In order to control for the effects of demographic variables, age and gender were entered in the first step. In the second step, childhood variables (peer acceptance, parental care, and maternal attitudes towards emotions) were entered. Parental expectations were not considered, because they were not significantly correlated with shame. In the third step, attachment styles (secure, fearful, and anxious) were entered. The dismissive attachment style was not included because, as the analysis shows, it was not significantly related to shame. In the next step, self-judgement was included. In the last step, coping styles (Attack Self, Withdrawal, and Attack Other) were entered. Avoidance was not considered because it was not significantly related to shame.

Since self-judgement, Attack Self, and Withdrawal are significantly correlated (Table 4.2), the Variance Inflation Factor (VIF) and Tolerance will be reported first. These values demonstrate that the data meets the assumption of collinearity (Attack Self, Tolerance = .29, VIF = 3.40; Self-judgement, Tolerance = .37, VIF = 2.67; Withdraw, Tolerance = .38, VIF = 2.56. Tolerance values ranged from .63 to .90 and VIF values ranged from 1.10 to 1.58 for the remaining variables). It has been reported that VIF values greater than 10 and Tolerance values below .01 suggest a serious problem and potential collinearity within data (Field, 2009); therefore, the findings suggest that multicollinearity was not a concern in the regression model.

The regression analysis (Table 4.3) produced a significant model for the prediction of shame ($F (3, 221) = 22.88$, $p < .000$); the variables accounted for 60% of the variance in shame. The results revealed that peer acceptance ($\beta = -.21$, $p < .05$) and parental care ($\beta = -.19$, $p < .05$) in step 2 and secure ($\beta = -.14$, $p < .05$), anxious ($\beta = .22$,

$p < .05$), and fearful ($\beta = .13$, $p < .05$) attachment styles in step 3 had a significant impact upon shame. However, they did not significantly contribute to shame vulnerability when the effect of self-judgement, Attack Self, and Withdrawal were considered (step 5, Table 4.3).

As self-judgement, Attack Self, and Withdrawal are significantly correlated, a series of partial correlations were conducted to investigate whether these variables make independent contributions to shame. Partial correlation (controlling for Attack Self and Withdrawal) found that self-judgement was significantly correlated with shame ($r = .22$, $p < .000$); partial correlation (controlling for self-judgement and Withdrawal) showed a significant relationship between Attack self and shame ($r = .26$, $p < .000$); and partial correlation (controlling for self-judgement and Attack Self) indicated a significant association between Withdrawal and shame ($r = .33$, $p < .000$).

Table 4.3

Hierarchical Regression Analysis Predicting Shame from Childhood Variables, Attachment Styles, Negative Self-judgement, and Coping Methods

	B	$SE\ B$	β	Adjusted R^2	R^2 change	F change
Step 1:				.01	.02	2.32
Age	.00	.00	-.01			
Gender	-.02	.07	-.01			
Step 2:				.14	.14	12.65**
Peer acceptance	.01	.03	.01			
Parental care	-.05	.03	-.09			
Emotion	-.03	.02	-.07			
Step 3:				.22	.09	9.55**
Secure attachment	-.01	.01	-.04			
Fearful attachment	.02	.01	.07			
Anxious attachment	.02	.01	.07			
Step4:				.48	.25	114.33**
Self-judgement	.16	.04	.22			
Step 5:				.60	.11	22.88**
Attack Self	.27	.06	.31			
Withdrawal	.23	.05	.27			
Attack Other	-.03	.04	-.03			

Note. B, SE, and *β* are from the final equation; *B*= Unstandardised Coefficient*; SE*= Standard Errors*; β*= Standardised Coefficient*;* Emotion = Maternal attitudes towards emotions; (*$p < .05$; **$p < .01$).

4.4.3. Mediation Analysis

Structural equation modelling was used to test the mediation model predicting that adverse childhood experiences indirectly affect shame through self-judgement. The hypothesised model has one latent causal antecedent (childhood experiences), one latent mediator variable (self-judgement), and one latent outcome variable (shame). The childhood latent variable was assessed with three parcels: parental care, peer acceptance, and perceived maternal attitudes towards emotions. Five items of the self-judgement subscale were used to assess the self-judgement latent variable. The shame latent variable was assessed by three sources: characterological shame, behavioural shame, and bodily shame. The model contains 11 observed variables. As a first step, the measurement model was evaluated using the AMOS programme (version 21).

The model was evaluated using the maximum-likelihood method. An initial test of the measurement model yielded a significant chi-square statistic, (χ^2 (119, $N = 396$) = 584.202, $p < .001$), suggesting that the variances and covariances implied by the model did not match the observed variances and covariances. However, Chi-square is inflated by sample size. Therefore, other fit indices are often recommended and regarded as more credible sources for evaluating a model (Byrne, 2009).

Three indices are usually used to evaluate the goodness of fit of the model (Hu & Bentler, 1999; Quintanan & Maxwell, 1999): comparative fit index (CFI; best if close to or greater than .95), the root-mean-square error of approximation (RMSEA; best if close to .06 or less, but values below .08 are acceptable), and the standardised root-mean-square residual (SRMR; best if close to .08 or less). Considering these indices, it was found that the measurement model had good fit: CFI = .94, RMSEA = .08 (90% lower confidence limit = .06, and 90% upper confidence limit = .10), and SRMR = .06. In addition, all factor loadings were significant ($p < .001$), suggesting that

the indicators measure the latent constructs relatively well, and all of the latent variables were significantly correlated with each other ($p < .001$).

In the next step, the structural model was tested. Initially, it was found that the direct path coefficient from childhood experiences (the predictor) to shame (the dependent variable) in the absence of self-judgement (the mediator) was significant $\beta = -.36$, $SE = .05$, $p < .001$. Then, a mediated model with self-judgement between childhood experiences and shame, and a direct path from childhood experiences to shame (Figure 4.1), was tested; this demonstrated a good fit: χ^2 (4, $N = 232$) = 103.53, $p = .000$; CFI =.94, RMSEA = .08, SRMR = .06. More importantly, the path coefficient from childhood experiences to shame was non-significant ($\beta = -.11$, $SE = .03$, $p = .10$) indicating that self-judgement fully mediated the relationship between childhood experiences and shame. The indirect effect of childhood experiences on shame was -.26. A bootstrap analysis (95% -.48 to -.08) and sobel test ($z = -3.78$, $SE = 0.03$, $p < .001$) indicated that the indirect effect was statistically significant.
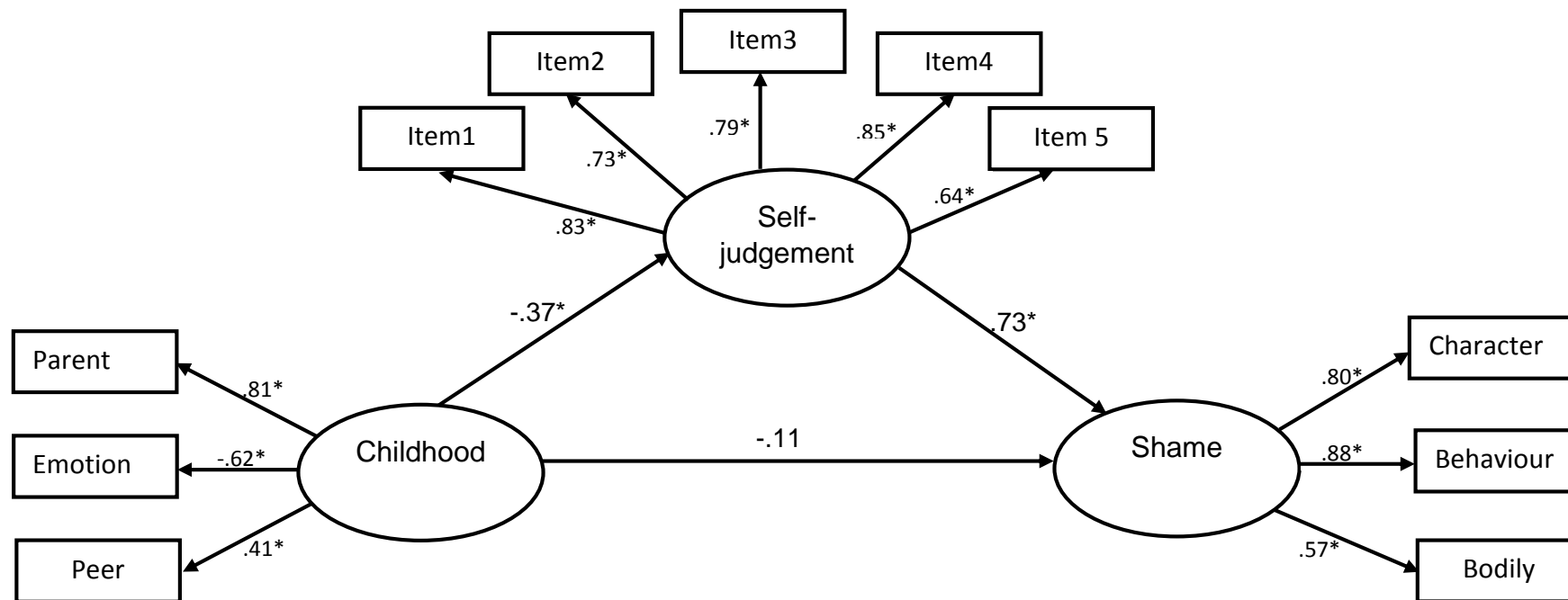
Figure 4.1. Self-judgement fully mediated the relationship between recall of childhood experiences and shame

Note. Factor loadings are standardised (*p* < .001). Childhood = Childhood experiences; Parent = Childhood parental care; Emotion = Maternal attitudes towards emotions; Peer = Peer acceptance; Item 1–Item 5 = Five items of the self-judgement subscale.

4.5. Discussion

Consistent with the previous findings and the hypothesis, the experience of shame was significantly and negatively associated with parental care and peer acceptance. In addition, this study revealed that shame was positively associated with perceptions that the mother or caregiver disapproved of negative emotions. These findings may imply that experiencing poor care, rejection, or a lack of acceptance during childhood in different shapes and forms is likely to contribute to emotional problems such as trait shame or self-hate. This resembles what Cooley (1902) called the "looking-glass self"; he believed that individuals perceive themselves based on how others view them (Mosquera, Fischer, Manstead, & Zaalberg, 2008). Similarly, Gilbert's conceptualisation of external shame, (Gilbert 1998, 2000, 2003), argues that external shame emerges when others have a negative image of the self, and he/she sees the self through the eyes of others. Indeed, the presence of others in the experience of shame cannot be ignored. Without fear of negative evaluations by others, shame may lose its meaning and significance. Thus, if one is rejected or perceived as unwanted or unattractive during childhood, he or she is likely to reject the self later on.

This interpretation was further corroborated; shame was significantly and negatively related to a secure attachment style, but positively related to anxious and fearful attachment styles. The self-confidence and self-respect achieved by securely attached individuals likely preclude the development of shame vulnerability. By contrast, the self-doubt and lower self-esteem observed in individuals with anxious and fearful attachment styles may make them more vulnerable to the experience of shame. This suggests that it may be possible to identify children who are at risk of experiencing low self-esteem and shame vulnerability in later life by their attachment style. This would allow preventive measures to be implemented.

In contrast with previous assumptions (M. Lewis, 1992), the experience of shame was not significantly associated with parent's expectations of excellence and high standards. However, the experience of shame was associated with maternal attitudes that conveyed the unacceptability of negative emotions. This suggests that it is not high maternal perfectionism that may be important, but rather unhealthy perfectionist attitudes towards emotions. When a child has gained the impression that negative feelings are unacceptable, they may learn to avoid expressing their feelings and feel greater shame about their emotions or themselves in general. Therefore, some parents may benefit from knowledge of how to respond when their child is distressed.

As expected, and in line with previous findings (Gilbert & Procter, 2006), shame was significantly associated with negative self-judgement. Additionally, the manner in which individuals responded to shame-inducing situations corresponded to shame vulnerability. In particular, Attack Self, Withdrawal, and Attack Other were significantly related to shame during the past year, while Avoidance was not associated with the experience of shame. However, these findings should be treated cautiously. There is a great possibility that individuals who score high in the Avoidance subscale also tend to suppress their responses when they complete questionnaires and apply avoidance-based strategies unconsciously or habitually without realising.

An important aspect of these findings was that the strength of the relationships between childhood variables and shame were moderate (moderate effect sizes: rs ranged from -.30 to .21). Moreover, when the effects of all of the variables were taken into account, only Attack Self, Withdrawal, and self-judgement showed a significant variance in shame. This might be due to the fact that we are comparing memories from long ago (recall of childhood experiences) with the current strategies that individuals employ. In other words, the findings might have been influenced by memory effect.

Alternatively, the findings may indicate that, while childhood variables contribute to the development of shame-proneness, they do not have as strong an influence over current shame vulnerability as factors such as negative self-judgement and submissive coping strategies (i.e., Attack Self and Withdrawal). The current findings suggest a model of shame vulnerability in which negative self-judgement and submissive coping strategies (Attack self and Withdrawal) not only explain a significant variance, beyond adverse childhood experiences and attachment styles, but also make independent contributions to shame. These findings are important, because they might imply that clinical interventions focussing on submissive coping styles and negative self-judgement may help patients who are highly vulnerable to shame regardless of significant adversity in childhood. It might be useful to teach such high-shame individuals skills they can substitute for defeat strategies in the face of shame-evoking situations. For instance, empirical research indicates that helping individuals to cultivate a self-compassionate attitude in times of failure or personal suffering can mitigate the feeling of shame (e.g., Gilbert & Procter, 2006). There are also validated treatments for low self-esteem such as the cognitive-behaviour therapy approach developed by Fennel (2009).

Mediator analysis further demonstrated that childhood experiences have an effect on shame through negative self-judgement. Similarly, Koestner et al. (1991) found that parental rejection at age 5 was related to the development of self-criticism at age 12. More recently, Irons, Gilbert, Baldwin, Baccus, and Palmer (2006) showed that the recall of controlling and rejecting parents was positively related to self-hatred and self-criticism. On the contrary, early memories of warmth and safeness (e.g., recalling feelings of warmth, and being cared for and accepted in childhood) abridge negative self-evaluation tendencies in adults (Matos, Pinto-Gouveia, & Duarte, 2013; Richter, Gilbert, & McEwan, 2009). The current study adds to the literature by demonstrating

that negative self-judgement mediates the relationship between the recall of negative childhood experiences and shame.

Furthermore, this study suggests that it would be valuable to explore how a negative self-concept is developed. What other factors may lead to the formation of a negative self-identity and subsequently shame? Put simply, why do some individuals feel shame because they are overweight or have a disability while others do not? One possibility might be that a secure attachment with the mother may help to buffer negative experiences in the wider social environment. In future studies, it would be valuable to examine the conditions under which adverse childhood experiences fail to lead to negative self-evaluation and shame. Although the experience of rejection or abandonment during childhood may foster shame vulnerability, this does not necessarily mean that all individuals growing up in hostile and threatening environments are prone to experiencing shame or other clinical problems. It is essential to identify which factors or resources can contribute to an individual's resilience against shame. In doing so, we may be able to help individuals who suffer from chronic shame.

There are several limitations to the present study. Although theoretically it makes sense to assume that adverse childhood experiences lead to negative self-judgement, which, in turn, are an antecedent to shame, this study was correlational. As such, we cannot conclude that adverse childhood experiences are a source of negative self-judgement, nor that negative self-judgement has a causal influence on shame. Thus, we cannot draw causal conclusions. However, the model suggested here, and supported by the data, provide a fair hypothesis for a causal chain. Further research, longitudinal or experimental, is needed to establish causal relations. Since this study was a single-source and single-method study, it incorporates error and bias. Because measures share source and method variance, the correlations could be inflated. Thus, it is necessary to

address the issues further in future studies by collecting data from multiple measures across multiple sources.

In addition, the aim of this study was to examine the factors that contribute to shame vulnerability in the general population. This study was advertised online on websites such as Psychological Research on the Net, Online Social Psychology Studies as well as on the online notice board at the University of Bath. As mentioned earlier, all of the materials for this study were presented online; participants were provided with a URL link through which they could participate in the study. Approximately 67% of the participants were students. An opportunity sample was used to minimise the time and cost of recruitment, as recruiting participants who were not students or those from the local community would have been both more costly and more lengthy. As such, and given the high representation of students, the findings may not generalise beyond the current sample. That being said, because previous studies suggest that there is a relationship between adverse childhood experiences and psychological problems in adulthood, it can be assumed that using a non-student population would produce similar results to those in this study, though the strengths of the correlations might differ. Future studies are required to verify whether the current findings replicate in the general population.

As noted earlier, it should also be acknowledged that correlations among self-judgement, Attack Self, Withdrawal, and the experience of shame were relatively high (rs ranged from .68 to .72) which may suggest overlapping content; this means that the results of the mediation model and regression analysis must be treated with caution. Furthermore, it is important to point out that the measure of coping that was administered was shame-specific; it assessed how individuals respond to shame-inducing situations, rather than measuring global coping tendencies (e.g., problem-

focused coping vs. emotion-focused coping). It might be informative to measure general coping tendencies in future studies and examine to what extent they influence shame vulnerability.

Another factor that should be considered is whether the recall of childhood experiences is influenced by one's current mood; in effect, those who score higher on the shame scale (which is likely to be associated with more negative mood) are more likely to recall negative memories rather than positive ones. Nevertheless, there are many longitudinal studies (e.g., Koestner et al., 1991; Stuewig & McCloskey, 2005; Zuroff, Koestner, & Powers, 1994) indicating a strong relationship between negative childhood experiences and psychopathology in adulthood. Moreover, it is believed that "memory bias for autobiographical events may only apply to recent events, and not to memory for remote experiences such as childhood upbringing" (Brewin, 1998, p. 281). Nevertheless, this limitation should be acknowledged in retrospective studies.

Furthermore, this study is subject to retrospective bias as it is possible that the recall of childhood experiences before age 4 is faulty. Indeed, it is unclear to what extent adults recall events in their lives that occurred prior to age 3 or 4 years; however, it is well-established that the quality of the early relationship between a child and primary caregiver is essential to the child's development and well-being. As such, it is debatable to what extent participants were indeed able to remember their parenting experiences prior to age 4 in this study. As a result, the findings from this study may reflect what participants recalled from these relationships after age 4, which would mean that important information about early relationships is not represented. However, though there are situations where a child is removed from a hostile environment or interventions occur to protect the child, it seems reasonable to assume that in most cases parenting styles and relationships between children and parents remain similar before

and after age 4. For example, if parents are caring and attentive to a child's needs at age 8, they were probably caring and provided a secure environment for their child at age 2. Put differently, in most cases, there is a consistent pattern of parenting and it can be argued that we focused and assessed parenting styles in this study.

In conclusion, this study provides new evidence supporting the hypothesis that adverse childhood experiences have a significant impact on the development of negative self-judgement and subsequently shame. The study also found that negative childhood experiences are related to shame through negative self-judgement. The findings further indicated that adopting submissive coping strategies may maintain shame vulnerability. Thus, therapeutic interventions that are tailored to tackle these types of coping strategies and negative self-judgement may have the potential to help high-shame individuals.

CHAPTER 5. The Acceptance of Shame and Embarrassment Scale

5.1. Abstract

There is increasing evidence that the unwillingness to experience negative emotions contributes to psychological maladjustment and the continuance of clinical problems. The aim of this chapter is to present the development of a new measure: Acceptance of Shame and Embarrassment Scale (ASES). This scale measures individuals' willingness to experience shame and embarrassment. Data was collected from 140 patients with chronic pain and 415 healthy volunteers. The ASES demonstrated good internal consistency and construct validity in both samples. In terms of factor structure a consistent pattern was seen in both samples: a single factor comprising 17 items. The data provided initial support for the psychometric properties of the ASES.

5.2. Introduction

There is no doubt that the experience of shame is acutely overwhelming and unpleasant. Some common reactions to painful feelings of shame are hiding, escape, and flight (Tangney, 1995; Tangney et al., 2007). Nonetheless, avoidance-based strategies, as opposed to approach-based strategies, are regarded as maladaptive and associated with clinical disorders (Carver & Connor-Smith, 2010; Connor-Smith & Flachsbart, 2007).

Hayes and colleagues (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996) have criticised the use of avoidance-based strategies. They believe that experiential avoidance, which is described as an unwillingness to experience negative emotions and thoughts, is associated with a lower quality of life and a wide variety of psychological disorders such as depression, anxiety, and suicide. According to their argument, negative emotions do not cause psychological maladjustment per se, but attempts to avoid or escape emotional experiences in any shape and form create psychological and physical problems (Blackledge & Hayes, 2001; Hayes et al., 1996). In other words, instead of resolving any negative feelings and emotions, avoidance-based strategies tend to contribute to maladjustments or may even cause them. It should also be noted that some of the methods used to avoid feelings of shame, such as the use of alcohol, drugs, food, exercise and so on, can bring their own problems if used to excess.

Avoidance-based tactics such as distraction, disengagement, or suppression might be spuriously beneficial or improve negative moods in the short term; nevertheless, overtime these strategies can be counterproductive, prevent individuals from dealing with problems efficiently, and deter them from taking necessary actions and living a meaningful life (Blackledge & Hayes, 2001).

Furthermore, it is well documented that intentional avoidance (e.g., suppression of thoughts and emotions) is inefficacious. For example, Wegner and colleagues (Wegner & Erber, 1992; Wegner et al., 1987) have demonstrated that attempts to control or suppress a particular thought or word (for instance "a white bear"), increase the accessibility of that thought or word. This phenomenon—ironic process theory or the "white bear problem"—is widely accepted and supported by researchers. For example, Marcks and Woods (2005) found that attempts to suppress thoughts was positively associated with the intensity of experiencing those thoughts and of distress, while the level of acceptance of thoughts was negatively related to the degree of intrusive thoughts.

There is growing evidence to suggest that the acceptance of negative emotions and thoughts is preferable to avoidance-based strategies (Gaudiano, 2009; Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Hofmann & Asmundson, 2008; Litvin, Kovacs, Hayes, & Brandon, 2012; Ruiz, 2010). For example, Alberts, Schneidder, and Martijin (2012) asked participants to either suppress or accept their emotional experience while watching a sad video. Afterwards, participants were asked to complete a control task in which they had to inhibit their response when they saw the stop signal. The findings indicated that participants who accepted their emotion while watching the video performed better on the control task than participants who suppressed their feelings or those who were in the control condition (i.e., received no instruction). Moreover, in a correlational study, Sauer and Baer (2009) explored the relationships between acceptance, change-based strategies (distraction and reappraisal), and well-being. They found that the tendency to apply acceptance-based strategies in response to negative internal experience is associated with greater well-being in comparison to the change-based strategies.

Furthermore, there are some indications that acceptance is a superior strategy than avoidance-based strategies for managing chronic pain. In particular, acceptance seems to improve the individual's adjustment and functionality (Kohl, Reif, & Glombiewski, 2012; McCracken & Vowles, 2014; Vowles et al., 2007), and it is negatively associated with psychopathology, obsession, anxiety, and depression (Aldao, Nolen-Hoeksema, & Schweizer, 2010; Marcks & Woods, 2005; Sauer & Baer, 2009).

Psychological acceptance is also one of the core processes that is implemented in Acceptance and Commitment Therapy (ACT) (Hayes et al., 1999); it has been defined "as allowing, tolerating, embracing, experiencing, or making contact with a source of stimulation, particularly private experiences, that previously evoked escape, avoidance, or aggression" (Hayes & Pankey, 2003, p. 4). Instead of trying to diminish shame, in ACT (Luoma, Kohlenberg, Hayes, & Fletcher, 2012), participants are encouraged to experience shame but at the same time try to notice and limit their conditioned responses and actions. Luoma et al. (2012) stated that suppressing shame,

> reduces access to the potentially useful functions of shame, such as signalling a violation of social roles and personal values. It may also serve to amplify shame since suppression and avoidance tend to lead to rebounding of thought or feeling being suppressed. (p. 44)

In ACT and acceptance-oriented approaches, individuals are encouraged to experience their psychological responses (emotions and thoughts) without trying to control or avoid them (Callaghan, Gregg, Marx, Kohlenberg, & Gifford, 2004; Hayes, Pistorello, & Levin, 2012). The key principle probably is that willingness to experience negative thoughts and emotions encourages individuals to take valued and needed actions to resolve unwanted feelings and attain their goals (Hayes & Pankey, 2003). Therefore, acceptance is likely to lead optimal outcomes. There is also a possibility that

acceptance of negative emotions reduces their significance, importance, and meaning (Bishop et al., 2004).

The potential benefit of psychological acceptance (Ruiz, 2010) has encouraged researchers to develop measures that assess not only individual differences in general psychological flexibility (Bond et al., 2011), but also specific forms of acceptance. For example, Lundgren, Dahl, and Hayes (2008) focused on the acceptance of epilepsy-related thoughts and feelings; Lillis and Hayes (2008) developed the Acceptance and Action Questionnaire (AAQ-II) for weight-related difficulties; and McCracken, Vowles, and Eccleston (2004) devised a measure that assesses the acceptance of chronic pain.

Although acceptance is considered as an adaptive emotion regulation strategy, research or studies that examine acceptance-based strategies in relation to shame are relatively rare. Given the advantages of acceptance-based strategies over avoidance-based strategies, and the association between shame and avoidance, it is important to assess acceptance of shame and embarrassment experiences and identify the extent to which they might influence psychological well-being and health outcomes.

Gauntlett-Gilbert and Rimes (2012) devised the ASES, which measures individual differences in willingness to accept shame and embarrassment experiences. From their clinical work, the authors concluded that unwillingness to experience shame and embarrassment might be a predictor of physical and mental problems, or it may even deter individuals from living a valued life. In particular, they argued that one of the predictors of disability and avoidance in patients with chronic pain is reluctance to experience shame and embarrassment.

The primary purpose of the current study was to validate the ASES and identify a coherent set of items that define this scale. The study examined the internal

consistency, factor structure, validity, and retest reliability of the ASES. Supporting the convergent validity of the scale, it was posited that scores on the ASES would correlate positively and significantly with general acceptance measures such as the AAQ-II and the acceptance component of the Philadelphia Mindfulness Scale (PHLMS). In contrast, it was thought that the ASES would correlate negatively and significantly with the Fear of Negative Evaluation Scale (BFNE). In order to establish some evidence for the discriminate validity of the scale, the strength of relationships between the ASES and the other three measures were all postulated to be in the moderate range, indicating that they would be measuring related but different constructs. Furthermore, because avoidance-based coping strategies are usually negatively associated with mental health and well-being, it was hypothesised that the scores on the ASES would predict health outcomes and depression.

5.3. Method

5.3.1. Participants

In order to increase the credibility of factor analysis and assess the extent that the ASES might be relevant to people who suffer from chronic pain, two samples were used. As noted earlier, from their clinical work and experience, Gauntlett-Gilbert and Rimes (personal communication, October 20, 2013) assumed that one of the predictors of disability and avoidance in patients with chronic pain might be unwillingness to experience shame and embarrassment. Therefore, this questionnaire might be highly relevant to their experience and can be further utilised by using samples of patients suffering from chronic pain.

Sample 1 consisted of 415 non-clinical participants (310 female; 100 male; five undeclared). Their mean age was 25.05 ($SD = 9.59$). The sample consisted of undergraduate students (54.1%), postgraduate students (8%), individuals who were

working full-time (26.5%), and other community members (11.4%). The participants were from the United Kingdom (38.7%), the United States (39.2%), Canada (3.9%), and other countries (18.2%).

Sample 2 (i.e., clinical data set) included 140 patients with chronic pain (80 female; 60 male) who consecutively attended residential pain rehabilitation programmes at the Bath Centre for Pain Services. These patients were substantially disabled and distressed due to their pain (Mean chronicity of pain = 115.7 months, SD = 92.5). They were receiving treatment for pain-associated disability at this treatment centre, because their clinical requirements could not be managed by their local institutions. Participants had visited the Bath Centre, on average 6.5 times. Some had surgeries (median 1, range 0–12), while others suffered from lower back pain and fibromyalgia (J. Gauntlett-Gilbert, personal communication, July 10, 2014). Their mean age was 41.9 years (SD = 13.8). The majority of participants in this group were unemployed due to pain (53.7%) or retired early because of pain (13.2%), while 4.4% continued to work full-time. The ethnic breakdown of the sample was 95% White, 0.7% Black (Caribbean), 0.7% Pakistani, 0.7% Bangladeshi and 2.9% other.

5.3.2. Procedures

For sample one (i.e., non-clinical participants), all of the materials were presented online, using the Bristol Online Survey; participants were provided a URL link through which they could access the study. Some participants were students from the University of Bath, participating in order to earn course credits. Other participants were recruited through platforms, such as www.onlinepsychresearch.co.uk or www.socialpsychology.org. The study was approved by the relevant ethics committee at the University of Bath (Reference number: 13-190). First, participants read the

information page and consent form, and those who wished to continue were instructed to complete a series of questionnaires (Appendix B) described in the next section.

For sample 2 (clinical data), ethical clearance for the study was obtained from the relevant NHS Research Ethics Committee, and Hospital Research and Development Committee. The data was collected by Gauntlett-Gilbert and colleagues. A clinician approached participants at the end of their assessment appointment at the pain centre. Participants were given information about the study and its purpose. A clinician informed them that they were free to decline to participate and that participation was voluntary and did not affect their care or health. In addition, participants were provided with an information sheet and consent form. Those who wished to participate were asked to give informed consent (J. Gauntlett-Gilbert, personal communication, December 10, 2014).

5.3.3. Measures

The Acceptance of Shame and Embarrassment Scale (ASES; Gauntlett-Gilbert & Rimes, 2012). Set of items were proposed to measure people's willingness (or unwillingness) to experience shame and embarrassment (see Appendix B). The items on this scale were generated by Gauntlett-Gilbert and Rimes, ensuring that they were positively and negatively keyed, and they reflected components of "willingness" (willingness to have the experience without terminating it) and "engagement" (willingness to persist behaviourally in the face of that feeling) which represent two primary theoretical aspects of acceptance. Afterwards, the proposed items were presented to a clinical team of pain specialists with ACT experience, who made some comments about content, compatibility, and relevance. After moderation, the final set of items was defined. These 23 items were selected to assess the extent individuals are willing to accept shame and embarrassment. Each item is rated on a 7-point scale

(0 = *never true,* 6 = *always true*). The instructions were as follows: "Below you will find a list of statements. Please rate the truth of each statement as it applies to you by circling a number. Use the following rating scale to make your choices. For instance, if you believe a statement is 'always true,' you would circle the 6 next to the statement."

Brief Fear of Negative Evaluation scale (BFNE) (Leary, 1983). This scale was developed to assess the extent to which individuals experience distress and apprehension over other's negative evaluations. This scale has 12 items and each item is rated on a 5-point scale (1 = *not at all characteristic of me,* 5 = *extremely characteristic of me*). The sample items are, "I worry about what other people will think of me even when I know it doesn't make any difference" and "I am unconcerned even if I know people are forming an unfavourable impression of me." Positive items are reverse coded and a higher score indicates a higher level of fear of negative evaluation. Internal consistency for the BFNE is reported .96 (Leary, 1983). In the non-clinical sample alpha was .92 and in the clinical sample was .95. It should be noted that in the clinical sample, the BFNE-S, which is an 8-item version of the BFNE, was used to measure fears of negative evaluation.

Acceptance and Action Questionnaire (AAQ-II) (Bond et al., 2011). The AAQ-II was designed to measure psychological flexibility and acceptance of private internal experiences (i.e., bodily sensations, thoughts, memories, and emotions) with items such as, "It's okay if I remember something unpleasant," and "My painful experiences and memories make it difficult for me to live a life that I would value." Responses are given on a seven-point scale (1 = *never true,* 7 = *always true*). Negative items are reverse coded, and a higher score suggests greater psychological flexibility and acceptance. Internal consistency for the AAQ-II has been estimated .84 (Bond et

al., 2011). In the present study, alpha coefficient for the non-clinical sample was .93

and .88 for the clinical sample.

The Philadelphia Mindfulness Scale (PHLMS) (Cardaciotto, Herbert,

Forman, Moitra, & Farrow, 2008). The PHLMS scale has two components: present

moment awareness and acceptance. The awareness subscale is assessed with items such

as, "I am aware of what thoughts are passing through my mind," and the acceptance

subscale is measured by items such as, "I try to distract myself when I feel unpleasant

emotions." This scale has 20 items (10 awareness and 10 acceptance), and each item is

rated on a 5-point scale (1 = *never,* 5 = *very often*). Items on the acceptance subscale are

reverse coded. Higher scores reflect a higher level of awareness and acceptance. Both

subscales demonstrated good internal consistency in several samples (Cardaciotto et al.,

2008). In the present study, the alphas for awareness and acceptance were .79 and .90,

for the non-clinical sample. In the clinical sample, the alphas for awareness and

acceptance were .80 and .85.

Patient Health Questionnaire (PHQ-9) (Kroenkek, Spitzer, & Williams,

2001). This 9-item measure is used for screening and diagnosing depression. Sample

items include, "Little interest or pleasure in doing things" and "Feeling down,

depressed, or hopeless." The scale inquires about the frequency of each symptom on a

4-point scale (0 = *not at all,* 3 = *nearly every day*). Higher scores reflect higher levels of

depression. In general, scores above 20 indicate major depression, scores of 15–19

indicate moderately severe depression, scores of 10–14 indicate minor depression, and

scores of 5–9 reflect minimal symptoms. The internal consistency of the PHQ-9 is

estimated at .89 (Kroenkek et al., 2001). In the present study, the Cronbach's alpha

value for the non-clinical sample was .89 and .78 for the clinical sample.

Chronic Pain Values Inventory (CPVI) (McCracken & Yang, 2006). The CPVI was developed to assess the importance (and subsequently success) of six value domains: family, intimate relations, friends, work, health, and growth and learning. Respondents are initially asked to rate how important each domain is for them on a 6-point scale (0 = *not at all important,* 5 = *extremely important*). They are then asked to rate how successfully they have been living according to their values on a 6-point scale (0 = *not at all successful,* 5 = *extremely successful*). In order to assess a respondent's success in meeting their goals, the average of the six success ratings is calculated. McCracken and Yang (2006) reported the Cronbach's alpha of .82 for the success scale. In the present study, the Cronbach's alpha value for the success scale in the non-clinical sample was .75 and .84 in the clinical sample. In addition, for the non-clinical sample, the first sentence of the scale, "many people with chronic pain find that their pain and other symptoms are barriers to engaging in activities that are personally important to them," was modified to "many people find it difficult to engage in activities that are personally important to them".

EQ-5D-5L (The EuroQol Group, 1990). EQ-5D-5L is a reliable and standard tool developed by The EuroQol Group to measure health status and quality of life. This measure has five dimensions: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. Each dimension has five levels: no problems, slight problems, moderate problems, severe problems, and extreme problems. Cronbach's alpha indicates good reliability for the non-clinical (.74) and clinical samples (.66). In this study, scores were summed according to the following method. First, the scores (values 1 = *no problem,* 5 = *severe problems*) on the five dimensions were computed together. Then, 5 was subtracted from this score and multiplied by 5 (see Hinz, Kohlmann, Stobel-Richter, Zenger, & Brahler, 2014, p. 444, for more information). At the end,

respondents were asked to indicate how their health was that day (0 = *the worst health you can imagine,* 100 = *the best health you can imagine*). In addition to the EQ-5D-5L sum, this score was used as a reflection of health status.

5.4. Results

The mean and standard deviation for all the measures in the two samples is presented in Table 5.1. There was a significant difference between the two samples in depression, health, general levels of psychological flexibility (AAQ-II), and values. The clinical sample reported significantly higher levels of depression and health problems than the non-clinical sample. In addition, the clinical sample had significantly lower scores on the Chronic Pain Value Inventory (CPVI-success), indicating that they had a difficulty to live their lives according to their values in comparison to the non-clinical sample.

Table 5.1

Means and Standard Deviations for All Measures in Both Samples

	Non-Clinical	**Clinical Sample**	**Independent *t*-test**	
	Mean (SD)	Mean (SD)	*t*	*p*
ASES	52.19 (18.43)	50.81 (22.09)	-.77	.43
BFNE*	24.11(8.38)	24.06 (10.12)	-.05	.96
AAQ-II	43.33(13.65)	38.93 (13.90)	-2.99	<.01
Awareness	36.22(5.91)	34.84(7.15)	-1.80	.07
Acceptance	26.69(8.45)	26.62(7.75)	-.07	.94
CPVI-importance	22.66(4.23)	24.70 (4.13)	4.87	<.01
CPVI-success	15.75(5.70)	8.65(5.93)	-12.18	<.01
PHQ-9	9.14(6.74)	16.40(5.41)	12.15	<.01
EQ-5D-5L	15.06(14.50)	56.99(14.68)	29.23	<.01

Note.* 8 items of BFNE-S were used for this comparison; ASES = Acceptance of Shame and Embarrassment Scale; BFNE = Brief Fear of Negative Evaluation Scale; AAQ-II = Acceptance and Action Questionnaire; Awareness = The awareness component of Philadelphia Mindfulness Scale; Acceptance = The acceptance component of Philadelphia Mindfulness Scale; CPVI =Chronic pain values inventory; PHQ-9 = Patient Health Questionnaire.

5.4.1. Factor Analysis

Factor analysis for sample 1 (non-clinical). First, the data was screened for the normality of the distribution, indicating that each item was normally distributed. The skewness values ranged from -.66 to .69 and the kurtosis values ranged from -.95 to -.17. Corrected item-total correlations were then calculated to determine the correlations between each item and the scale's total score. For this calculation, relevant items (2, 3, 5, 8, 9, 11, 12, 14, 15, 18, 21, and 22) were reverse coded. Item 2 was eliminated from the following factor analysis because it correlated negatively with the scale's total score (-.19): "Nothing is so important that it is worth feeling ashamed or humiliated for."

Next, a principal axis factoring analysis with a varimax rotation was conducted with a cut-off point of .4 for the inclusion of a variable in the interpretation of a factor. Since the aim was to have maximally distinct factors, the varimix rotation was selected. However, the oblimin rotation produced essentially the same pattern of loadings. Therefore, it can be confidently said that the choice of rotation did not make much difference. Three factors were extracted with eigenvalues of 9.77, 1.16, and 0.62. Factor 1 explained 44.42%, factor 2 explained 5.28% and factor 3 explained 2.86 % of the variance.

Two items did not load on any of the three factors:

1. Item 17: "When people don't think much of me, I just accept it"
2. Item 19: "I regularly go into situations where I might feel embarrassed or awkward."

Four items loaded on factor three:

1. Item 9: "If other people make me feel stupid, I have to defend myself immediately" (.61),
2. Item 11: "I hate it when I feel that people are judging me" (.54),

3. Item 12 "If I feel embarrassed or ashamed it makes me angry" (.49), and

4. Item 22: "If I feel judged I feel very defensive" (.78).

Four items loaded on factor two:

1. Item 23: "I always try to let people see the 'real me', even if it makes me feel foolish" (.72),

2. Item 15: "I often hide what I am really like" (-.72),

3. Item 6: "I don't let feeling embarrassed get in the way of doing things I want to do" (.51), and

4. Item 21: "I am no longer doing things that matter because other people might judge me or give me a hard time" (-.47).

The remaining 12 items (1, 3, 4, 5, 7, 8, 10, 13, 14, 16, 18, and 20) were loaded on factor one, which accounted for 44.42 % of the variance. Because of the low item numbers, factors two and three were difficult to interpret. In addition, because the examination of the scree plot (Figure 5.1) indicated one central factor, one factor solution was deemed more reasonable and meaningful. A principal axis factoring analysis was conducted, specifying one factor to be extracted. The factor explained 44.13% of the variance. Items 9, 12, 17, and 19 did not load on the factor, having values lower than .4.

Scree Plot
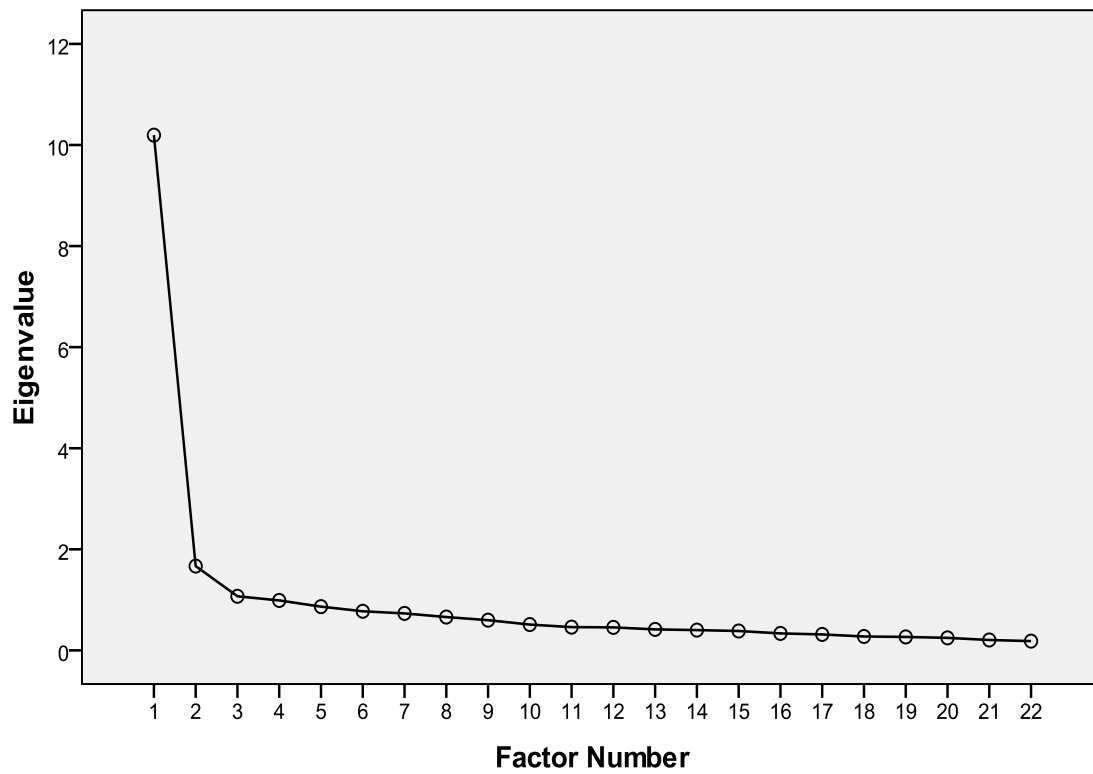
Figure 5.1. Scree plot for the non-clinical sample

Factor analysis for sample 2 (clinical). As with the previous section, I examined the distribution of data for each item in sample 2. The items were normally distributed, with the skewness values ranging from -.84 to .50 and the kurtosis values ranging from -1.33 to -0.30. Second, the corrected item-total correlations were calculated to determine the correlation between each item and the scale's total score. Item 2—"Nothing is so important that it is worth feeling ashamed or humiliated for"— was eliminated from the factor analysis, because it correlated negatively/inappropriately (-.36) with the measure's total score.

A principal axis factoring analysis with a varimax rotation was conducted with a cut-off point of 0.4 for the inclusion of a variable in the interpretation of a factor. The eigenvalues were 9, 1.48, 0.62 and 0.71. The analysis revealed two factors with eigenvalues greater than 1. Factor one explained 40.90 % of the variance and factor 2 explained 6.39% of the variance.

Eleven items loaded on factor one: 1, 4, 6, 7, 10, 13, 15, 16, 17, 20 and 23. Five items (3, 12, 14, 18, 21) loaded on factor 2, four items (8, 9, 11, 22) on factor 3, and two items (5, 19) on factor four. Once again, a one factor solution seemed more reasonable and intelligible (Figure 5.2), and a principal axis factoring analysis was conducted, specifying one factor to be extracted. The factor explained 40.37% of the variance. Items 5, 9, 17, and 19 did not load on the factor because they had values lower than .4.

The aim of conducing factor analysis on both samples was to generate a scale that could be applied in both clinical and non-clinical populations. Therefore, item 2 was dropped due to poor wording/item-total correlation, and items that did not load on the main factor (< .4) in sample one (9, 12, 17, 19) and sample two (5, 9, 17, 19) were eliminated. Removing these items (2, 5, 9, 12, 17, 19) resulted in the production of the

17-item ASES. Factor loading for the ASES scale is presented in Table 5.2. In addition, an independent *t*-test was used to compare total scores on the ASES scale between sample 1 and sample 2 (Table 5.1); the findings indicated that the difference was not significant (t (510) = -.77, p=.43) between the clinical and non-clinical samples. Participants in the non-clinical sample reported a slightly higher level of acceptance of shame and embarrassment than individuals in the clinical sample.
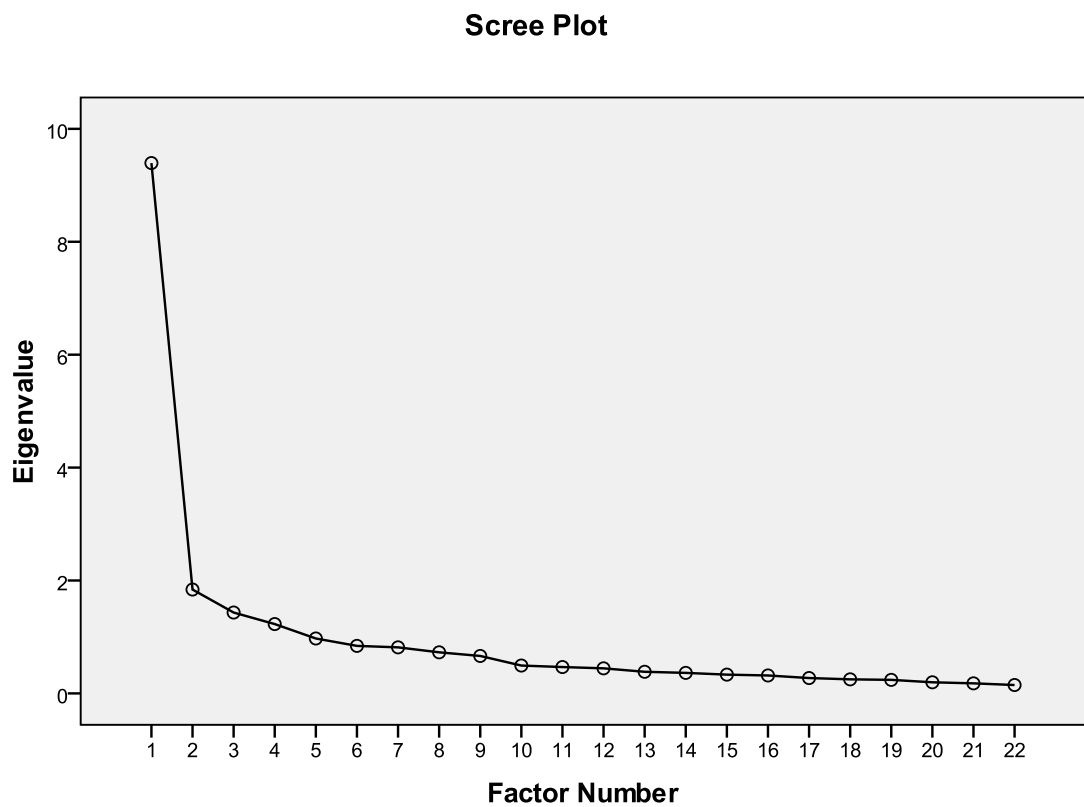
Scree Plot

Figure 5.2. Scree plot for the clinical sample

Table 5.2

ASES Factor Analysis for Non-Clinical and Clinical Samples

Items	Non-Clinical	Clinical
14. I can't bear feeling embarrassed or ashamed	-.842	-.800
10. I can put up with being embarrassed or ashamed without too much difficulty	.829	.765
20. I don't mind if I feel embarrassed	.820	.514
7. My life is not restricted by fear of embarrassment	.786	.767
18. There are situations that I am not willing to go into because I might feel ashamed or embarrassed	-.774	-.785
6. I don't let feeling embarrassed get in the way of doing things I want to do	.753	.786
3. If I start to feel embarrassed or ashamed, I have to leave the situation	-.730	-.728
1. If I get embarrassed around other people, I can live with it	.729	.727
16. Being in embarrassing situations is better than avoiding things	.717	.685
4. When I get embarrassed I accept this as a normal part of life	.711	.795
8. I am not prepared to feel stupid or humiliated in front of other people	-.705	-.476
13. If I am doing what's important to me, being embarrassed is worth it	.702	.661
23. I always try to let people see the 'real me', even if it makes me feel foolish	.661	.644
11. I hate it when I feel that people are judging me	-.618	-.713
21. I am no longer doing things that matter because other people might judge me or give me a hard time	-.601	-.607
15. I often hide what I am really like	-.591	-.564
22. If I feel judged I get very defensive	-.487	-.545

5.4.2. Reliability and Retest Reliability

Cronbach's alpha for the 17-item ASES scale in the non-clinical sample was .94, and .92 for the clinical sample. In addition, 47 participants from sample one completed a retest of the ASES after an interval of at least 15 days (Minimum days = 15, Maximum days = 52, Mean = 27.38, SD = 11.34). The new 17-item scale had good retest reliability with a correlation coefficient of $r = .91$, $p < .001$.

5.4.3. Construct Validity

In order to establish construct validity, the ASES was compared with the following measures: (a) the acceptance subscale of the Philadelphia Mindfulness Scale (PHLMS), (b) the Acceptance and Action Questionnaire (AAQ-II), and (c) the Brief Fear of Negative Evaluation Scale (BFNE).

As demonstrated in Table 5.3, in sample 1 the ASES was significantly and positively correlated with general levels of psychological flexibility (AAQ-II) and acceptance (PHLMS), while the ASES was significantly and negatively associated with the BFNE. Similarly, in sample 2, the ASES was positively and significantly associated with psychological flexibility and acceptance, while it was negatively related to the fear of negative evaluation. In both samples, the ASES was positively associated with better quality of life and health outcomes but negatively associated with depression.

Table 5.3

Correlations between All Variables in Both Samples

	1	2	3	4	5	6	7	8	9
1. ASES		-.73**	.68**	.00	.47**	.14	-.53**	-.37**	.27**
2. BFNE	-.77**		-.72**	.14	-.50**	-.16	.52**	.21*	-.23**
3. AAQ-II	.67**	-.62**		-.13	.23*	.23*	-.65**	-.31**	.19*
4. PHLMS-A	.11*	.01	.08		-.23*	.19	-.09	-.04	.08
5. PHLMS-B	.51**	-.50**	.73**	-.05		-.02	-.29*	-.14	-.03
6. CPVI	.13**	.03	.22**	.23**	.09*		-41**	-.38**	.30**
7. PHQ-9	-.33**	.44**	-.71**	.01	-.58**	-.26**		.37**	-.28**
8. EQ-5D-5L	-.40**	.33**	-.61**	.00	-.46**	-.29**	.71**		-.29**
9. Health	.29**	-.24**	.49**	.04	.34**	.25**	-.58**	-.67**	

Note. Correlations for the non-clinical sample are presented on the left side and for the clinical sample on the right side; ASES = Acceptance of Shame and Embarrassment Scale; BFNE = Brief Fear of Negative Evaluation Scale; AAQ-II = Acceptance and Action Questionnaire; PHLMS-A = The awareness component of Philadelphia Mindfulness Scale; PHLMS-B = The acceptance component of Philadelphia Mindfulness Scale; CPVI =Chronic pain values inventory; PHQ-9 = Patient Health Questionnaire; Health = Health score at the end of the EQ-5D-5L questionnaire; * $p < 0.01$, ** $p < 0.001$.

5.4.4. The ASES, Depression, and Health Outcomes

The next goal of this study was to analyse whether the acceptance of shame and embarrassment (the ASES scale) predicts unique variance in quality of life and depression. In both samples, two separate multiple regressions were performed. In the first regression, scores on the depression scale (PHQ-9) were regressed on fear of negative evaluation (BFNE), acceptance (acceptance component of the PHLMS), psychological flexibility (AAQ-II), and acceptance of shame and embarrassment (ASES). In the second regression, health scores were regressed on the BFNE, acceptance component of the PHLMS, the psychological flexibility (AAQ-II), and acceptance of shame and embarrassment (ASES). Since age was significantly associated with depression scores and acceptance, it was entered in the first step to

control for its effect in sample 1. In both samples, the ASES did not significantly

contribute to depression and health condition (Table 5.4) when other variables were

controlled.

Table 5.4

Multiple Regressions Predicting Depression and Health in Both Samples

	Sample 1 (Non-Clinical)		Sample 2 (Clinical)	
	Dependent variables		Dependent variables	
Predictors	**Depression**	**Health**	**Depression**	**Health**
	β	*β*	*β*	*β*
ASES	.01	04	-.01	-.18
BFNE	.00	.15*	.08	-.58**
AAQ-II	-.60**	.59**	-.59**	.20
PHLMS (acceptance)	-.14*	.01	.05	-.35*

Note. β = Standardised coefficients; ASES = Acceptance of Shame and Embarrassment Scale; BFNE = Brief Fear of Negative Evaluation Scale; AAQ-II = Acceptance and Action Questionnaire; PHLMS = The Philadelphia Mindfulness Scale- acceptance; PHQ-9 = Patient Health Questionnaire; Health = Health score at the end of the EQ-5D-5L questionnaire; *p* < .05, **p* < .01.

5.5. Discussion

This study investigated the psychometric properties of a new measure of

acceptance of shame and embarrassment. To my knowledge, the ASES is the first

questionnaire developed that measures the willingness to experience shame and

embarrassment.

The findings demonstrate promising psychometric characteristics. In the clinical

and non-clinical samples, a one factor solution seemed more reasonable and intelligible.

In both samples, one item correlated inappropriately with the scale's total score. This

item was inappropriately worded and was difficult to understand: twelve participants

did not respond to this item leaving it blank, therefore, this item was omitted from the

analysis. Four items (9, 17, 19, and 5) in the non-clinical sample, and four items (9, 17,

19, and 12) in the clinical sample, had poor psychometric properties; these items did not

correlate well with the other items (*r* < .3). Consequently, they did not load highly on

their targeted factor (they had values lower than .4), and due to poor psychometric properties, these items were also removed from the scale. The final scale had 17 items, excluding items 2, 5, 9, 12, 17, and 19.

In both clinical and non-clinical samples, the ASES demonstrated good internal consistency. The Cronbach's alpha value was above .90 in both samples. Furthermore, the 17-item scale showed good retest reliability after an interval of at least 15 days.

The findings also indicate that the ASES possesses good construct validity. In both samples, the ASES was significantly negatively correlated with the fear of negative evaluation measure, and significantly positively associated with psychological flexibility and the acceptance component of mindfulness. In addition, it was found that individuals with higher levels of shame and embarrassment acceptance reported lower levels of depression and better health outcomes.

Nevertheless, in both samples, a weak association emerged between the acceptance of shame and embarrassment and the awareness component of mindfulness. In addition, the strength of the relationship between the ASES and the CPVI, which reflects individuals' success in taking value-based action, was slight. In other words, in this study, acceptance of shame and embarrassment experiences were not highly related to whether individuals lead a value-based life.

There are a number of weaknesses in the study which should be acknowledged. First, the number of participants in the clinical sample was relatively small for conducting factor analysis and the findings for that particular group should be treated cautiously. Second, around 60% of the participants in the non-clinical sample were students; it remains questionable whether the current results can be replicated in other populations. Third, the association between the ASES and AAQ-II, and the ASES and BFNE was relatively high (in both samples, rs ranged from .67 to -.77). These results

may indicate that these scales measure a very similar construct. Ideally, the correlations between the ASES and these other measures should be in the moderate range (around .50). In fact, the AAQ-II was a better predictor than the ASES regarding the depression and health scores. After accounting for the effects of the AAQ-II, the acceptance of shame and embarrassment scale (ASES) did not significantly predict depression and health status in the samples. However, it should be noted that, while the ASES is a narrow measure designed to assess acceptance of shame and embarrassment, the AAQ-II is a broader measure of psychological flexibility and acceptance. The correlation between these instruments may be the result of the AAQ-II subsuming the acceptance of negative emotions, such as shame and embarrassment. Furthermore, the AAQ-II includes items such as 'emotions cause problems in my life,' and 'worries get in the way of my life,' which measure the impairment resulting from emotional distress rather than acceptance or psychological flexibility. Therefore, it is not surprising that the AAQ-II is more strongly associated with depression than the ASES.

Future studies need to determine the advantages that a specific measure such as the ASES has over broader scales like the AAQ-II. In other words, why is it necessary to have a new scale if the older ones measure similar but broader constructs? In what areas is the measure of willingness to accept shame and embarrassment useful? Lillis and Hayes (2008) stated that "researchers applying ACT to new areas should seriously consider the need for targeted process measures rather than relying on more general measures that may prove to be insensitive to changes in a targeted domain" (p. 38). The ASES is a narrower measure than the AAQ-II as it focuses specifically on shame-related willingness and avoidance instead of items relating to distress. Therefore, it can be inferred that a need exists for specific measures such the ASES when shame-related avoidance is targeted in therapies and the goal is to examine whether the acceptance of

shame over time assist individuals deal better with chronic pain or other problems. It is interesting to investigate how willingness to experience shame predicts or mediates treatment outcomes. The advantage of scales such as the ASES is that they can specifically record one's willingness to experience a particular emotion and examine how this willingness may impact quality of life. Demonstrating these factors would lead to greater insight about possible interventions.

Furthermore, it should be noted that throughout the scale, the authors use shame and embarrassment interchangeably. As noted in Chapter 1, some theorists believe that embarrassment is a milder version of state shame (e.g., M. Lewis, 1992, 1995, 1998) or that the role of self and personal failure are more prominent in the experience of shame than embarrassment (e.g., Sabini et al., 2001). Feelings of embarrassment tend to be less self-evaluative (e.g., Tracy & Robins, 2004) and they should be considered as separate emotions. Nevertheless, Elison, Lennon, et al. (2006) also used "variations of shame emotions (e.g., guilt, embarrassment, rejection)" in order to develop the CoSS which is designed to measure shame-coping styles (p. 224). Similarly, adjective-based measures of shame (e.g., Hoblitzelle, 1987; Mosher & White, 1981) usually assess shame by applying a list of shame-related adjectives such as humiliated, disgraced, and embarrassed. Although it is not ideal to use shame and embarrassment interchangeably, it is a common practice, and people usually have difficulty distinguishing one from the other or recognising the differences. For example, a particular situation may induce high level of embarrassment, but low level of shame or high embarrassment and high-shame (Saftner & Tantillo, 2011).

Aside from these limitations, it should be noted that the use of avoidance-based strategies such as distraction or disengagement might be involuntary, automatic, and habitual. These methods also tend to improve mood. For these reasons, avoidance is

likely to be an easier, effortless, and probably preferable option in short term, while acceptance is more likely to be emotionally demanding or psychologically challenging. Additionally, those who are willing to accept negative emotions such as shame and embarrassment should be able to postpone self-gratification. For those who believe in hedonism, for example, acceptance of shame and embarrassment seems unreasonable if not sadistic. It is only when we consider personal goals and keep future targets in mind that willingness to sacrifice immediate happiness seems valuable and sensible. Thinking practically rather than theoretically, willingness to acceptance negative emotions is hard to implement; it takes a great deal of effort and determination. There is a danger that willingness to accept and acknowledge shame and embarrassment, especially shame, misapplied or misunderstood. It worth emphasising in this context that acceptance does not mean resignation, and it is not assumed to further validate and internalise feelings of self-hate and self-judgement. Hayes et al. (1999) believe that ACT's implementation of willingness does not equate with tolerance; it is also not a passive process. It merely allows aversive stimuli or experience to happen, rather than struggle against or avoid it, in order to take action and achieve valued outcomes.

In summary, given the consistent pattern seen across the two samples in the current study, the ASES seems to be a promising instrument for assessing willingness to experience shame and embarrassment. The present data provide preliminary support for the psychometric properties of the ASES. This study was the first step for developing the ASES scale. Nevertheless, more data needs to be collected and the results of this study replicated. Future research should also examine the usefulness of the scale and its association with other important psychological processes.

CHAPTER 6. Mindfulness, Self-compassion, and Shame Relationships

6.1. Abstract

Mindfulness has been proposed as an effective tool for regulating negative emotions and emotional disorders. However, little is known about the relationship between mindfulness and shame. The purpose of the current study was to investigate associations between mindfulness, self-compassion, and shame. One hundred and fifty-nine participants completed the Five-Facet Mindfulness Questionnaire, the Self-Compassion Scale- Short Form, the Acceptance of Shame and Embarrassment Scale, and the Experience of Shame Scale. As expected, mindfulness, self-compassion, and acceptance of shame and embarrassment were negatively correlated with the experience of shame. In addition, self-compassion was found to mediate the relationship between mindfulness and shame. In an effort to explore this relationship further, the associations between specific facets of mindfulness (e.g., observing, describing, acting with awareness, non-reactivity, and non-judgement), and shame were examined. The results showed that the non-judgement facet remained a significant predictor of shame even after controlling for self-compassion. These findings highlight the negative self-evaluative nature of shame, suggesting that shamed individuals may benefit most from interventions that foster non-judgement attitudes towards feelings and thoughts.

6.2. Introduction

In recent decades, the concept of mindfulness has received substantial attention from clinicians and psychologists. Mindfulness-based therapies, such as Mindfulness-Based Stress Reduction (MBSR) (Kabat-Zinn et al., 1992) and Mindfulness-Based Cognitive Therapy (MBCT) (Segal, Williams, & Teasdale, 2002), are used to reduce the symptoms of psychopathology and distress. In addition, interventions such as Dialectical Behaviour Therapy (DBT) (Linehan, 1993) and Acceptance and Commitment Therapy (ACT) (Hayes et al., 1999) use elements of mindfulness training in order to enhance individual functioning and the possibility of positive outcomes.

In a mindful mode of processing, individuals approach their moment-by-moment experience with acceptance and openness (Bishop et al., 2004; Kabat-Zinn, 2005). Mindful individuals tend to observe their experiences without overwhelming reaction or elaboration (Crane, 2009); these individuals are open and receptive toward present moment experiences regardless of their valence or desirability (Bishop et al., 2004). Mindful individuals do not make any assumptions or form any beliefs about their experiences; they just observe them as objects with openness and acceptance (Bishop et al., 2004).

In order to identify central elements of mindfulness, Baer, Smith, Hopkins, Krietemeyer, and Toney (2006) combined all items from the five pre-existing measures of mindfulness and performed exploratory factor analysis. The findings from the factor analysis indicated that mindfulness comprised of five components. These components were: (a) observing—noticing and attending to internal and external experiences, such as bodily sensations, emotions, sound, smell; (b) describing—an ability to express internal experiences with words; (c) acting with awareness—being aware of ongoing behaviour or activity; (d) non-judgement of inner experience—taking a non-evaluative

stance towards feelings and thoughts; and (e) non-reactivity to inner experience—not reacting to internal and external experiences. Baer et al. (2008) found that these five skill sets are associated with psychological well-being and meditative experiences.

Furthermore, research on mindfulness-based therapies and mindfulness training support the notion that mindfulness is beneficial in the regulation of negative emotions and emotional disorders such as depression, stress, worry, and social anxiety (Arch & Craske, 2006, 2010; Goldin & Gross, 2010; Goodall, Trejnowska, & Darling, 2012; Erisman & Roemer, 2010; Evans & Segerstorm, 2011; Farb et al., 2010; Hill & Updegraff, 2012; Verplanken & Fisher, 2013). Even brief mindfulness training can have a significant impact on emotional regulation. For example, Arch and Craske (2006) assigned participants to one of the following conditions: (a) focused breathing—participants were instructed to focus their attention on the present moment, especially on their experience of breathing; (b) worry—participants were instructed to think and worry about different domains, such as money, health, and achievement; or (c) unfocused attention—participants were instructed to think about whatever came into their mind. Before and after the experimental condition (i.e., focused breathing, worry or unfocused attention), participants were asked to view a series of emotion-evoking slides (positive, negative, or neutral). This study demonstrated that participants in the focused breathing condition were more agreeable to viewing the negative slides and were less negatively affected by them than the participants in the worry group.

Although mindfulness is a mental quality that can be cultivated and enhanced through mental training, individuals differ in the degree they are mindful in daily life (Brown & Ryan, 2003). A general tendency to be mindful has been associated with emotional well-being and psychological health (Bowlin & Baer, 2012; Brown, Ryan, & Creswell, 2007; Keng, Smoski, & Robins, 2011) and negatively correlated with

psychological disorders (Eisenlohr-Moul, Walsh, Charnigo, Lynam, & Baer, 2012;

Fossati, Vigorelli, Maffei, & Borroni, 2012). For instance, Hill and Updegraff (2012)

asked participants to report their emotional experiences six times a day over one week.

They found that a higher level of dispositional mindfulness was related to a lower level

of emotional reactivity and fluctuations. In addition, mindful individuals were more

able to discriminate between their emotional experiences. In other words, mindful

individuals were more aware of their emotional states, but less affected by them.

In mindfulness, negative emotions are less threatening and upsetting, since there

is a tendency to observe the experience objectively and without any assumptions or

assigning meaning (Bishop et al., 2004). Attention to ongoing experiences in

mindfulness is adaptive. It is without judgement (non-judging) and overwhelming

reaction (non-reactivity) (Baer, 2007). Contrary to mindfulness, shame is one of the

self-conscious emotions that is associated with maladaptive self-focused attention and

self-conscious thoughts (Joireman, 2004). Individuals often get carried away and caught

up in their experience of shame without the ability to empathise with others or consider

different perspectives (Tangney & Dearing, 2002). According to Tracy and Robins

(2004, 2007b), shame arises when individuals make internal, stable, and uncontrollable

attributions regarding a negative event. In shame experiences, the focus of evaluation is

on the self rather than on the action (Niedenthal et al., 1994; Tangney & Dearing,

2002). As a result, the self is often devalued and considered inadequate, incompetent,

inferior, and worthless (Allan et al., 1994). Moreover, shame is associated with self-

criticism and self-evaluation (Tangney & Dearing, 2002), which contradicts

characteristics that mindfulness promote. Because of the accepting, non-judgemental,

and objectivity qualities inherent in mindfulness, a negative relationship between

mindfulness in daily life and shame can be expected in the current study.

Furthermore, Baer et al. (2006) argues that to understand the relationship between mindfulness and other constructs, it is important to examine mindfulness at a subscale level; each facet may have a different relationship with different outcome variables. It is beneficial to pinpoint exactly which facets are responsible for the relationship between mindfulness and shame. This may enable clinicians to enhance specific attributes of mindfulness in order to regulate shame. Since the subscale of 'non-judging of inner experience' taps into self-criticism—the hallmark of shame—it is expected that the strongest association between this subscale and shame will emerge. On the contrary, it can be assumed that the 'observe' and 'describe' facets of mindfulness are less relevant to the experience of shame in a non-meditating population.

Assuming there is a significant association between shame and mindfulness, the next natural question, and the more important one, is how mindfulness affects shame. This study proposes that mindfulness is related to shame through self-compassion. Like mindfulness, self-compassion is a construct derived from Buddhist psychology (Neff & Germer, 2013). Neff (2003a) defined self-compassion as "being open to and moved by one's own suffering, experiencing feelings of caring and kindness toward oneself, taking an understanding, non-judgmental attitude toward one's inadequacies and failures, and recognising that one's experience is part of the common human experience" (p. 224).

Moreover, Neff (2003a, 2003b) postulated that self-compassion has three components: self-kindness versus self-judgement, common humanity versus isolation, and mindfulness versus over-identification. Self-kindness versus self-judgement refers to treating oneself with kindness and compassion when experiencing failure and pain, as opposed to judging oneself harshly. The dimension of common humanity versus

isolation refers to seeing one's failures and imperfections as part of the human experience, instead of feeling isolated by them. Mindfulness versus the over-identification element of self-compassion refers to taking a balanced view of one's failures, personal suffering, and self-relevant experiences rather than exaggerating or suppressing them. This component of self-compassion suggests that to show compassion towards the self, one must be aware and mindful of personal failure or suffering without trying to suppress or exaggerate them (Neff & Germer, 2012).

Research has shown that greater self-compassion is associated with psychological well-being, and with reduced depression and anxiety (Neff, 2003a, 2009; Neff et al., 2007; Raes, Pommier, Neff, & Van Gucht, 2010). In addition, studies have demonstrated that self-compassion facilitates coping with failure (Neff et al., 2005) and dealing with negative life events (Leary et al., 2007). For instance, in an experimental study, Neff et al. (2007) found that self-compassion assists individuals to cope better with self-evaluative anxiety. In their study, participants took part in a mock interview and were asked to answer difficult questions such as "please describe your greatest weakness." After the task, self-compassion, self-esteem, anxiety, and mood were measured. The results of the interview showed that self-compassion was significantly associated with lower levels of anxiety, even when the effect of self-esteem was controlled.

With respect to shame, Gilbert and Proctor (2006) found that the self-compassion intervention helped patients with severe psychological problems, such as shame and self-criticism. In this trial, participants were encouraged to recognise their feelings, understand their self-criticism tendencies, explore different aspects of the self, cultivate self-compassionate imagery, and bring this imagery to their mind to induce feelings of warmth and kindness. The results demonstrated a significant improvement in

various factors over the course of the 12-week intervention. After the treatment period, patients reported lower levels of depression, self-criticism, self-hate, shame, and anxiety.

Additionally, Johnson and O'Brien (2013) corroborated the therapeutic benefits of self-compassion for shame. In their study (Study 2), shame-prone individuals were instructed to recall and describe a shame-eliciting experience; then, participants were assigned to one the following conditions: (a) describe the event self-compassionately (i.e., being kind and understanding considering that others may experience similar problems, etc.); (b) describe the event and express any feelings towards it (i.e., expressive writing); or (c) describe the event without any instruction (control condition). Participants were also asked to complete a series of measures, including state shame. This process was repeated three times during a one-week period. Those participants who were in the self-compassion condition reported a lower level of state shame and negative emotions than participants in the expressive writing condition. In addition, the practice of self-compassion decreased the level of shame-proneness from baseline (before the experiment) to two weeks after completing the experiment.

Three components of self-compassion (self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification) identified by Neff (2003a, b) appear to diverge from the central characteristics of shame (Johnson & O'Brien, 2013). Specifically, the self-kindness aspect of self-compassion is contradictory to the self-evaluative nature of shame. The common humanity aspect is in opposition to the self-focused attention and social withdrawal tendencies that are often observed in shame. Instead of thinking that suffering is specific to oneself, this aspect of self-compassion probably normalises the experience of shame by reminding individuals that they are not alone and that others may encounter similar situations. The

mindfulness aspect of self-compassion also encourages individuals to hold a balanced view, rather than trying to generalise, aggrandise, suppress, or avoid natural emotional responses (Johnson & O'Brien, 2013; Mosewich, Kowalski, Sabiston, Sedgwick, & Tracy, 2011).

More importantly, feelings of compassion are generally regarded as a core component within mindfulness (Kuyken et al., 2010), and mindfulness training seems to foster self-compassion and self-acceptance (Kuyken et al., 2010; Shapiro, Astin, Bishop, & Cordova, 2005; Trich, 2010). It is not unreasonable to assume that self-compassion mediates the effect of mindfulness on psychological adjustments (or maladjustments). Indeed, a number of studies provide support for this interpretation. For example, Hollis-Walker and Colosimo (2011) found that self-compassion partially mediated the relationship between mindfulness and psychological well-being. In this cross-sectional study, Hollis-Walker and Colosimo (2011) measured self-compassion, five-facets of mindfulness, and psychological well-being. To establish a mediation link, they used the Baron and Kenny (1986) approach. It was found that mindfulness significantly predicted psychological well-being and self-compassion. In addition, when self-compassion and mindfulness were considered together, both significantly predicted well-being; however, the effect of mindfulness was substantially reduced. Hollis-Walker and Colosimo (2011) assert that "mindfulness cultivates a compassionate attitude, which in turn safeguards against the pernicious effects of negative feelings such as guilt and self-criticism, and facilitates well-being" (p. 226).

In addition, Baer, Lykins, and Peters (2012) found that both mindfulness and self-compassion were significantly correlated with well-being. However, self-compassion was a stronger predictor of well-being than mindfulness. Van Dam, Sheppard, Forsyth, and Earleywine (2011) also found that self-compassion was a better

predictor of depression and anxiety than mindfulness. The present study is intended to expand upon the results of these previous studies and to explore the relationship between shame, self-compassion, and mindfulness. It is proposed that self-compassion mediates the relationship between mindfulness and shame.

In order to explore the relationship between shame and acceptance-based strategies further, it was decided to assess acceptance of shame and embarrassment with a newly designed and validated measure; the ASES. This measure was discussed comprehensively in Chapter 5; the scale assesses the level of willingness to experience shame and embarrassment. The essence of mindfulness, self-compassion, and acceptance is very similar; the embrace of experiences without judgement or overreaction and with compassion and kindness is emphasised (Germer, 2009). Therefore, a negative association can be expected between the unwillingness to experience shame and experiencing shame. Ironically, those individuals, who are reluctant to experience shame and take punitive or avoidant attitudes towards their vulnerability, may be more prone to experience of shame. A self-critical attitude towards shame is likely to maintain the underlying negative self-judgement that is a fundamental core of shame vulnerability. Furthermore, there is theoretical argument (Hayes et al., 1999) and some research evidence (Marcks & Woods, 2005) that attempts to avoid or suppress emotional experiences can prevent adequate emotional processing and result in an inadvertent increase in distress.

To summarise, in this study four hypotheses are tested. The first hypothesis is that mindfulness is negatively correlated with shame experiences; the second hypothesis is that self-compassion is negatively related to shame experiences; the third hypothesis is that self-compassion will mediate the relationship between mindfulness and shame;

and the fourth hypothesis is that acceptance of shame and embarrassment is negatively associated with shame experiences.

6.3. Method

6.3.1. Participants

One hundred and fifty-nine people (125 female; 33 male, one undeclared, M_{age} = 27.61, SD =10.62) participated. The sample included undergraduate students (51.6%), postgraduate students (22.6%), people who work full-time (17%), as well as other community members (8.8%). Participants were from the United Kingdom (50.3%), the United States and Canada (43.4%), and other countries (6.3%).

6.3.2. Procedures

The study was approved by the relevant Department of Psychology Research Ethics Committee at the University of Bath (Reference number: 12-104). All of the materials were made available online using the Bristol Online Surveys (BOS) tool, and participants were provided with a web address through which access to the study. The study was advertised online on the University of Bath's website. In addition, other websites, such as www.onlinepsychresearch.co.uk and www.socialpsychology.org, were used to recruit participants. Initially, participants read an information sheet and consent form online and those who wished to participate were instructed to complete a series of questionnaires (Appendix C), which are described below.

6.3.3. Measures

The Experience of Shame Scale (ESS) (Andrews et al., 2002). This 25-item scale asks questions about three specific characteristics (i.e., personal qualities, behaviour, and physical appearance) that may induce feelings of shame. Sample questions include: "Have you felt ashamed of any of your personal habits?" and "Have you felt ashamed of your body or any part of it?" Responses were given on a four-point

scale (1 = *not at all*, 4 = *very much*), with a higher score indicating a higher level of

shame. Internal consistency for this measure is estimated above .90 (Andrew et al.,

2002). Cronbach's alpha for this sample was 0.94.

The Self-Compassion Scale-Short Form (SCF-SF) (Raes et al., 2010). This

12-item scale measures self-compassion with statements such as "I try to be

understanding and patient towards those aspects of my personality I don't like" and "I

try to see my failings as part of the human condition." Each of these items is rated on a

five-point scale (1 = *almost never*, 5 = *almost always*), with a higher score indicating a

higher level of self-compassion. The short form has a near perfect correlation with the

long scale of self-compassion; estimated Cronbach's alpha is above .86 (Reas et al.,

2010). Cronbach's alpha for this sample was 0.90.

The Five-Facet Mindfulness Questionnaire (Baer et al., 2006). This scale

consists of 39 items and measures five subscales of mindfulness, namely observing (i.e.,

paying attention to sensations and cognitions: "When I'm walking, I deliberately notice

the sensations of my body moving"), describing (i.e., ability to label internal feelings:

"I'm good at finding words to describe my feelings"), non-judgement of inner

experience (i.e., being non-judgemental towards feeling and thoughts: "I criticize

myself for having irrational or inappropriate emotions"), non-reactivity to inner

experience (i.e., let thoughts and feelings come and go without reacting to them: "I

perceive my feelings and emotions without having to react to them"), and acting with

awareness (i.e., being present in the moment: "When I do things, my mind wanders off

and I'm easily distracted"). Each item is rated on a five-point scale (1 = *never or very*

rarely true, 5 = *very often or always true*), with a higher score indicating a higher level

of mindfulness. Alpha coefficients for this measure ranged from .75 to .91 (Baer et al.,

2008). In this sample, Cronbach's alpha was .91 for the total score and ranged from .85 to 0.93 for the subscales.

Acceptance of Shame and Embarrassment Scale (ASES). The ASES is validated in Chapter 5 of this thesis (for items see Table 5.2). The scale assesses the willingness of individuals to engage with their shame and embarrassment experiences rather than to avoid them. The scale includes 17 items and is rated on a 7-point scale (0 = *never true,* 6 = *always true*). Sample items include: "If I get embarrassed around other people, I can live with it" and "If I start to feel embarrassed or ashamed, I have to leave the situation." Higher scores indicate a higher level of acceptance. In the previous chapter, Cronbach's alpha was above .90. For this sample, Cronbach's alpha was .92.

6.4. Results

The data was initially examined for normality of distribution. Preliminary analysis revealed normally distributed measures. Skewness values ranged from -.05 to .56 and Kurtosis values ranged from -.02 to -.64 for the scales. Furthermore, the effect of demographic variables (e.g., gender, age, and nationality) on the experience of shame, self-compassion, mindfulness, and acceptance of shame and embarrassment were examined. Nationality did not have a significant effect on any of the variables. However, gender was significantly correlated with self-compassion ($r = .17$, $p = .03$). Men scored higher ($M = 3.17$, $SD = .70$) on the Self-Compassion Scale than women ($M = 2.80$, $SD = .91$; $t (156) = -2.54$, $p < .05$). In addition, older participants had higher scores on the mindfulness scale than younger participants ($r = .32$, $p < .001$). Therefore, the effects of age and gender will be controlled in the following analyses.

6.4.1. Correlation Analysis

In the first section, the association between shame, self-compassion, mindfulness, and acceptance of shame and embarrassment was investigated. As expected, partial correlations, controlling for age and gender, showed that shame was negatively and significantly correlated with self-compassion ($r = -.60$), mindfulness ($r = -.39$), and acceptance of shame and embarrassment ($r = -.60$). In other words, participants who scored higher on the shame scale also reported lower scores on the measurements for self-compassion, mindfulness, and acceptance of shame and embarrassment. Moreover, as can been seen in Table 6.1, mindfulness, self-compassion, and acceptance of shame and embarrassment were significantly and positively correlated.

Table 6.1

Bivariate Correlations between Shame, Self-compassion, Mindfulness, and Acceptance

	Shame	**Compassion**	**Mindfulness**	**Mean**	*SD*	**Score Range**
Shame				58.42	16.07	25–100
Compassion	-.62**			34.43	10.62	12–59
Mindfulness	-.42**	.61**		123.30	20.42	83–182
Acceptance	-.61**	.67**	.51**	54.42	17.96	28–115

Note. Compassion = Self-Compassion Scale; Acceptance = Acceptance of Shame and Embarrassment Scale; $*p < .05, **p < .01$

6.4.2. Mediation Analysis

The proposed mediation model was then tested. In order for the mindfulness→self-compassion→shame model to hold, the following conditions were necessary (Baron & Kenny, 1986): (a) mindfulness significantly predicted self-compassion; (b) mindfulness significantly predicted shame; (c) self-compassion significantly predicted shame (while controlling for mindfulness); and (d) mindfulness failed to predict shame when controlling for self-compassion.

The above model was assessed with a set of three regression analyses. In the first regression analysis, mindfulness significantly predicted self-compassion ($\beta = .62$, $\Delta R^2 = .34$, $p < .001$). In the second regression analysis, mindfulness significantly predicted shame ($\beta = -.40$, $\Delta R^2 = .15$, $p < .001$). In the final analysis, multiple regression was conducted with mindfulness and self-compassion predicting shame simultaneously. When mindfulness and self-compassion were considered together, self-compassion significantly predicted shame ($\beta = -.57$, $\Delta R^2 = .35$, $p < .001$, (t) $= -6.87$) and mindfulness was no longer a significant predictor of shame ($\beta = -.05$, $p = .56$, (t) $= -.58$). These results imply that the relationship between mindfulness and shame is fully mediated through self-compassion (Figure 6.1). Additionally, a bootstrap analysis (95% boostrap confidence interval $= -.29$; $-.25$) and Sobel test ($z = -5.76$, $p < .001$) confirmed that the indirect effect was statistically significant, supporting the hypothesis that mindfulness is related to shame through self-compassion.
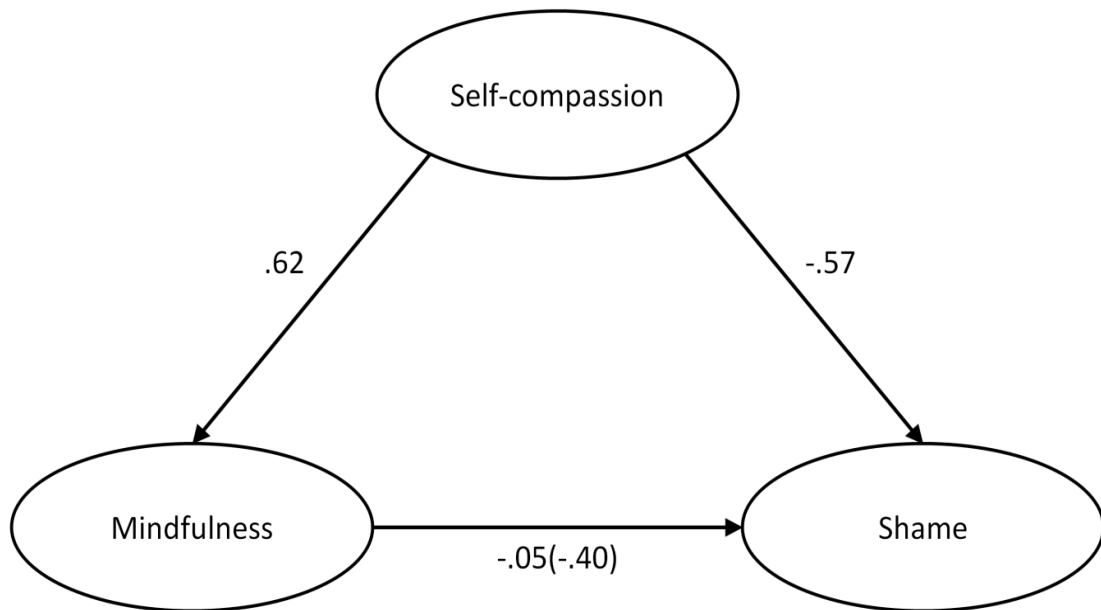
Figure 6.1. Self-compassion fully mediating the mindfulness-shame relationship.

Note. Values on arrows represent standardised beta coefficients; the value within parenthesis represents the direct effect of mindfulness on shame.

Although the above model made rational sense and was theoretically credible, an alternative model (self-compassion→mindfulness→shame) was tested in order to get a clearer picture. Similar regression analyses were conducted. Self-compassion significantly predicted mindfulness ($\beta = .58$, $p < .001$, $\Delta R^2 = .32$, $p < .001$) and shame ($\beta = -.60$, $\Delta R^2 = .34$, $p < .001$). However, since mindfulness did not significantly predict shame when considered simultaneously with self-compassion, it cannot be concluded that mindfulness mediates the association between self-compassion and shame. Put differently, self-compassion was a stronger predictor of shame than mindfulness.

6.4.3. Shame, Self-Compassion, Mindfulness Facets

In this section, the relationships between facets of mindfulness, shame, and self-compassion are examined (Table 6.2). In order to explore the predictive weight of each factor, the mindfulness construct was investigated at the level of its constituting facets. Five factors were calculated based on the findings of Baer et al. (2006): observing, describing, acting with awareness, non-reactivity, and non-judgement. Initially, partial

correlations for five factors with shame were inspected, controlling for age and gender.
It was observed that shame was not significantly correlated with the 'observe' ($r = .05$)
or 'describe' ($r = -.09$) subscales. On the contrary, shame was significantly and
negatively correlated with the 'acting with awareness' ($r = -.23$, $p < .01$), 'non-react' ($r = -.35$, $p < .001$), and 'non-judgement' ($r = -.52$, $p < .001$) facets.

Table 6.2

Bivariate Correlations between All Variables

	Shame	Compassion	Mindfulness	Observe	Describe	Awareness	Non-Judge	Non-React
Shame								
Compassion	-.62**							
Mindfulness	-.42**	.61**						
Observe	.04	.06	.46**					
Describe	-15	.24**	.70**	.23**				
Awareness	-.27**	.37**	.67**	.07	.38**			
Non-judge	-.54**	.64**	.63**	-.04	.22**	.38**		
Non-react	-.38**	.62**	.66**	.25**	.29**	.30**	.35**	
Acceptance	-.61**	.67**	.51**	.20**	.23**	.20*	.43**	.54**

Note. Compassion = Self-Compassion Scale; Observe = Observing facet; Describe = Describing facet; Awareness = Acting with awareness facet; Non-react = Non-reactivity to inner experience facet; Non-judge = Non-judgement of inner experience facet; Acceptance = Acceptance of Shame and Embarrassment Scale; *$p < .05$, **$p < .01$.

A multiple regression was next conducted, regressing shame on acting with
awareness, non-react, non-judgement facets of mindfulness, and self-compassion. The
observe and describe subscales were not included, because they were not significantly
related to shame. It was revealed that the non-judgement facet and self-compassion
significantly predicted shame, while the acting with awareness and non-react subscales
were not significant predictors of shame (Table 6.3).

Table 6.3

Multiple Regression Predicting Shame from Acting with Awareness, Non-react, Non-judgement, and Self-compassion

Predictors	*B*	SE	*t*
Awareness	-.01	.06	-.13
Non-react	-.03	.07	-.34
Non-judgement	-.25**	.06	-2.95
Self-compassion	-.43***	.08	-4.27

Note. Predictor variables were entered simultaneously into a single regression equation; R^2 for model = .38. controlling for age and gender (age and gender entered in the first step); **$p < .01$, ***$p < .001$.

To investigate whether non-judgement was able to add incremental predictive power after controlling for self-compassion, a hierarchical regression was conducted. Age and gender were entered in the first block, self-compassion in the second block, and the non-judgement facet in the third (Table 6.4). Both self-compassion and the non-judgement facets accounted for a significant increment in the variance. In particular, the non-judgement factor explained a significant amount of variance after self-compassion was controlled.

Table 6.4

Hierarchical Multiple Regression Analysis Predicting Shame from Self-compassion and Non-judgement

	B	R^2	ΔR^2	F Change
STEP 1		.01	.02	2.15
Age	-.01			
Gender	-.01			
STEP 2		.36	.34	81.70***
Self-compassion	-.44***			
STEP 3		.39	.03	.003**
Non-judgement	-.25**			

Note. B = Beta coefficients are from the final equation; **$p < .01$, ***$p < .001$.

6.5. Discussion

The primary aim of the current study was to explore the relationship between mindfulness, self-compassion, and shame, and to propose that self-compassion was a mediator of the mindfulness-shame relationship. Consistent with this prediction, shame was negatively associated with mindfulness, self-compassion, and the acceptance of shame and embarrassment. In line with the mediation analysis, self-compassion fully mediated the relationship between mindfulness and shame.

Additionally, relationships between the five facets of mindfulness and shame were examined. When the effect of self-compassion was considered, the only significant predictor of shame was the tendency of a person to be non-judgemental of inner experience. In fact, the non-judgement facet of mindfulness accounted for a significant incremental amount of the variance over and beyond the effect of self-compassion. This may indicate that developing a non-judgemental attitude towards distressing thoughts and feelings promotes self-compassion and acceptance (Desrosiers, Klemanski, & Nolen-Hoeksema, 2013), which then protects individuals from the experience of shame.

More recently, Woods and Proeve (2014) investigated the association between mindfulness, self-compassion, shame, and guilt-proneness. Consistent with the current study, Woods and Proeve (2014) reported that when self-compassion and mindfulness were considered together, self-compassion significantly predicted shame-proneness, while mindfulness did not. In other words, self-compassion was more relevant to the experience of shame than mindfulness. Since the non-judgement facet of mindfulness had incremental validity in the current study, it might be inferred that this aspect of mindfulness is also relevant and efficaciousness in dealing with to the experience of shame.

In general, non-judgement has the highest (inverse) association with psychological symptoms and neuroticism of all mindfulness facets (Baer et al., 2006). Previous studies have demonstrated an association between the non-judgement facet and lower levels of depression, anxiety, and stress in comparison to other facets (Cash & Whittingham, 2010), as well as responsibility for the relationship between mindfulness and worry (Evans & Segerstrom, 2011).

The 'non-judging of inner experience' subscale measures the extent to which individuals take an evaluative stance towards their feelings and thoughts. Shame has been linked to feelings of worthlessness and self-devaluation. Self-blame and self-criticism can be displays of shame (Cheung, Gilbert, & Irons, 2004; Gilbert & Miles, 2000). As a result, individuals experiencing high levels of shame can struggle to exhibit self-love or to be self-compassionate (Rockliff, Gilbert, McEvan, Lightman, & Glover, 2008). Further, there is often a perception that self-compassion is challenging or impossible to develop. For example, Pauley and McPherson (2010) concluded that individuals with depression and anxiety symptoms perceived self-compassion positively and believed having compassion was constructive. However, they thought that fostering self-compassion is demanding and difficult. In fact, Gilbert, McEvan, Matos, and Rivis (2011) argued that fear of compassion can be a major obstacle to recovery for high-shame individuals. Self-critical attitudes make individuals particularly resistant to the idea of self-compassion; these individuals may prefer to use avoidance or other safety strategies (e.g., submissive strategies) to deal with the experience of shame (Gilbert, 2009). These strategies can be ineffectual and unhealthy in the long term; however, they may seem more convenient, safer or less challenging in the short term. Although previous studies suggest that self-compassion is one of the most effective ways to regulate shame (e.g., Gilbert & Procter, 2006; Kelly et al., 2009), the problem seems to

be how to convince or encourage high-shame individuals to use constructive methods, like self-compassion, to regulate shame rather than unconstructive ways.

This study has also established that individuals who were more reluctant to experience shame and embarrassment and tend to avoid shame-related situations, reported higher levels of shame. In other words, those who had higher scores on items such as "I can't bear feeling embarrassed or ashamed" and "I hate it when I feel that people are judging me" also had higher scores on the shame scale. It is likely that a tendency to experience higher levels of shame will result in greater unwillingness to tolerate situations where shame may occur. However, it is also possible that a tendency to avoid shame-related experiences may inadvertently foster shame-proneness in the long-term. This association might also be due to other factors: social sensitivity, fear of rejection, or low self-worth influences both shame and the acceptance of shame and embarrassment. As there are likely reciprocal relationships between multiple factors, the cultivation of acceptance, compassion, and non-judgemental attitudes, in addition to reducing avoidance, may have substantial benefits for high-shame individuals.

Previous research has demonstrated that the observation facet of mindfulness is strongly related to psychological well-being in participants with mindfulness training, but it is unrelated to well-being in participants with no prior training (Baer et al., 2008). Similarly, in the current study, the observe and describe facets of mindfulness were not significantly correlated with the experience of shame. A similar disjunction was found between being present in the moment and shame. Being present in the moment is an essential element of mindfulness, and most definitions of mindfulness focus on this aspect. Attending to the present moment, rather than ruminating over negative events, helps individuals deal better with negative emotions and difficulties. However, acting with awareness was not a significant predictor of shame when the effects of other

variables were considered. Similarly, in the previous chapter, it was demonstrated that the awareness component of mindfulness is less relevant to the ASES scale than the acceptance component of mindfulness. The current study was conducted in a general population sample. It is possible that participants with mindfulness training have access to different resources for dealing with emotional difficulties. Future research is required to confirm these relationships in samples of subjects with mindfulness training.

In fact, it is important to mention that around 70% of participants in this study were university students. University students may not be representative of the general population, as they tend to be of a certain age, social class, and intellectual ability. Therefore, the findings from this study may not necessarily generalise to the general population. Ideally, our sample should have been recruited to participate in mindfulness training and exercises over a period of time (e.g., two weeks) and examined to measure changes in levels of shame and self-compassion. Such a design would have allowed us to further assess causality between self-compassion, mindfulness, and shame. However, these types of studies require training for both participants and researchers, as well as a time commitment from participants to do the exercises. Furthermore, these sorts of intervention studies are costly, and require adequate funding, space for training, and time. Given these considerations, an intervention study was deemed unfeasible and we decided to rely on a cross-sectional design and an opportunistic sample. However, as such, the findings must be replicated in broader samples to verify their generalisability and validity.

Moreover, it is essential to recognise that mindfulness and self-compassion are conceptually different constructs. Self-compassion tends to focus on personal sufferings, while the focus of mindfulness is on positive, negative, or neutral experiences. Self-compassion tends to focus on the "self", whereas mindfulness is more

broadly focused on internal experiences, such as emotions, thoughts, or sensations (Baer et al., 2012; Neff & Germer, 2013). For example, Neff and Germer (2013) stated that:

> In the case of lower back pain, mindful awareness might be directed at the changing pain and sensations, perhaps noting a stabbing, burning quality, whereas self-compassion would be aimed at the person who is suffering from back pain. Self-compassion emphasizes soothing and comforting the 'self' when distressing experiences arise, remembering that such experiences are part of being human. (p. 2)

Although mindfulness and self-compassion are theoretically different concepts (Baer et al., 2012; Neff & Germer, 2013), there are some similarities between the scales used in this study. In particular, the mindfulness scale includes a subscale regarding the non-judging inner experience and contains items such as "I criticize myself for having irrational or inappropriate emotions," which are similar to items on the self-judgement subscale of self-compassion (e.g., "I'm disapproving and judgmental about my own flaws and inadequacies"). In the current study, self-compassion was measured using the short form of the Self-Compassion Scale, which has 12 items, of which two measure self-judgement. In addition, the correlations among self-compassion, mindfulness, and mindfulness facets ($r = .61$ for mindfulness and self-compassion: rs ranged from .06 to .64 for the relationships between mindfulness facets and self-compassion) were relatively high. Therefore, the overlap between these two measures is a limitation of this study.

Another limitation of this study is that, due to the correlational design, none of these relationships can be assumed causal. Indeed, the proposed model can be challenged because the mediation analysis was cross-sectional. Theoretical accounts

and research on the mindfulness-based therapies indicate that mindfulness training is likely to increase self-compassion (e.g., Kuyken et al., 2010) and mindfulness is a broader concept than self-compassion. Thus, it is rational to presume that mindfulness cultivates self-compassion and self-compassion mediates the relationship between mindfulness and shame. However, alternative models cannot be dismissed. This issue could be addressed in future longitudinal research. In future studies, it might be necessary to explore whether being non-judgemental towards the self, acts as a protective factor in buffering the experience of shame or lessens feelings of shame after they occurred. Quite possibly, it is effective in both processes. However, it requires further explorations.

Despite its limitations, the present study makes a valuable contribution to the literature; first, by establishing a link between mindfulness, acceptance, and shame, and then by identifying a potential process that underlies this relationship. The experience of shame is highly negative, painful, and difficult to manage. Identifying resources that enhance adaptive functioning and help individuals to deal with emotional experiences is essential. In line with previous studies, this study demonstrates that higher level of self-compassion is significantly associated with lower level of shame. In general, interventions that target judgemental attitudes towards the self and promote self-acceptance are likely to be highly beneficial in dealing with both shame and a wide variety of psychological disorders. Specifically, in addition to the self-compassion focused therapy, loving-kindness meditation might be constructive for those who suffer from negative self-judgement and shame (Woods & Proeve, 2014).

Chapter 7. Shame and Mind-Wandering

7.1. Abstract

The purpose of this study was to investigate the effects of shame on mind-wandering. One hundred and twenty participants were recruited for this study. Participants were systematically assigned to shame, pride, or control conditions. Participants were asked to recall a personal experience of shame or pride and then to read few pages about geography in order to assess mind-wandering. The amount of the time participants spent on the reading task, their scores on a comprehension text, their self-reported frequency of mind-wandering, and their reported number of unrelated thoughts were used to determine mind-wandering. The results demonstrated that participants in the shame condition did not differ from participants in the pride and control conditions with respect to mind-wandering. However, participants who had a higher score on trait shame reported a significant frequency of mind-wandering despite the experimental conditions. The reasons for, and implications of these findings are discussed.

7.2. Introduction

Feeling shame can be unbearably painful and devastating. A natural response is to avoid, remove, suppress, or escape feeling of shame. Kaufman (1996) proposed that individuals use defensive strategies, such as rage, contempt, humour, withdrawal, blaming others, denial, and striving for perfection or power to cope with shame. As noted previously, Nathanson (1992) presented a shame management model indicating that individuals engage in four maladaptive strategies: avoidance, withdrawal, attack of self, and attack of another to deal with the experience of shame.

Goss and Allan (2009) explored responses to shame in individuals with eating disorders. The authors argued that individuals adopt various coping strategies, such as aggression, submission, concealment, avoidance and withdrawal, destruction of the object of shame (e.g., self-harm), compensation (reparation), or seeking help. In addition, Schoenleber and Berenbaum (2012) identified three classes of dysfunctional shame regulation strategies: (a) prevention (e.g., perfectionism, fantasy); (b) escape (e.g., social withdrawal and the diversion of attention from the self); and (c) aggression (self-directed or other-directed).

In these theories, shame-based responses can range from avoidance, withdrawal, and attacking others to striving for power and perfection. However, in support of these theses there is a paucity of empirical evidence. One exception is de Hooge's et al. (2010, 2011) demonstration that shame motivates individuals to seek self-enhancement strategies in order to restore the devalued self. The authors showed that after shame experiences, individuals engage in different hypothetical compensatory actions to improve their self-image. For example, shamed individuals were more likely to perform a difficult and challenging task to enhance their self-image than a simple or easy task that did not have any effect on their self-image.

Similarly, Chao, Cheng, and Chiou (2011) demonstrated that shamed participants spent more time on an unsolvable task (they did not realise was unsolvable) than a control group. The authors suggested that shamed participants were more determined to resolve the task and show their competence, which in turn would help them to affirm a positive view of the self. In another study, Wang, Cheng, Chiou, and Kung (2012) found that individuals in a state of shame were less likely to donate money. They suggested that having more money is associated with being more competent and deserving.

With the exception of these experimental studies, the literature implies that individuals vulnerable to the experience of shame are inclined to use withdrawal or avoidance-based strategies (Sheikh& Jenoff-Bulman, 2010; Yi & Baumgartner, 2011). For instance, Reid, Harper, and Anderson (2009) found that hypersexual patients react to the experience of shame by showing withdrawal or self-attack tendencies. Furthermore, proneness to shame has been associated with escapist responses (e.g., Tangney, 1995; Tangney, Miller et al., 1996), anger or transferring blame (Stuewig et al., 2010; Thomaes et al., 2011), self-focused attention (Joirman, 2004), chronic rumination over the shameful incident (Orth et al., 2006), and alcohol and drug abuse (Dearing et al., 2005). It is possible, if not likely, that shame-prone individuals use alcohol, food, and other similar strategies in order to numb the painful feelings of shame.

It is generally very difficult to talk about shameful experiences (Keltner & Buswell, 1996) and people's descriptions of shame are very abstract and vague (Tangney, 1992); this perhaps shows that shamed individuals are trying to distance themselves physically or emotionally from their shame-inducing experiences. They may avoid thinking about the shameful incidents, and if they are reminded, they may distract

themselves by thinking about something less intense and unpleasant. They may change the focus of their attention from the shameful incident to something more neutral or positive.

In line with Shoenleber and Berenbaum's (2012) proposition, the current study postulates that individuals attempt to disengage themselves mentally from their shameful experiences by engaging in daydreaming or mind-wandering. Although the relationship between daydreaming/mind-wandering and shame has not yet been investigated, it is a common belief that daydreaming increases at times of stress (e.g., Greenwald & Harder, 1997), or that daydreaming may help those who have experienced failure (Lynn & Rhue, 1998). The purpose of this study is to investigate the relationship between mind-wandering and shame. However, it is important to understand what mind-wandering is and how it is defined.

7.2.1. What is Mind-Wandering?

Smallwood, O'Connor, Sudbery, and Obonsawin (2007) have defined mind-wandering as "a shift in the focus of attention away from the here and now towards one's private thoughts and feelings" (p. 818). During everyday activities, the mind wanders about 30–35% of the time (Langens & Schmatt, 2002). While performing automatic tasks (e.g., driving), mundane tasks, or when someone is exhausted this wandering can increase significantly (Smallwood, Mrazek, & Schooler, 2011).

Attention is diverted away or decoupled from the task and directed towards private thoughts or concerns when the mind-wanders. Consequently, the occurrence of mind-wandering impairs task performance (Smallwood, McSpadden, & Schooler, 2008). Studies have shown that when the mind wanders, reading comprehension, memory retrieval, encoding information and signal detection are negatively affected (Smallwood et al., 2008; Smallwood & Schooler, 2006).

Mind-wandering is usually measured using a probe-caught measure or self-caught sampling (Smallwood & Schooler, 2006). In the former, when participants are engaged in a task (e.g., reading), they are periodically interrupted and asked to report their current thoughts. In the latter, participants are required to monitor their thoughts during a task and then report whenever their minds wander (Smallwood & Schooler, 2006).

Furthermore, mind-wandering may have a variety of functions. For example, it may help individuals to keep "an optimal level of arousal" during mundane tasks (Mason et al., 2007, p.3) or to encourage planning for future goals (Baird, Smallwood, & Schooler, 2011). It may also promote creative thinking, emotional regulation, and problem solving (Stawarczyk, Majerus, Maj, Van der Linden, & D'Argembeau, 2011).

Notwithstanding these potential functions, mind-wandering is not always rewarding. Indeed, mind-wandering can be distracting, disturbing, monotonous, and at times, unproductive. Research on mindfulness, which is often considered as the state of being present and conscious of moment-to-moment activities (Brown & Ryan, 2003), reveal that mindfulness are associated with well-being and reduced psychological symptoms (Chapter 6).

In fact, modern spirituality teachings and clinical practices put a high emphasis on awareness and consciousness. For example, Tolle (1999) asserted that living in the present moment is a key to happiness. According to Tolle (1999), patterns of thoughts are often repetitive. The mind usually wanders to the same old thoughts and new thoughts are relatively rare. According to Tolle's argument, insight and creativity only occur when the mind stops dreaming and wandering. More importantly, mind-wandering or thinking without awareness can become compulsive. Wandering thoughts

could become a source of speculations, fear, judgements, complains, unhappiness, and comparisons (Tolle, 1999).

7.2.2. Mind-Wandering and Emotion

The relationship between mind-wandering and emotions is relatively complex. On the one hand, past research indicates that negative emotions lead to mind-wandering (Smallwood, Fitzgerald, Miles, & Phillips, 2009; Smallwood, O'Connor, & Heim, 2005). On the other hand, more current findings suggest that negative moods are a consequence of mind-wandering (e.g., Kilingsworth & Gilbert, 2010).

In comparison with the general population, dysphoric individuals seem to be more concerned with self-relevant information and report a higher level of off-topic thoughts (Smallwood et al., 2007). Moreover, dysphoric students seem to be less able to concentrate on different cognitive tasks, such as reading, proofreading, or listening to a lecture (Lyubomirsky, Karsi, & Zehm, 2003).

Smallwood et al. (2009) investigated the association between mood and mind-wandering, finding that after inducing a negative mood, participants reported a higher frequency of unrelated thoughts than participants in the positive mood condition did. The investigators also reported that the negative mood participants made more errors on a Sustained Attention to Response Task (SART), a go/no-go task in which participants were asked to respond as quickly as possible to a non-target and to inhibit their responses to the target. This task is occasionally used for measuring mind-wandering indirectly. Additionally, Mrazek et al. (2011) demonstrated that when participants are exposed to a stereotypical threat that induces negative emotions (e.g., asking female participants to do a math test in front of male participants), the frequency of mind-wandering rises.

These studies indicate that negative emotions are antecedent to mind-wandering. However, it is equally possible that mind-wandering precedes negative emotions. The mindfulness literature indicates that awareness of the present moment influences well-being and mood, which indirectly implies that mind-wandering diminishes well-being and positive emotions. Indeed, Killingworth and Gilbert (2010) asked more than 2000 participants to report their level of mind-wandering and feelings at random intervals throughout the day. Their findings suggest that there is a prospective association between mind-wandering and feeling unhappy later. However, there was no relationship between feeling unhappy and later mind-wandering. In other words, mind-wandering preceded unhappiness, but unhappiness did not precede mind-wandering.

In another investigation, Poerio, Totterdell, and Miles (2013) revealed that inducing sadness increased the frequency of mind-wandering and mind-wandering by itself did not promote negative feelings. The investigators reported that the content of mind-wandering, whether it is aversive or not, significantly influences later emotions. For example, when the affective content of mind-wandering is sad, participants report higher levels of sadness 15 minutes later. Similarly, anxious mind-wandering is related to higher levels of anxiety 15 minutes later.

The findings of studies on mind-wandering and emotions are encouraging. This area of research can be explored further by using specific negative emotions, such as shame, and using different methods for measuring mind-wandering. In addition, research on mind-wandering and shame may indirectly contribute to the literature on mindfulness.

Therefore, in the current study, it is hypothesised that shame has a significant effect on mind-wandering according to the following reasoning:

1. Negative moods promote the likelihood of mind-wandering about a past event and rumination (Smallwood & O'Connor, 2011). Therefore, feelings of shame may lead individuals to ruminate over the shameful incident and the past.

2. Individuals may engage in mind-wandering in order to improve their mood (Mason, Brown, Mar, & Smallwood, 2013).

3. Shamed individuals are likely to use different strategies to avoid thinking about or feeling shame; they may engage in mind-wandering/daydreaming in order to escape from painful feelings of shame.

Because this study induces a state of shame (vs. pride), it is important to measure trait shame and self-compassion, and to explore how individuals who score high in these measures differ from those who score low in relation to mind-wandering. However, before undertaking the main study, to assist with developing a new paradigm for inducing shame, an exploratory pilot study was conducted to explore shame induction as well as individuals' patterns of thoughts after shame induction.

7.2.3. Pilot Study

To gather information about the development of a new paradigm for inducing shame, 20 to 30 participants were invited to recall and write about their personal experience of shame. Consistent with the literature, participants' accounts were idiosyncratic. Shame did not seem to have any clear antecedent. Tangney and Dearing (2002) stated that "most types of events (e.g. lying, cheating, stealing, failing to help another, and disobeying parents) were cited by some people in connection with feelings of shame and by other people in connection with guilt" (p. 17). For example, suppose someone tells a lie and the lie causes distress. If that person thinks, "I am a horrible human being," he or she is likely to feel shame. However, if he/she focuses on a single behaviour (i.e., telling a lie) and concludes, "My action was bad, not me," he or she is

likely to feel guilt (Niedenthal et al., 1994). Everything depends on how the individual interprets the role of the self (Parker & Thomas, 2009). After examining students' personal experiences and the literature thoroughly, it was decided that the best way to induce shame in this study was through an autobiographical recall procedure. Using participants' own shame experiences rather than a standardised trigger event gets around the problems associated with idiosyncratic nature of shame.

Autobiographical recall procedures are often used for evoking negative or positive emotions (Leith & Baumeister, 1996), and shame has previously been induced using this method (Yang et al., 2010). Although the extent to which someone can remember a personal experience and re-evoke a past feeling is debatable, the method takes individual differences into consideration, which can be considered an advantage. Moreover, rather than focusing on a hypothetical situation, this method asks participants to recall a real life episode of shame, potentially adding to the value of the emotion elicitation.

The primary aim of the next part of the pilot study was to induce shame and then investigate participants' patterns of thought. The study was approved by the Department of Psychology Research Ethics Committee (Refrence number: 12-007) and conducted during a psychology lecture. Participants were first asked to describe a personal experience of shame. They were further instructed to try to remember how they felt, to re-evoke the feelings that they had experienced at the time. Unknown to participants, two confederates were seated in the front row of the lecture room; the plan envisioned that participants would write about their experience for a maximum of 4 minutes, while the confederates would keep writing until the lecturer told them to stop. The participants had to wait approximately 3 minutes for the confederates to finish writing.

The main purpose of this was to examine the thoughts that participants experienced during those 3 minutes.

After this procedure, participants were asked to answer several questions about their recent thoughts (see Appendix D). Participants indicated that we were interested about what they were thinking immediately after writing about their shame memory. They were asked, for example, to indicate how much they were thinking about good things that had happened in the past, thinking about everyday things, daydreaming about future, etc.

To check for the effectiveness of the manipulation, participants were asked at the end to indicate how much shame they felt when they were writing about their shameful experience, and also how much shame they felt at that moment, on a 5-point scale (1 = *Not at all*, 5 = *Extremely*). Out of the 27 participants who participated in this study, 2 did not feel ashamed at all, 7 felt slightly ashamed, 11 felt moderately ashamed, and 7 felt very ashamed when describing their personal experience of shame. A decision was made to exclude the results of those 9 participants who did not feel any shame at all or felt it very slightly. The majority of the remaining participants reported that during the three minutes interval, they were thinking about the shameful event they had described or the purpose of this study (i.e., why they are being asked to write about their experiences and what is the aim of this study?).

Responses to questions asking about positive situations (Q1, Q3, Q6, Q9, Q12, and Q14) and thinking about negative situations (Q4, Q5, Q8, Q11, and Q13) were added together. The result was that participants had more negative thoughts ($M = 8.22$, $SD = 2.13$) than positive thoughts ($M = 7.66$, $SD = 1.98$). However, the difference between the means was not significant ($t (26) = -.96$, $p = .34$).

A few main points can be concluded from this pilot study:

1. Inducing shame is challenging. The majority of the participants in the study reported moderate feelings of shame after describing their personal experiences. However, it should be noted that evoking feelings, especially painful feelings such as shame, are likely to be more difficult in crowded places, such as a lecture room, where the presence of everyone can be sensed.

2. After the recall of the shameful experience, participants reported slightly more negative than positive thoughts.

3. During the 3-minute period, the majority of participants (n = 17) stated that they thought about the shameful incident they had been asked to describe (i.e., rumination).

Nonetheless, the results from this study should be treated cautiously, because the study was done in a lecture room, and not all of the participants followed the instructions they were given (e.g., some of them started to talk to their friend during the 3 minutes and some were reluctant to remain quiet). For the primary study, it seems more reasonable to examine the relationship between shame and mind-wandering using a more rigorous method than that used in the lecture room. As noted earlier, the main hypothesis of this study is that the participants in shame-inducing condition will show more signs of subsequent mind-wandering than those in the pride or control condition.

7.3. Method

7.3.1. Participants

One hundred and twenty participants (82 female and 38 male, M_{age} = 24.28, SD = 8.12) were recruited for this study. The sample included students from the University of Bath (60%), as well as people who work at the University of Bath or visited the

University. The majority of the participants (93.3%) were native English speakers and the remainder were fluent in English to participate in the study.

7.3.2. Procedures

This study was approved by the Department of Psychology Research Ethics Committee (Reference number: 12-105). Before commencing the study, the procedure was piloted with a group of approximately 20-30 volunteers who gave comprehensive feedback in order to improve the process. The main study was advertised at the University of Bath. Participants were offered the choice between course credits or £5 for their time. The study was conducted in the social psychology laboratory at the University of Bath. In order to protect the privacy of participants, only one participant was invited to the lab during each time slot. All of the materials were presented on a computer and the computer recorded the responses of the participants using MediaLab software.

Participants were systematically assigned to the shame, pride, or control condition (Appendix D). The first participant was assigned to the shame condition, the second participant to the pride condition, the third participant to the control condition, and so forth. Emotions were evoked using an autobiographical recall procedure (Yang et al., 2010). Since shame is a negative self-conscious emotion, it was decided to include pride, which is a positive self-conscious emotion and contradicts characteristics of shame. Considering pride as well as shame allows us to control the effects of emotional conditions and to examine whether a negative self-conscious emotion, such as shame, affects mind-wandering differently than a positive self-conscious emotion, such as pride.

For the shame and pride conditions, participants were initially asked to take a few seconds to think about shame or pride in general. They were then asked to recall

and write as vividly as possible about a personal experience, in which they had felt a strong sense of shame or pride. They were asked to think about this event in detail by responding to the following questions: (a) What was the emotional event? (b) Why did it happen? (c) How did you feel then? and (d) What was the consequence of that event? (Yang et al., 2010). Most importantly, they were asked to recall how they felt; re-evoking the feelings that they had at the time.

For the control condition, participants were first asked to recall and write about what they had eaten for dinner the night before. For example, they were asked to think and write about the following questions: (a) What did you have last night for dinner? (b) Why did you have that? (c) How did you prepare that (or where did you buy that)? and (d) How long did it take to prepare (or buy) that meal? The aim was to make the control condition as equivalent as possible to the conditions in which the participants were experiencing emotions.

As a manipulation check, participants were asked to indicate the extent to which they felt shame, pride, sadness, or happiness after writing about their experiences (1 =*not at all, 5 = extremely*).

In order to measure mind-wandering, participants were then instructed to read a three page text about the geography of rivers that was not very engaging (Appendix D). After reading the text, participants were asked to report on their unrelated thoughts while reading. The frequency of mind-wandering was measured by answering the following question on a 10-point scale: "To what extent did your mind wander during the reading?" Participants were also asked to answer six surprise questions about the text; mind-wandering is thought to affect text comprehension as well as the speed of reading (Sayette, Reichle, & Schooler, 2009). The amount of the time participants spent reading the text, the reading test scores (i.e., memory test), the frequency of mind-

wandering, and the subjective report of unrelated thoughts, were all used to assess mind-wandering.

In the next step, participants assigned to pride and shame conditions were asked to answer three questions: (a) "During the reading task, to what extent did you have thoughts or feelings related to the memory we asked you to think/write about?" (b) "To what extent did you feel shame (or pride for those assigned to the pride condition) when you were thinking and writing about your personal experience of shame (or pride)?" and (c) "Sometimes strong emotions can be uncomfortable for us. Our minds are reluctant to stay with them. To what extent did you find that, during the memory task (recalling and writing about shame/pride experiences), your mind would go to different things so as not to feel a strong emotion?"

The aim of the first question was to measure the *frequency of emotionally related thoughts* during the reading task in the pride and shame conditions. The second question measured the *intensity of the emotional experience* in the shame and pride conditions. The last question assessed the level of *avoidance* during the shame and pride condition.

At the end of the experiment, the participants were asked to complete the trait shame and self-compassion scales described below. Finally, the participants were fully debriefed upon completion and thanked.

7.3.3. Measures

Trait shame was measured using the Experience of Shame Scale (ESS) (Andrews et al., 2002). As mentioned in the previous chapters, this scale consists of 25 items that ask direct questions about three specific areas (i.e., personal characteristics, behaviour, and physical appearance) about which individuals may feel shame. Each of these item is rated on a 4-point scale (1 =*not at all*, 4 = *very much*), with a higher score

indicating a higher level of shame. The internal consistency for this scale has been reported as .92 (Robins et al., 2007).

Self-compassion was assessed with the Short Form of the Self-Compassion Scale (SCF-SF) (Raes et al., 2010). This scale consists of 12 items rated on a 5-point scale (1= *almost never*, 5= *almost always*), with a higher score indicating a higher level of self-compassion. An estimated Cronbach's alpha for this scale is above .86 (Raes et al., 2010).

7.4. Results

7.4.1. The ESS and the Self-Compassion Scale

In the current study, the internal reliabilities for the Self-Compassion Scale (α = .84) and the shame scale (α = .92) were relatively high. The mean self-compassion score was 34.12 (SD = 7.31), and the mean for the shame scale was 57.45 (SD = 13.59). The correlation between self-compassion and shame was -.55 ($p < .001$).

7.4.2. Emotion Manipulation Check

The shame induction protocol was successful, with participants assigned to the shame condition feeling significantly more shame (M = 2.88, SD = 1.02) than the participants assigned to the pride condition (M = 1.43, SD = .78) and control condition (M = 1.50, SD = 1.50) (F (2, 117) = 34.60, $p < .001$). They also felt significantly more sadness (M = 2.38, SD = 1.25) than participants assigned to the pride condition (M = 1.68, SD = 1.07) and control condition (M = 1.55, SD = .85) (F (2, 117) = 6.90, $p < .001$). Participants in the shame condition, reported a significant level of shame after controlling for sadness (F (2, 116) = 25.13, $p < .001$).

The pride induction protocol was also successful. Participants assigned to the pride condition felt significantly more pride (M = 3.60, SD = 1.06) than participants assigned to either the shame condition (M = 1.73, SD = 1.06) or control condition (M =

2, $SD = .96$) (F (2, 117) = 38.83, $p < .001$). In addition, participants assigned to the

pride condition reported a significantly higher level of happiness ($M = 3.40$, $SD = .90$)

than those assigned to either shame ($M = 1.85$, $SD = .97$) or control ($M = 2.65$, $SD = .74$) conditions (F (2, 117) = 24.03, $p < .001$). Participants in the pride condition,

reported a significant level of pride after controlling for happiness (F (2, 116) = 15.71, $p < .001$).

7.4.3. Themes in Shame Descriptions

The most common theme reported were memories of hurting and upsetting

someone or of failing to be a good person (31.4%). Another common theme was

dishonesty or breaking the trust of someone (22.9%) by cheating on someone,

complaining about someone behind their back, breaking something, or blaming

someone else. A third theme was failure to achieve or perform (20%): failing an exam

or being dropped from a sports team. Some participants (14.3%) described a situation

where they felt embarrassed in front of others (e.g., being scolded in a class or saying

something embarrassing in front of others). Another common theme was stealing or

shoplifting (11.4%). About 5.8% indicated that they still felt ashamed as a result of the

event they described.

7.4.4. Themes in Pride Descriptions

Most participants assigned to the pride condition described achievement or

performance related situations. For example, they described their graduation day, the

day that they got their A-level results, or when they won competitions. Only one person

described a situation in which he or she felt a great sense of pride because of helping

others.

7.4.5. Number of Words in each Condition

Participants assigned to the shame condition wrote longer descriptions of their personal experiences than participants assigned to the pride or control conditions. However, a one-way ANOVA (Table 7.1) yielded no significant differences between the groups with respect to the number of words.

Table 7.1

Means, Standard Deviations, and ANOVAs for Variables in Shame, Pride, and Control Condition

	Shame		Pride		Control		ANOVA	
	Mean	*SD*	Mean	*SD*	Mean	*SD*	*F*	*p*
Number of words	157.05	84.60	139.87	80.45	131.30	71.70	1.10	.34
Recall time	679393	41066	50333	24109	39335	13318	10.48	<.01
Describe time	432563	226189	374543	215321	290362	170181	4.98	<.05
Mind-wandering	5.75	2.35	5.90	2.42	5.85	2.51	.04	.96
Memory test	3.55	1.39	3.07	1.56	3.57	1.55	1.40	.25
Thoughts	2.60	2.28	2.90	2.15	3.12	2.06	.57	.57
Unrelated words	48.22	51.86	49.42	45.63	46.30	36.48	.05	.95
Reading time	100407	40730	92446	44454	91074	29348	.66	.52

Note. Mind-wandering = The frequency of mind-wandering; Memory test =The scores in the reading test; Thoughts= The numbers of unrelated thoughts that participants had while they were reading the text; Unrelated words= The counting words written in response to the unrelated thought question; Reading time = the time participants spent on the reading task. Time values were recorded in milliseconds.

7.4.6. Recall and Describe Time in each Condition

A one-way ANOVA demonstrated that participants assigned to the shame condition spent significantly more time recalling and describing their personal experiences of shame than participants assigned to either pride or control conditions (Table 7.1).

7.4.7. Mind-Wandering

Participants in the three conditions did not differ significantly in terms of the frequency of mind-wandering, performance on the memory test, or the extent of unrelated thoughts. In addition, the effect of the conditions on the time spent reading the text, after controlling for the effect of participants' reading speed, was non-significant (Table 7.1). Therefore, the primary hypothesis of this study is rejected.

7.4.8. Trait Shame and Mind-Wandering

Regardless of the experimental condition, trait shame significantly predicted the frequency of mind-wandering ($\beta = .21$, $R^2 = .04$, $p < .05$). However, trait shame did not explain a significant proportion of variance in the memory test ($\beta = -.02$, $p = .79$), the extent of unrelated thoughts ($\beta = .15$, $p = .09$), or the amount of time spent on the reading task ($\beta = -.10$, $p = .24$).

7.4.9. Trait Self-Compassion and Mind-Wandering

As with the previous section, regression analyses were conducted to examine the influence of trait self-compassion on mind-wandering. It was found that trait self-compassion did not significantly predict the frequency of mind-wandering ($\beta = -.16$, $p = .06$), scores on the memory test ($\beta = -.13$, $p = .14$), the level of unrelated thoughts ($\beta = -.05$, $p = .52$), or reading time ($\beta = .03$, $p = .74$).

7.4.10. Frequency of Emotional Thoughts, Intensity of Emotion, and the Level of Avoidance

In this section, the responses to the three questions asked of the participants in the shame and pride conditions after the memory test are considered (Table 7.2). An independent t-test demonstrated that participants assigned to the shame condition did not significantly differ from participants who were in the pride condition regarding the frequency of emotionally related thoughts during the reading task or the level of

avoidance. However, with respect to the intensity of the emotional experience, participants assigned to the pride condition felt significantly more pride and were more able to evoke feelings of pride when they were thinking and writing about their personal experience of pride than participants who were assigned to the shame condition and were asked to recall a personal experience of shame.

Table 7.2

Means and Standard Deviations for Emotional Thoughts, Intensity, and Avoidance in Shame and Pride Conditions

	Shame		Pride		t-Test	
	Mean	SD	Mean	SD	t	p
Emotional thoughts	3.80	2.45	3.43	2.77	.64	.52
Intensity	6.85	2.71	8.13	2.32	-2.28	<.05
Avoidance	4.08	2.45	4.03	2.68	.08	.93

Note. Emotional thoughts = The extent participants had thoughts and feelings related to the memory during the reading task (Q1); Intensity = The extent participants felt shame/pride when they were remembering their experience (Q2); Avoidance = The extent participants' mind wandered in order to avoid feeling a strong emotion (Q3).

7.4.11. Effects of Trait Shame and Self-Compassion on Emotional Thoughts, Intensity of Emotional Experience, and Avoidance

It was decided to next consider the effects of trait shame and self-compassion on the frequency of emotional thoughts, the intensity of emotional experience, and avoidance after shame and pride manipulations. Trait shame did not significantly predict the level of emotionally related thoughts during the reading task (Question 1), the intensity of emotional experience (Question 2), or the level of avoidance (Question 3) for either condition (Table 7.3).

For shame and pride conditions, trait self-compassion also did not significantly predict the level of emotionally related thoughts or the intensity of emotional experience. For the shame condition, trait self-compassion did not explain a significant proportion of the variance in the level of avoidance. However, for the pride condition,

trait self-compassion significantly predicted the extent of avoidance (Table 7.3).The

findings indicated that participants in the pride condition who had a higher score for

self-compassion were less likely to avoid their evoked emotions, while those who had a

lower score on self-compassion were reluctant to stay with their feelings of pride and

more inclined to avoid these feelings.

Table 7.3

Regression Analyses Predicting Emotional Thoughts, Intensity, and Avoidance from
Trait Shame and Self-compassion in Shame and Pride Conditions

	Shame Condition						Pride Condition					
	Emotional thoughts		**Intensity**		**Avoidance**		**Emotional thoughts**		**Intensity**		**Avoidance**	
	β	*p*	*B*	*p*	*β*	*p*	*β*	*p*	*B*	*p*	*β*	*p*
Trait shame	.08	.60	.16	.30	-.04	.78	-.01	.97	.09	.57	.23	.14
Self-compassion	-.20	.19	-.17	.27	-.12	.46	-.02	.89	.09	.56	-.44	.004

Note. *β* = Standardised Coefficients; Emotional thoughts = The extent participants had thoughts and feelings related to the memory during the reading task (Q1); Intensity = The extent participants felt shame/pride when they were remembering their experience (Q2); Avoidance = The extent participants mind wandered in order to avoid feeling a strong emotion (Q3).

7.5. Discussion

This study has demonstrated that participants in the shame condition spent

significantly more time recalling and writing about their shameful experiences than

participants in the pride and control conditions. These results are consistent with

previous studies (e.g., Tangney, 1992) indicating that retrieval of shame related

memories can be a taxing task. In fact, this study demonstrates that participants in the

pride condition were more able to evoke feelings of pride in comparison to those who

were in the shame condition. Evoking feelings of pride is considerably less demanding

than evoking feelings of shame.

In the pride condition, self-compassion was inversely associated with the level of avoidance; it significantly predicted the avoidance of emotional thoughts and feelings during the reading task. However, such association and prediction was not observed in the shame condition. In addition, self-compassion did not influence the frequency and the intensity of emotional thoughts and feelings in the shame condition, a factor which is inconsistent with the previous results. For example, in the self-compassion literature, Leary et al. (2007) reported that self-compassion functions as a buffer against negative emotions and life events; self-compassionate individuals seemed to be less affected by failures and negative outcomes (Leary et al., 2007).

For mind wandering, the results demonstrated that individuals high in trait shame reported a significantly higher frequency of mind-wandering than participants low in shame in all experimental conditions. This finding implies that individuals suffering from significant levels of shame engage in more mind-wandering than individuals who do not often experience shame. However, since both shame and the frequency of mind-wandering were self-reported, we should interpret this relationship with caution. Alternatively, the association between trait shame and mind-wandering might be due to the existence of other factors, such as neuroticism (Brown & Ryan, 2003; Mason et al., 2013).

Aside from the association between trait shame and the frequency of mind-wandering, the main findings of the study indicate that shame does not have a significant effect on mind-wandering; this leads to the rejection of the main hypothesis. Participants in the shame condition did not have a significantly lower (or higher) score in the memory test; they did not spend significantly more time on the reading task; and they did not report a higher number of unrelated thoughts during the reading task than participants in the pride or control conditions.

The lack of a clear causal relationship between shame and mind-wandering might be due to several factors. It appears that methods used to assess mind-wandering are of debateable use for detecting associations between negative emotions and mind-wandering. For example, Mrazek, Smallwood, and Schooler (2012) found that negative emotion was correlated with errors on the Sustained Attention to Response Task (SART), but not with a self-reported measure of daydreaming. "The association between mind-wandering and negative effect may emerge only during pronounced task-disengagement" (Mrazek et al., 2012, p. 5).

More importantly, shame can be a transitory emotional state (state shame) or chronic emotional disorder (trait shame). Shame as state emotion is likely to last for only a short period. It may also be substituted by a less painful emotional state, such as anger or regret (Hahn, 2000). Individuals also cope with state shame or trait shame differently (Behrendt & Ben-Ari, 2012; Lickel, Kushlev, Savalei, Matta, & Schmader, 2014). For instance, de Hooge et al. (2010, 2011) challenged the link between state shame and withdrawal tendencies. The authors argue that individuals who experience state shame attempt to repair a devalued self rather than withdraw from the situation. According to this argument, shamed individuals should have performed better on the reading and memory task in this study in comparison with those who were in the control group. However, the difference between conditions was non-significant. The research on state shame indicates that individuals may behave less consistently after experiencing state shame (induced shame). Many factors can interfere with how people react to the experience of shame. Sometimes it seems impossible to identify a distinct pattern. For example, factors such as situational context (Silfver, 2007), personality traits (Carver & Conner-Smith, 2010), and cultural factors (Bagozzi et al., 2003) may

affect how individuals who are not prone to shame cope/deal with the experience of shame.

In real life experiences, it is still conceivable that the immediate response after experiencing state shame is likely to be avoidance and withdrawal (e.g., desire to hide or escape from the shame-inducing situation), after which, individuals may start to ruminate over the shameful incidents. In the long term, however, individuals may seek to enhance their self-image and take compensatory actions. For example, if one feels shame after giving a bad presentation, the immediate reaction would likely be to leave the situation. In future presentations, that person may work harder to avoid further failure or restore their self-image. The response depends on the nature of the situation or the level of motivation that one may have.

In contrast, when shame is experienced frequently or almost frequently (i.e., chronic shame), and individuals do not have access to resources or options to seek self-enhancement, they are likely to use avoidance-oriented strategies (de Hooge et al., 2010, 2011). For example, if one feels ashamed of being poor or unattractive, and they do not have any options to change the situation, he or she may attempt to use escapism strategies (e.g., daydreaming/mind-wandering) in order to alleviate mood or, in extreme situations, make life bearable. It is similar to watching TV or reading a fictional book, activities that are often pursued to forget the harsh reality of life. Therefore, it is possible that highly shamed individuals (trait shame) engage in mind-wandering or daydreaming frequently and compulsively, the use of strategies, like mind-wandering, may temper a negative mood and depression (Schoenleber & Berenbaum, 2012). As noted in Chapter 2, it may be that individuals who ruminate over their feeling of shame become depressed, while those who engage in positive mind-wandering (wishful thinking) can discard negative emotions, at least temporarily. In the long term, however,

compulsive mind-wandering and wishful thinking can be maladaptive and frustrating. It should also be noted that the association between trait shame and mind-wandering may be only palpable in real life situations rather than in laboratory research.

The extent to which participants are able to evoke feelings of shame in the laboratory remains questionable. Participants might be remembering the shameful incident rather than the actual experience of shame; they may have come to terms with previous feelings or the situation may have been resolved, but it is still in their memory. In addition, writing about positive (Burton & King, 2004), negative or stressful experiences and emotions (Baikie & Wilhelm, 2005) can have therapeutic effects; it may assist individuals to rectify their unresolved feelings. Therefore, recalling and describing a negative emotion may have contradictory effects; on the one hand, it may induce negative emotions, and on the other, it might resolve evoked negative emotions. This paradoxical effect of the autobiographical procedure should be acknowledged.

In addition, since the study relied on autobiographical recall to elicit shame, there was a great variation in shame memories and descriptions. Some participants recalled a situation where they had cheated on their partner, others described their academic failures, and still others recalled situations where they had done something wrong, such as lying, stealing or upsetting someone. Though autobiographical recall is a well-established methodology, we cannot be certain that only feelings of shame were evoked during the recall of the majority of these situations. Recall of a negative situation can induce a wide variety of negative emotions such as sadness, guilt, shame, and embarrassment. For example, after lying or cheating, people are very likely to feel guilt or embarrassment as well as shame. As such, we can only assume that shame was the dominant emotion in some of these situations. This much said, it is clear that emotions, specifically self-conscious emotions such as shame and guilt, are highly

intertwined with one another, and therefore it is unreasonable to suppose that they can be studied as absolute discrete entities.

It is also possible that the manipulation check in this study was affected by demand characteristics. Because participants were explicitly asked to re-evoke feelings they had at the time, and afterwards were asked to rate their emotion, it is a possibility that they felt obliged to feel shame or pride and rate their feelings accordingly. Furthermore, had participants been able to evoke genuine feelings of shame, these feelings may have been short-lived and would have diminished before commencing the reading task. It is also possible that the participants in each of the conditions engaged in mind-wandering, because they found the reading task mundane, demanding, or irrelevant to their current goal.

Another issue that should be considered is that this study was conducted in the social psychology laboratory at the University of Bath. Our recruitment target was 120 participants (40 in each condition) as this number would ensure relatively adequate statistical power for the analyses. As no funds were available to compensate volunteers for their time initially (for the first few months), recruitment took about 9 months and the majority of the participants were students. It can be argued that recruiting participants from the local community would have taken a longer time since it is not very convenient for the population outside of the university to commute in order to participate in a study that took 30 minutes. Therefore, it was more suitable to rely on the individuals who studied, lived, or worked at the University of Bath at the time of recruitment and students were more available and willing to participate. However, as mentioned in previous chapters, the use of a student sample may have reduced the validity and generalisability of the study as results may be subject to sampling bias.

Overall, inducing shame in the laboratory is very challenging. It still unclear whether shame can be studied in the laboratory and to what extent studying shame in the laboratory is credible. Furthermore, there is a disparity between experiencing shame (state shame) and having a shame-prone identity (Harper, 2011). It is reasonable to believe that shame-prone individuals tend to use avoidance-oriented coping (e.g., denial, mental disengagement, self-distraction, etc.); dealing with the experience of shame (state shame) depends more on the nature of the shameful event or the individuals' disposition. Although continuing this line of research is laborious, it is likely to make a considerable contribution to our understanding of shame and coping. Clearly, some methods of coping are more efficacious in promoting well-being than others. It is important to learn about short-term benefits and long-term costs of the shame management methods; not only might (negative) mind-wandering cause unhappiness, worry, and lead to rumination, but the empirical evidence also indicates that those who gain pleasure from mind-wandering still feel distress when they notice that their mind has drifted and respond negatively (Mason et al., 2013). Since compulsive mind-wandering may occur automatically, without intention or plan, it might be difficult to regulate. That is perhaps why mindfulness and the ability to train the mind to be present-oriented can be highly effective in regulating emotions and thoughts.

Chapter 8. Discussion and Conclusion

8.1. Introduction

This thesis aimed to: a) explore potential factors that contribute to shame vulnerability; b) examine the association of adverse childhood experiences, negative self-judgment and shame; c) investigate the factor structure for the Acceptance of Shame and Embarrassment scale; d) consider the relationships between willingness to experience shame and embarrassment, depression and health outcomes; e) investigate the relationships between mindfulness, self-compassion and shame, and f) examine the effect of shame on mind-wandering.

This final chapter will summarise the results of the empirical studies, examine the implications of these findings, discuss their overall limitations, and suggest avenues for future investigation.

8.2. Summary of Findings

8.2.1. Shame and Adverse Childhood Experiences

Study 1 examined the correlations between adverse childhood variables: recall of parental care versus control, peer acceptance versus rejection, and mothers' socialisation of emotion and shame. As expected, shame was negatively associated with parental care and peer acceptance. In addition, recall of mothers' (or primary carers') reactions to negative emotions during childhood was significantly related to shame, which is consistent with the notion that parents' socialisation of emotions during childhood influences psychological adjustment and emotion regulation. For instance, when parents are receptive to children's emotions, children are more capable of regulating their emotions effectively in later life (Mills, 2005). In addition to considering traditional factors such as parenting styles, it was beneficial and novel to explore the relationship between maternal attitudes towards emotions and shame in this

study. However, it should be mentioned that, in contrast to expectations (M. Lewis, 1992), Study 1 demonstrated that perfectionistic parental expectations did not have a significant association with shame.

8.2.2. Self-judgment and Adverse Childhood Experiences

The review of shame in Chapter 1 indicated that negative self-evaluation and self-hate are prevalent in the experience of shame, and that recalled parenting styles are associated with shame in adulthood. The first study supported a mediation model, that adverse childhood experiences influenced negative self-judgment, which affected the experience of shame. In other words, negative self-judgement mediated the relationship between childhood experiences and shame.

8.2.3. Submissive Coping Strategies and Shame Vulnerability

Study 1 further demonstrated that submissive coping strategies, such as attacking the self in shame-eliciting situations or withdrawing from such situations, explain significant variances in shame over and above adverse childhood experiences. In fact, the effect of adverse childhood experiences on shame became almost non-existent when the effect of submissive coping styles and negative self-judgment were considered. Thus, submissive coping strategies were highly relevant to shame vulnerability.

8.2.4. The Acceptance of Shame and Embarrassment Scale (ASES)

Study 2 provided the first empirical test of the factor structure of the ASES. The study employed an Exploratory Factor Analysis on two independent samples. Findings from both samples indicated that the one factor solution is the best option. The reliability test, test-retest reliability, and associations with similar constructs demonstrated that the ASES had a good internal consistency and construct validity, and provided initial support for the psychometric properties of the ASES.

8.2.5. Acceptance of Shame and Embarrassment, Depression, and Health

Study 2 further demonstrated that scores on the Acceptance of Shame and Embarrassment Scale (ASES) and other acceptance-related variables were significantly correlated with depression and quality of life. In other words, those participants who showed willingness to experience shame and embarrassment reported better health conditions and lower levels of depression.

A question raised following this study was whether the ASES has more incremental validity than do other acceptance-based measures. In Study 2, the ASES did not explain the significant variance in depression and health scores over and above other measures. However, the other acceptance-based measures include items that assess distress and impairment, thus inflating the apparent relationship between acceptance and distress. Given the preliminary nature of this research, further research is needed to investigate this matter. Furthermore, the ASES has a specific focus on shame and embarrassment, while other acceptance-based measures are broader and consider general emotions and thoughts, so the ASES may be valuable for shame-related research. Future research on the willingness to experience shame and embarrassment will contribute to the literature on psychological flexibility and acceptance.

8.2.6. Shame, Self-compassion, Mindfulness, and Acceptance of Shame and Embarrassment

Consistent with the predictions and previous studies (Woods & Proeve, 2014), shame was significantly and negatively correlated with self-compassion and mindfulness. This study further demonstrated that shame and acceptance of shame and embarrassment are significantly and negatively associated.

8.2.7. Self-compassion and the Mindfulness-Shame Relationship

Study 3 demonstrated that the association between mindfulness and shame was fully mediated by self-compassion. These findings may imply that self-compassion is a potential process that underpins the mindfulness-shame relationship.

8.2.8. The Non-judgmental Component of Mindfulness and Shame

The data in Study 3 further indicated that different aspects of mindfulness do not act homogenously with regard to shame. In particular, the non-judgemental component of mindfulness, which measures the evaluative tendency towards feelings and thoughts, showed the strongest (inverse) relationship with the experience of shame; it explained a significant variance in shame over and above self-compassion.

8.2.9. Mind-wandering and Shame

Study 4 explored the effect of shame on mind-wandering during a tedious reading task. Participants were assigned to either the shame, pride, or control condition. The study demonstrated that participants spent more time on recalling and describing their experience of shame than participants in the pride and control conditions. However, participants in the shame condition did not significantly experience different levels of mind-wandering or unrelated thoughts than participants in the pride and control conditions during the reading task. There was also no sign that the text comprehension of participants in the shame condition was affected by the shame induction. Overall, the shame/pride manipulation did not affect the level of mind-wandering. It is noteworthy that regardless of the experimental condition, trait shame significantly predicted the frequency of mind-wandering.

8.2.10. Shame and Awareness-related Strategies

In this thesis, shame was not associated with awareness-related regulation strategies (Chapters 5, 6, and 7). Specifically, in Study 2, the awareness component of

mindfulness was not related to the ASES scores. In Study 3, the relationship between shame and the act with awareness component of mindfulness was relatively small. In addition, Study 4 demonstrated that shame had an insignificant effect on mind-wandering.

Overall, this thesis mainly focused on shame vulnerability and shame management. The first study examined factors that might contribute to shame vulnerability. This study found that shame management and the ways people cope with experiences of shame are more important than adverse childhood experiences and contribute more to shame vulnerability. In fact, adverse childhood experiences did not explain a significant percentage of the variance in shame vulnerability when coping strategies were considered. The literature suggests that avoidance-based strategies such as withdrawal and hiding may contributes to the experience of shame. Aligned with these suggestions, the second study considered acceptance as opposed to avoidance as an effective coping strategy. Findings from the second study showed that individuals who engaged with situations that might have been potentially shaming and who were more willing to experience that shame not only had lower depressive symptom scores but also had higher physical health and quality of life scores. Similarly, the third study suggested that mindfulness and self-compassion, which can be regarded as acceptance-based coping strategies, are beneficial in regulating shame. The findings from the third study indicated that individuals who were more mindful and self-compassionate were less vulnerable to the experience of shame and had lower shame vulnerability scores. Mindfulness and self-compassion might buffer the experience of shame and perhaps protect individuals against the experience of shame. In the last study, the effect of shame on mind-wandering was considered. As Study 3 suggested that being mindful is beneficial in regulating shame, Study 4 sought to assess whether, after the experience of

shame, individuals would engage in mind-wandering or wishful thinking in order to avoid thinking about the shame incident or numb their feelings towards it. The results however seemed to indicate that shame did not significantly influence mind-wandering.

8.3. Implications

8.3.1. Submissive Coping Methods and Childhood Experiences

The impact of parenting on shame has been highlighted in the literature (Gilbert et al., 1996; Lutwak & Ferrari, 1997b; Mills, 2005; Tangney & Dearing, 2002). According to the object-relations theory, shame arises when there is a disruption in early relational bonds (Mills, 2005). Furthermore, Schore (1998) argued that early interactions between infants and primary caregivers affect the brain and neurobiological development of the infants. According to Schore, when shame is activated, parental interactions are crucial for a transition between states (from negative to positive), repairing the state, and regulating shame. Misattunement between a child and his or her parents may impair the child's ability to regulate shame, which causes psychopathology. According to this notion, failing to regulate shame rather than the feelings of shame causes psychological maladjustments. Moreover, Harper and Hoopes (1990) proposed that proneness to shame or the internalisation of shame is associated with the absence of accountability, intimacy, and appropriate dependency in families.

It can be concluded that there is a strong theoretical link between parenting and shame in the literature, and a disposition to shame might be cultivated through shame-promoting experiences during childhood (Mills, 2005; Tangney & Dearing, 2002). However, in Study 1, the degree of correlation of shame with variables measuring adverse childhood experiences was relatively small (*rs* ranged from .20 to .30), while the correlations between submissive coping strategies, negative self-judgment, and shame were strong ($r > .60$).

The results are consistent with the theory that adverse childhood experiences will contribute to chronic shame through the development of submissive coping strategies and/or negative self-judgements. It might be also implied that, regardless of adverse childhood experiences, interventions and strategies that target self-judgment and submissive coping strategies may be efficacious for individuals highly vulnerable to the experience of shame.

Although it should be acknowledged that Study 1 was retrospective and might have been biased by the participants' moods or memory, we can be tentatively optimistic about the findings and investigate them further in future studies. Accepting, and dealing with childhood experiences or memories can be a very challenging process from a personal and a therapeutic point of view; it is likely that many people will find memories of their early adverse experiences very upsetting. As a result, tackling negative self-beliefs and destructive coping strategies might be less demanding and challenging. Different therapeutic models place more emphasis on the emotional processing of early experiences than current beliefs and behaviours (e.g. psychodynamic therapies versus cognitive behaviour therapy respectively).

8.3.2. Self-judgement, Self-compassion, and Shame

Aligned with previous research (Baer et al., 2012; Hollis-Walker & Colosimo, 2011), this thesis demonstrated that self-compassion is a stronger predictor than is mindfulness in relation to the experience of shame. Therefore, the importance of self-compassion must be stressed in future research (Ferreira et al., 2013; Gilbert, 2009; Mosewich et al., 2011).

Furthermore, negative judgment (measured by the five facet of mindfulness scale; see Chapter 6) and negative self-judgment (measured by the self-compassion scale; see Chapter 4) both correlated strongly with shame. These findings might point to

a self-evaluative origin of shame, and support the notion that shame can be manifested through self-blame and self-criticism (Gilbert & Miles, 2000). However, since these studies were correlational, any conclusions of a causal nature remain speculative. Therefore, it cannot be concluded with certainty that reducing negative self-judgment necessarily decreases shame. That being said, given the results of previous studies (e.g., Johnson & O'Brien, 2013) and interventions such Compassion Focused Therapy (CFT; Gilbert, 2009), it seems likely that self-accepting attitudes and self-compassion are highly beneficial for individuals high in shame. Furthermore, one strong advantage of these coping strategies, especially for individuals so high in shame they avoid social encounters (even, for example, visiting a therapist), is that they can be self-administered (Johnson & O'Brien, 2013). Of course, for those individuals who are able to visit a therapist, it is likely that receiving acceptance from a therapist may facilitate the cultivation of the person's own self-acceptance

8.3.3. Acceptance of Shame and Fear of Negative Evaluation

In Study 2, the ASES scale, which is measured with items such as "I can't bear feeling embarrassed or ashamed" and "There are situations that I am not willing to go into because I might feel ashamed or embarrassed," was significantly correlated ($r > -.70$) with the construct of fear of negative evaluation; the latter is measured using items such as "I worry about what other people will think of me even when I know it doesn't make any difference" or "I am frequently afraid of other people noticing my shortcomings." This high correlation implies that apprehension about the evaluation and judgement by others (which is closely related to social anxiety), inhibits an individual's willingness to experience shame and embarrassment. For example, if one fears judgement and evaluation, he or she is less likely to put him/herself in situations that might elicit shame or embarrassment. Overcoming the fear of negative evaluation may

provide a context for willingness to experience shame and embarrassment, or vice versa.

Furthermore, Study 3 demonstrated that acceptance of shame and embarrassment was significantly associated with self-compassion ($r = .68$) and mindfulness ($r = .51$). Mindfulness and self-compassion are conceptualised in such a manner that acceptance seems to be an essential part of them (Germer, 2009; Kuyken et al., 2010). Specifically, the non-judgemental and non-reactive aspects of mindfulness, which were significantly correlated with the ASES, invite individuals to respond to their thoughts and emotions without judgment or reaction (Baer et al., 2008). Non-judgement inherently means acceptance. In other words, when emotions or thoughts are accepted (willingly experienced), they are no longer judged or criticised.

Therefore, it can be suggested that high correlations of the ASES with fear of negative evaluation, self-compassion, and mindfulness occurred because all elements measure judgemental (non-judgemental) tendencies. Simply put, the factors that connect these constructs appear to be judgement and evaluation. This may re-emphasises the importance of judgement and self-judgement, and how it may influence well-being and quality of life.

8.4. Reflections

8.4.1. Shame Contexts

With hindsight, I believe that the context in which shame occurred and was recalled by participants in Study 4 was important. In future studies, it will be necessary to clarify if feelings of shame are due to a sense of wrong (cheating, shoplifting, and disrespecting parents), or if individuals feels shame because they have characteristics considered shameful (poor, disabled or unattractive). If someone has done something wrong and feels responsibility and shame, that person may manage shame differently

from a person who has not done anything wrong but is somehow "made to" feel shame.

As noted in Chapter 1, Gilbert (1998) distinguished between feelings of shame and

being shamed, and it is very likely that the differences between different forms of

shame influence the characteristics and nature of shame management strategies.

For a better understanding, it might be helpful to look at Van Vliet's (2008)

study. Although shame does not have a recognisable elicitor (M. Lewis, 1992), after

interviewing participants, Van Vliet (2008) categorised shamed-related events

according to four groups:

(a) social, moral, or personal transgression (e.g., becoming drunk and blacking

out at a formal social event, in full view of people whom the participant had

wanted to impress; lying to a friend, against the participant's moral and religious

convictions; being accused of rape and being demoted from work as a result;

being caught stealing and convicted of petty theft); (b) personal failure (e.g.,

declaring personal bankruptcy; being turned down for medical school 2 years in

a row); (c) ostracism or social rejection (e.g., being ostracized after being

convicted of a highly publicized crime; being shunned by family members at a

funeral after undergoing a sex-change operation); and (d) trauma (e.g., being

raped). (p.237)

In this thesis (Chapter 7), the most common shaming situation participants

recalled involved personal failure and moral transgression (upsetting someone, cheating

on someone, breaking trust, academic failure, and shoplifting). Shame that is the result

of personal failure and transgression (i.e., academic failure) is more likely to motivate

individuals to take compensatory action than shame that is caused by trauma (i.e., being

raped). Therefore, the contexts of shame and the extent to which shame may have long-

lasting effects may be crucial when exploring shame management methods in future

studies. In fact, an immediate response to a shaming situation might differ from a long-term shame management strategy (Lickel et al., 2014).

Furthermore, in some situations, when individuals take compensatory actions, feelings of shame might be substituted by pride or happiness adding another layer of complexity. For instance, shame that is induced as a result of academic failure may motivate someone to compensate by working hard in the next exam and ultimately getting a good grade. Now, if someone recalled and described such as a scenario in Study 4, did he/she really feel shame or pride? The situation initially induced shame, but consequently led to achievement.

Although the success of the emotion-induction protocol was confirmed in Study 4, the use of an autobiographical recall method for inducing emotions such as shame is problematic. The advantage of this method is that it captures the idiosyncratic nature of shame; however, it is highly context dependent. There is a great degree of variation in shame recollections and descriptions. A problem present throughout this thesis, and which remains unsolved, is how to induce feelings of shame ethically and realistically.

8.4.2. The Importance of Being Present

While this thesis showed that shame was not highly associated with attention-based strategies (Chapters 6 and 7), the importance of being present and acting with awareness should not be neglected. Many strategies that are employed to regulate shame might be subtle and maladaptive. There is a possibility that these subtle strategies occur automatically and without awareness (Fitzsimons & Bargh, 2004). For example, day dreaming or other forms of avoidance-related methods may occur without realisation, especially when they provide an incentive such as temporarily inducing positive feelings. Although it is highly beneficial to recognise and identify subtle methods used to manage shame, it is not always possible. Therefore, learning to act in

the moment could counteract automatic shame management methods and indirectly lead to effective regulation. It would be beneficial to promote these kinds of strategies for individuals suffering from chronic shame and engaging in maladaptive regulation strategies.

8.5. Shame Management

8.5.1. Why is Studying Shame Management Important?

The intention of this thesis was not to vilify shame. There are, of course, occasions in which feelings of shame might be constructive (Chapter 2), or can enhance self-improvement, growth, and self-awareness (Van Vliet, 2008). In fact, the belief and perceptions that shame is extremely painful and unbearable, called shame aversion, is associated with psychopathology (Schoenleber & Berenbaum, 2010). As suggested by the ASES measure, extreme fear of shame and a high motivation to reduce shame may lead individuals to avoid any circumstances that might potentially be shame eliciting, which, in turn, increases the possibility of psychological maladjustment (Schoenleber & Berenbaum, 2010).

Indeed, Lickel et al. (2014) demonstrated that after recalling a personal experience of shame, participants reported a higher degree of motivation to change the self, describing an ''urge to become a better person'' or a strong desire to ''change aspects of my personality'' (p.1052), in comparison to the participants who recalled a personal experience of embarrassment. However, according to Lickel et al. (2014), a strong determination to suppress painful feelings of shame and avoid shame inducing situations might counteract that desire for change.

Moreover, as mentioned in Chapter 1, the desire to eliminate shame can occasionally motivate individuals to take drastic measures to save face and reduce shame (for example, by engaging in honour killing). Thus, the fear of anticipated

shame, a tendency to view shame as an extremely painful emotion, and the desire to avoid shame at any cost, are likely to cause grievous damage.

However, if feelings of shame are so persistent and overwhelming that they paralyse various aspects of life, they should be managed. It is well established that difficulties in regulating emotions can lead to the development of a variety of emotional disorders (Campbell-Sills & Barlow, 2007). In Chapter 2, it was argued that the manner in which shame is managed can have a great impact on how shame is resolved or whether it reoccurs. More often, the use of maladaptive strategies contributes to feelings of shame and the maintenance thereof. In other words, maladaptive coping strategies create a vicious cycle that does not only resolve feelings of shame, but which also has a negative impact on other aspects of life.

For example, Brown (2012) suggested that, in order to foster resilience to shame, shame messages should be recognised and identified (what is shameful for me and when do I feel shame). These shame messages should then be critically evaluated to determine whether they are real or achievable. In addition, ashamed individuals need to connect/share their shame experiences with empathic and trusting allies who are able to understand their shame and vulnerability, and who can help them to deal with the shaming situation with kindness and compassion. Brown also argued that connection and a sense of belonging are vital for resolving feelings of shame and shame recovery. Indeed, Chen, Hewitt, and Flett (2015) demonstrated a significant association between need to belong and shame; Leeming and Boyle (2013) found that connections with others and social validation were essential for rehabilitating feelings of shame.

Using qualitative methods, Van Vliet (2008) also concluded that individuals try to rebuild the self through five processes after experiencing shame: (a) connection: trying to socialise with others, talk about their shame experiences, or connect with a

higher power; (b) refocusing: focusing on positive things, self-enhancement, and taking some action; (c) acceptance: accepting the shaming situation and expressing one's feelings; (d) understanding external factors: separating the self from shame, developing self-awareness, and trying to evolve; and (e) resisting: rejecting negative judgements and challenging others' beliefs about the self.

Previous research implies that social relationships, social support, and a sense of belonging are essential for overcoming feelings of shame. Individuals with a high degree of shame long to be accepted, desired, and to belong. However, a tendency to avoid or withdraw, which is often observed in individuals vulnerable to the experience of shame (Tangney & Dearing, 2002), becomes a significant barrier to building social connections and relationships (Black, Curran, & Dyer, 2013). When high-shame individuals fear judgement not only by strangers, but also from close friends and family members (Fall, 2014), and withdraw from social situations, they have little chance of breaking down feelings of isolation. As argued in the thesis, avoidance, as a coping strategy, might have detrimental long-term effects and results in negative outcomes (Carver & Connor-Smith, 2010; Connor-Smith & Flachsbart, 2007). Therefore, it is extremely important to recognise and identify factors that contribute to the maintenance of shame, and factors that might break the vicious cycle of shame. Research in such areas is key to cultivating shame resilience and to resolving chronic shame.

8.5.2. Shame-focused Interventions

In an ideal world, we should look for shame management strategies that are both effective and accessible, feasible, cost effective, and convenient to implement. One way to assess the success of shame-management methods is to inspect therapies and interventions that directly and specifically target shame. While these shame-focused

approaches are rare (Dearing & Tangney, 2011), there are some recommendations, which can be focused alternatively.

One of the basic methods for addressing shame is provided by Tangney and Dearing (2002); they claimed that educating individuals about the difference between shame and guilt could be highly beneficial and argued that the maladaptive nature of shame and its focus on the self, as opposed to the adaptive nature of guilt and its focus on transgressive behaviours, should be highlighted. By taking this informative approach it is hoped that parents, teachers, or other authorities will separate the actions from the self, and condemn the actions rather than the person.

As mentioned in Chapter 2, reattribution strategies (Tracy & Robins, 2007a) can be employed to manage and resolve shame. Instead of attributing negative events to the self and one's characteristics, individuals high in shame could be encouraged to concentrate on their actions or behaviour (Van Vliet, 2008). For example, instead of believing that *I am a bad person*, ashamed individuals should consider an alternative such as *I did a bad thing*. Reinforcing the idea that the self is not defined by actions is very appealing; however, the extent to which people are able to successfully and realistically separate the self from actions is debatable.

Furthermore, reappraisal skills (Gross, 1998) or cognitive-based therapies and techniques, such as Cognitive Behavioural Therapy (CBT; Fennell, 2009) may help individuals suffering from chronic shame. CBT is based on the idea that elicitations of emotions are influenced by beliefs and interpretations of events; hence, CBT focuses mainly on cognition and thought processes (Hofmann & Amundson, 2008). In the experience of shame, CBT-based techniques may help individuals to identify destructive thoughts and beliefs and to challenge "the shame-elicited dysfunctional thoughts" (Treeby, 2011, p. 236).

Other types of strategies that are useful to tackle shame are those that target shamed-focused action tendencies (avoidance, withdrawal, and hiding). For instance, Rizvi and Linehan (2005) employed Opposite Action strategy, which is a primary element of Dialectical Behaviour Therapy (DBT; Linehan, 1993), to reduce shame in women with borderline personality disorder. Their results showed that asking participants to act against what shame urges (e.g., instead of hiding or withdrawing from a situation, they were asked to engage or approach a specific situation) had a great impact on reducing shame.

This thesis has advocated the use of self-compassion, mindfulness, and acceptance as adaptive strategies in managing shame. As noted previously, there is a strong conceptual compatibility between these constructs, with a focus on non-judgmental and acceptance attitudes. The literature indicates that engaging with emotions, using problem-solving methods, or expressing emotions are more beneficial than avoidance or disengagement-related strategies (Aldao et al., 2010). There are even some indications that acceptance-based strategies are superior to other emotion regulation strategies such as suppression, distraction, and reappraisal (Kohl, Rief, & Glombiewski, 2012).

One advantage that acceptance-based strategies may have for managing shame is that there is a sense of shame about feelings of shame (Fall, 2014). The stigma that surrounds feelings of shame may lead to the development of other maladjustments and mental issues. Thus, acceptance, mindfulness, and self-compassion (especially the common humanity aspect of self-compassion) may remove the stigma and normalise feelings of shame as a human experience, rather than as something taboo or unacceptable that should be avoided (Luoma, 2011). Ironically, when an individual's aim is to not eliminate the shaming experience but rather to accept shame, there is a

chance of shame reduction. Therefore, instead of trying to eliminate shame directly, it might be more practical to alter our relationship with it and to become "more mindful and accepting of the experience" (Luoma, 2011, p. 1210).

8.5.3. Are Acceptance-based Strategies Better than Other Strategies?

There is a heated debate about the advantages that acceptance-based strategies might have over cognitive-based strategies, and vice versa (Arch et al., 2012; Gaudiano, 2009; Hofmann & Asmundson, 2008). The important question is whether it is better to challenge negative thoughts and emotions or accept them (Hayes & Pankey, 2003). Although the idea of challenging negative thoughts and emotions by methods such as repeating positive statements ("I am lovable") is appealing and popular in media or self-help books, there is some evidence against the benefits, particularly for those who already have a negative self-image (Wood, Perunovic, & Lee, 2009). Remarkably, individuals prefer information about the self that is consistent with their own beliefs or images (Swann, 1987). Thus, individuals with a negative self-view would prefer negative comments or feedbacks that confirm and validate their current self-view (Swann & Pelham, 2002). In support of this notion, Wood et al. (2009) demonstrated that repeating positive statements such as "I am a lovable person" did not benefit individuals with low self-esteem. Ironically, these individuals felt worse after repeating these statements. Those who need to improve their self-image most are not able to do so by merely adopting a positive attitude or thinking positively.

Nonetheless, Kelly et al. (2009) demonstrated that a strategy encouraging resistance to self-attacks and self-criticism was effective in reducing shame, as was a strategy based on self-compassion and self-soothing. According to these authors, since shame and self-criticism are highly associated, interventions that affect one might also influence the other. They further speculated that resisting self-attack messages might be

more instrumental in the short-term, while engaging in self-soothing and self-compassion exercises may have a long-lasting influence on shame recovery.

Although there is a burgeoning interest in acceptance-based strategies, it is inaccurate to claim that they are superior to other strategies. (Arch et al., 2012; Gaudiano, 2009; Hofmann & Asmundson, 2008). Instead, they should be seen as alternative ways of managing shame. While some individuals may find cognitive-based strategies more effective, others may find acceptance-based or self-compassion strategies more appealing. The main purpose is to expand and improve upon existing methods by providing evidence for the value of each, not to pit one against the other. Individual experiences of shame are diverse, and not all people respond similarly to internal and external encounters. Therefore, all of the methods that can be employed for managing shame should be appreciated and acknowledged.

8.5.4. Is Increasing Self-compassion the Same as Increasing Self-esteem?

Throughout this thesis, the importance of self-compassion in the management of shame was emphasised. However, an important point that needs to be clarified is that, although self-compassion seems very similar to self-esteem at first glance (both are directed towards the self and generate positive feelings), they are assumed to be distinctive constructs (Neff, 2003a, 2011). Self-compassion is less dependent on self-evaluation than is self-esteem (Neff et al., 2007). As a result, self-compassionate individuals are less defensive and more objective about their characteristics, performances, and abilities. Individuals with high self-esteem feel good about themselves because they succeed, achieve, or perform at the level that meets their standards, while self-compassionate individuals are able to be kind to the self in spite of difficulties and imperfections (Neff, 2011). As expected, stressing self-evaluation and a desire to view the self favourably in self-esteem can lead to the development of

narcissist tendencies and selfishness (Neff et al., 2005), while the essence of self-compassion is *compassion*. Overall, self-compassion is regarded more favourably than is self-esteem. It is seemingly efficacious in managing shame. Quite possibly, self-compassion acts as a preventive coping strategy that blocks the development of chronic shame, as well as reducing feelings of state shame after they emerge. Thus, its use as a shame-managing method should be promoted.

8.6. Limitations

The particular limitations of each empirical study have already been explored in each applicable chapter. However, there are some overarching shortcomings regarding the study of shame that require further exploration.

A fundamental difficulty inherent in studying shame is the assessment of shame. Shame is a complex emotion to measure (Tangney & Dearing, 2002). As noted in Chapter 3, shame is primarily assessed by self-report measures. However, self-reported measures of shame tend to be very similar to measures of negative self-judgement or self-evaluation. On one hand, this similarity between shame and negative self-evaluation is understandable, since shame focuses on the self and negative self-evaluation. In the literature (Chapter 1), it is often claimed that self-blame and self-criticism are evident in shame, but they can also be experienced in other situations or independently (Andrews, 1998). On the other hand, shame theorists (Andrews, 1998; Gilbert, 2000) believe that shame is much more than negative self-evaluation and self-judgement. As a result, an important question that remains is how shame, that is more than negative self-judgment, can be measured. In fact, what does "more than" entail? At the moment, shame measures suggest that shame is a negative emotion that is highly associated with negative self-judgment or negative judgement of the self by others. This thesis indicates that negative self-judgment and shame are highly correlated ($r > .60$);

this can be considered a limitation for interpreting the analysis and the mediation models presented in the thesis. I personally find it substantially challenging to locate and identify the difference between low self-esteem and chronic shame. Although shame is considered an emotion, if it is experienced chronically, can it still be considered an emotion or is it personal identity? Do chronic shame and low self-esteem always occur together (interdependently)? Without an accurate conceptualisation and measures of shame, it is difficult to go any further. Additional work is needed to clarify what shame is and is not, and how it can be measured.

Along this line of thought, Randles and Tracy (2013) have recently argued that individuals prone to experiencing shame are less likely to acknowledge their shameful feelings. According to these authors, individuals tend to hide or avoid their shameful experiences in self-report measures of shame; hence, shame should be measured implicitly through methods such as coding of non-verbal behaviour associated with shame. They believe that a narrowed chest and slumped shoulders are two specific behaviours that can be regarded as indicators of shame or failure. However, the question here is whether shame and failure can be considered interchangeably. As noted in Chapter 1, shame does not have distinct non-verbal expressions; therefore, relying on non-verbal behaviour or expressions in order to measure shame can become overly complicated, although it should not be dismissed. It requires enquiry and exploration.

A further issue that needs consideration is the cost and benefit of experimental and correlational studies. As seen in this thesis, experimental study and inducing shame in the laboratory may lack ecological validity; however, experiment allows us to make causal inferences. The main problem is how to induce shame in a way that is ethical and pragmatic, and to elicit shame rather than other emotions. To what extent we can distinguish shame from similar emotions such as guilt, embarrassment, or even

humiliation in practice? If we ask participants to describe a personal experience of shame and a personal experience of guilt, as Tangney and colleagues (Tangney, 1992; Tangney & Dearing, 2002) have done in their studies, participants might be able to distinguish shame from guilt. However, if we ask participants to recall a personal experience of shame without mentioning guilt, they are very likely to describe a personal experience of shame, guilt, embarrassment, or a combination of all three because, in reality, we often tend to experience these emotions together, and it is very difficult to distinguish between them. When I do something wrong (guilt), I might also think that I am a bad person (shame). The fact that emotions are so intertwined and can be substituted, changed or replaced makes them difficult to separate (Leeming & Boyle, 2013). It is inconceivable to assume that we are examining absolute discrete emotional experiences in most cases. Therefore, we should bear this issue in mind when conducting or planning to conduct experimental research regarding emotions such as shame.

Correlational studies measure a kind of shame—chronic shame—that is problematic and associated with a myriad of psychological maladjustments; these studies are more ecologically valid, easier to implement, and less burdensome on participants. Nevertheless, correlational research is not without problems. The main concern is spurious correlation. For instance, there is a possibility that shame is related to negative self-judgment not because there is a direct causal relationship between them, but because their association is due to the existence of a third variable (a common cause) that was omitted or not considered in the research. In addition, there is a possibility that they are measuring a very similar construct or that the correlation is inflated because of item overlap. Therefore, we cannot infer causal connection based on the correlational studies, and results from these studies remain limited because of their

correlational nature. Longitudinal studies can be useful for clarifying the direction of causality, however, these studies remain scarce, which might be due to their time-consuming and resource-costly nature. Specifically, they are challenging to conduct without sufficient financial resources.

Two common criticisms of psychological research that are pertinent in the current work are the use of self-report measures and convenience sampling. As noted in the previous chapters, the majority of participants in these studies were students. Students are not representative of the general population as they typically are of a certain age and social class, have less life experience, and relatively high intellectual ability. As such, the sampling method used reduces the validity and generalisability of the current studies. However, using opportunity samples made up largely of student participants made it possible to conduct four empirical studies and one pilot study with sufficient sample sizes to ensure adequate statistical power during my time at the University of Bath, and this, despite the fact that recruiting participants and collecting data for one study took about 9 months due to lack of funds at the start. Recruiting participants from outside of the university would have been more time-consuming and less cost-effective as advertising in local communities requires extra funding. Furthermore, to attract participants, it is usually necessary to be able to offer incentives and to compensate participants for their time, which was impossible for three of the studies reported above. In addition, the rate of participation is typically lower in non-student populations. Therefore, future studies are necessary to confirm the validity of these findings in the general population.

8.7. Future Studies

The limitations discussed above indicate that the experimental results from this thesis require further validation and replication. Specifically, examining methods and ways that can be employed to manage shame are crucial. Because of the role shame plays in mental and physical health, learning more about shame resiliency is essential in future studies. Case studies that investigate recovery from shame and how people tend to rebuild the self after shame are particularly invaluable (Leeming & Boyle, 2013; Van Vliet, 2008).

In addition, exploration of specific interventions that target negative self-judgment without relying on meditation is necessary. For instance, Neff and Germer (2013) recently developed the Mindful Self-Compassion (MSC) programme. Its main purpose is to help individuals cultivate self-compassion; however, its structure is similar to that of mindfulness-based stress reduction programmes, as it teaches seated meditation and some mindfulness skills in addition to self-compassion exercises. Neff and Germer's (2013) study found that, in comparison to the control group, participants who took part in the MSC programme showed a significantly greater increase in life satisfaction and compassion for the self and others, while their levels of anxiety and stress decreased.

Whether negative self-judgment can be tackled by merely focusing on self-kindness and compassion and without engaging in meditation or mindfulness practices merits further investigation (Hollis-Walker & Colosimo, 2011). This might be helpful for those who are resistant to the idea of meditation or concentration, and who find them alien and unfamiliar

At the same time, we have to bear in mind that shame might inhibit feelings of self-compassion and kindness, or fear of self-compassion might exist in individuals who

experience a high degree of shame (Gilbert et al., 2010). Kelly et al. (2009) suggested that strategies that combine both self-attack resistance and self-compassion might be beneficial for resolving psychological maladjustments that are influenced by negative self-views. In future studies, it would be beneficial to examine Kelly and associates' suggestion, to consider both methods together, and to explore how they might influence shame, or whether they improve outcomes and reduce shame substantially in comparison to the current strategies.

Another issue that requires further investigation is the use of self-administrated shame-management methods. Because of its secretive and shaming nature, and the prevalent use of avoidance and withdrawal in shame, individuals with high levels of shame might suffer silently and refuse to see a therapist or to ask for help even when they need it most. Therefore, methods that can be self-employed independently from therapy might offer a worthwhile solution, or might at least help individuals to take the first step to reveal their problems to a trusted friend. In addition, self-administrated shame-management methods might be helpful because shame and withdrawal tendencies substantially influence therapeutic alliance and reduce the chance of successful therapy and effective interpersonal relationships (Black et al., 2013).

In terms of parenting, what is concerning and requires further attention is the fact that shame and negative self-judgment might be transferred from parents to children implicitly. In particular, it has been proposed that living in an environment in which parents are prone to the experience of shame or experience it frequently may affect children's attitudes towards themselves (M. Lewis, 1992; Mills, 2005). For example, by modelling or imitating parents, children may start to use self-blaming attributions observed in the experience of shame, and consequently develop a disposition towards shame (M. Lewis, 1992; Mills, 2005). It is alarming that a child that

grows up in a loving household, but has insecure parents who tend to judge themselves harshly, may become vulnerable to the experience of shame. This is an important issue and should not be neglected.

Furthermore, different shame contexts require extended clarification. As noted earlier, shame that results from doing something wrong may possibly have different consequences or elicit different responses than shame that is caused by unwanted characteristics and attributes. It is also worth investigating the conditions and factors under which state shame might facilitate the emergence of shame-proneness.

8.8. Summary

Chapter 1 of the thesis reviewed previous literature and examined characteristics and the nature of shame, explored differences between shame and similar constructs, and considered the experience of shame in social and cultural contexts. Chapter 2 categorised shame-management methods by employing Gross' (1998) process model of emotion regulation and common coping strategies. The aim was to integrate disparate literature in this area, and to provide an overview. A number of novel findings emerged from the empirical studies in this thesis, and some of the previous results were confirmed. First, the studies showed that shame was associated with childhood adversity through negative self-judgment; however, the association between shame and negative childhood experiences was not as strong as were the associations between shame, negative self-judgment, and submissive coping methods. Second, negative self-judgment, which was measured using the five facet of mindfulness scale (Chapter 6), and negative self-judgment that was measured by the self-compassion scale (Chapter 4) both revealed a very high correlation with shame; this confirms the self-evaluative nature of shame, while simultaneously raising an important question regarding measures of shame and their limitations. Third, the thesis validates a newly designed

scale for measuring willingness to experience shame and embarrassment, and demonstrated that this measure is related to depression and the quality of life. Fourth, the findings in Chapter 6 showed that self-compassion mediated the relationship between mindfulness and shame in a cross-sectional study. Finally, the thesis demonstrated that shame induced in the laboratory by using the autobiographical recall method did not significantly influence mind-wandering tasks that were measured by reading a tedious text.

In conclusion, it might be accurate to say that we are living in a shame-prone culture. A culture that focuses on competition and comparison creates insecurity, power imbalance, and shame (Gilbert, 2009). In addition, unrealistic expectations and standards, and believing in perfection feed feelings of insecurity, self-doubt, and shame (Mills, 2005). This is why studying shame and talking about it is vital. Although this ubiquitous emotion is notoriously unpleasant and difficult to acknowledge (Dearing & Tangney, 2011), it contributes greatly to emotional and psychological problems, and affects our well-being (Tangney & Dearing, 2002). Although the secretive nature of shame makes it complex to examine and study, shame is far too important to be ignored; hence, in the last few decades it has become the focus of many studies. This thesis also attempted to contribute to the existing knowledge on shame and shame management.

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Appendix

Appendix A: Study 1

Parental Bonding Instrument

This questionnaire lists various attitudes and behaviours of parents. As you remember your MOTHER (FATHER) in your first 16 years, please select the most appropriate response to each statement.

When I was growing up, my mother/father...

1- Spoke to me in a warm and friendly voice
2- Did not help me as much as I needed
3- Let me do those things I liked doing
4- Seemed emotionally cold to me
5- Appeared to understand my problems and worries
6- Was affectionate to me
7- Liked me to make my own decisions
8- Did not want me to grow up
9- Tried to control everything I did
10- Invaded my privacy
11- Enjoyed talking things over with me
12- Frequently smiled at me
13- Tended to baby me
14- Did not seem to understand what I needed or wanted
15- Let me decide things for myself
16- Made me feel I wasn't wanted
17- Could make me feel better when I was upset
18- Did not talk with me very much
19- Tried to make me feel dependent on her
20- Felt I could not look after myself unless she was around
21- Gave me as much freedom as I wanted
22- Let me go out as often as I wanted
23- Was overprotective of me
24- Did not praise me
25- Let me dress in any way I pleased

Childhood Experiences of Emotions

Please think about your mother or main caregiver when you were growing up. At this time, what message did you get from them about your own negative thoughts and feelings? They may not have said anything directly but you may have been able to guess from how they acted. We are interested in the impression that you gained as a child, even if now you may think differently. Please tick a box to indicate your best guess.

As a child, I got the impression from my mother or main caregiver that…

1- It is a sign of weakness if I have miserable thoughts.
2- If I have difficulties I should not admit them to others.
3- If I lose control of my emotions in front of others, they will think less of me.
4- I should be able to control my emotions.
5- If I am having difficulties it is important to put on a brave face.
6- If I show signs of weakness then others will reject me.

7- I should not let myself give in to negative feelings.
8- I should be able to cope with difficulties on my own without turning to others for support.
9- To be acceptable to others, I must keep any difficulties or negative feelings to myself.
10- It is stupid to have miserable thoughts.
11- It would be a sign of weakness to show my emotions in public.
12- Others expect me to always be in control of my emotions.

Parental Expectations Subscale

Please indicate your level of agreement or disagreement with the following statements.

1. My parents set very high standards for me.
2. My parents wanted me to be the best at everything.
3. Only outstanding performance is good enough in my family.
4. My parents have expected excellence from me.
5. My parents have always had higher expectations for my future than I have.

Peer Acceptance Scale

While I was growing up...

1. Most of the kids I knew liked me
2. I didn't have many friends
3. I usually found it easy to make new friends
4. I was not very popular

The Relationships Questionnaire

Following are descriptions of four general relationship styles that people often report. Please rate each of the following relationship styles according to the 'extent' to which you think each description corresponds to your general relationship style.

1- It is easy for me to become emotionally close to others. I am comfortable depending on them and having them depend on me. I don't worry about being alone or having others not accept me.
2- I am uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I worry that I will be hurt if I allow myself to become too close to others.
3- I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them.
4- I am comfortable without close emotional relationships, it is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me.

Self-judgment Subscale

1- I'm disapproving and judgmental about my own flaws and inadequacies.
2- When times are really difficult, I tend to be tough on myself.
3- I'm intolerant and impatient towards those aspects of my personality I don't like.
4- When I see aspects of myself that I don't like, I get down on myself.
5- I can be a bit cold-hearted towards myself when I'm experiencing suffering.

The Compass of Shame Scale

Below is a list of statements describing situations you may experience from time to time. Following each situation are four statements describing possible reactions to the situation. Read each statement carefully and indicate the frequency with which you find yourself reacting in that way. Please respond to all four items for each situation.

(AO= Attack Other, AS= Attack Self, AV= Avoidance, WD= Withdrawal)

A- When an activity makes me feel like my strength or skill is inferior:

- a. I act as if it isn't so. (AV)
- b. I get mad at myself for not being good enough. (AS)
- c. I withdraw from the activity. (WD)
- d. I get irritated with other people. (AO)

B- In competitive situations where I compare myself with others:

- a. I criticize myself. (AS)
- b. I try not to be noticed. (WD)
- c. I feel ill will toward the others. (AO)
- d. I exaggerate my accomplishments. (AV)

C- In situations where I feel insecure or doubt myself:

- a. I shrink away from others. (WD)
- b. I feel others are to blame for making me feel that way. (AO)
- c. I act more confident than I am. (AV)
- d. I feel irritated with myself. (AS)

D- At times when I am unhappy with how I look:

- a. I take it out on other people. (AO)
- b. I pretend I don't care. (AV)
- c. I feel annoyed at myself. (AS)
- d. I keep away from other people. (WD)

E- When I make an embarrassing mistake in public:

- a. I hide my embarrassment with a joke. (AV)
- b. I feel like kicking myself. (AS)
- c. I wish I could become invisible. (WD)
- d. I feel annoyed at people for noticing. (AO)

F- When I feel lonely or left out:

- a. I blame myself. (AS)
- b. I pull away from others. (WD)
- c. I blame other people. (AO)
- d. I don't let it show. (AV)

G- When I feel others think poorly of me:

- a. I want to escape their view. (WD)
- b. I want to point out their faults. (AO)
- c. I deny there is any reason for me to feel bad. (AV)
- d. I dwell on my shortcomings. (AS)

H- When I think I have disappointed other people:

- a. I get mad at them for expecting so much from me. (AO)

b. I cover my feelings with a joke. (AV)
c. I get down on myself. (AS)
d. I remove myself from the situation. (WD)

I- When I feel rejected by someone:

a. I soothe myself with distractions. (AV)
b. I brood over my flaws. (AS)
c. I avoid them. (WD)
d. I get angry with them. (AO)

J- When other people point out my faults:

a. I feel like I can't do anything right. (AS)
b. I want to run away. (WD)
c. I point out their faults. (AO)
d. I refuse to acknowledge those faults. (AV)

K- When I feel humiliated:

a. I isolate myself from other people. (WD)
b. I get mad at people for making me feel this way. (AO)
c. I cover up the humiliation by keeping busy. (AV)
d. I get angry with myself. (AS)

L- When I feel guilty:

a. I push the feeling back on those who make me feel this way. (AO)
b. I disown the feeling. (AV)
c. I put myself down. (AS)
d. I want to disappear. (WD)

The Experience of Shame Scale

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 with a click.

1- Have you felt ashamed of any of your personal habits?
2- Have you worried about what other people think of any of your personal habits?
3- Have you tried to cover up or conceal any of your personal habits?
4- Have you felt ashamed of your manner with others?
5- Have you worried about what other people think of your manner with others?
6- Have you avoided people because of your manner?
7- Have you felt ashamed of the sort of person you are?
8- Have you worried about what other people think of the sort of person you are?
9- Have you tried to conceal from others the sort of person you are?
10- Have you felt ashamed of your ability to do things?
11- Have you worried about what other people think of your ability to do things?
12- Have you avoided people because of your inability to do things?
13- Do you feel ashamed when you do something wrong?
14- Have you worried about what other people think of you when you do something wrong?
15- Have you tried to cover up or conceal things you felt ashamed of having done?
16- Have you felt ashamed when you said something stupid?
17- Have you worried about what other people think of you when you said something stupid?

18- Have you avoided contact with anyone who knew you said something stupid?

19- Have you felt ashamed when you failed in a competitive situation?

20- Have you worried about what other people think of you when you failed in a competitive situation?

21- Have you avoided people who have seen you fail?

22- Have you felt ashamed of your body or any part of it?

23- Have you worried about what other people think of your appearance?

24- Have you avoided looking at yourself in the mirror?

25- Have you wanted to hide or conceal your body or any part of it?

Appendix B (Study 2)

Proposed items for the Acceptance of Shame and Embarrassment Scale

Directions: Below you will find a list of statements. Please rate the truth of each statement as it applies to you by circling a number. Use the following rating scale to make your choices. For instance, if you believe a statement is "Always True", you would circle the 6 next to that statement.

1- If I get embarrassed around other people, I can live with it
2- Nothing is so important that it is worth feeling ashamed or humiliated for
3- If I start to feel embarrassed or ashamed, I have to leave the situation
4- When I get embarrassed I accept this as a normal part of life
5- Feeling stupid or awkward is awful
6- I don't let feeling embarrassed get in the way of doing things I want to do
7- My life is not restricted by fear of embarrassment
8- I am not prepared to feel stupid or humiliated in front of other people
9- If other people make me feel stupid, I have to defend myself immediately
10- I can put up with being embarrassed or ashamed without too much difficulty
11- I hate it when I feel that people are judging me
12- If I feel embarrassed or ashamed it makes me angry
13- If I am doing what's important to me, being embarrassed is worth it
14- I can't bear feeling embarrassed or ashamed
15- I often hide what I am really like
16- Being in embarrassing situations is better than avoiding things
17- When people don't think much of me, I just accept it
18- There are situations that I am not willing to go into because I might feel ashamed or embarrassed
19- I regularly go into situations where I might feel embarrassed or awkward
20- I don't mind if I feel embarrassed
21- I am no longer doing things that matter because other people might judge me or give me a hard time
22- If I feel judged I get very defensive
23- I always try to let people see the 'real me', even if it makes me feel foolish

Brief Fear of Negative Evaluation Scale

Read each of the following statements carefully and indicate how characteristic it is of you according to the following scale:

1- I worry about what other people will think of me even when I know it doesn't make any difference.
2- I am unconcerned even if I know people are forming an unfavorable impression of me.
3- I am frequently afraid of other people noticing my shortcomings.
4- I rarely worry about what kind of impression I am making on someone.
5- I am afraid others will not approve of me.
6- I am afraid that people will find fault with me.
7- Other people's opinions of me do not bother me.
8- When I am talking to someone, I worry about what they may be thinking about me.
9- I am usually worried about what kind of impression I make.
10- If I know someone is judging me, it has little effect on me.
11- Sometimes I think I am too concerned with what other people think of me.
12- I often worry that I will say or do the wrong things.

Acceptance and Action Questionnaire-II

Below you will find a list of statements. Please rate how true each statement is for you by circling a number next to it. Use the scale below to make your choice.

1- It's OK if I remember something unpleasant.
2- My painful experiences and memories make it difficult for me to live a life that I would value.
3- I'm afraid of my feelings.
4- I worry about not being able to control my worries and feelings.
5- My painful memories prevent me from having a fulfilling life.
6- I am in control of my life.
7- Emotions cause problems in my life.
8- It seems like most people are handling their lives better than I am.
9- Worries get in the way of my success.
10- My thoughts and feelings do not get in the way of how I want to live my life.

The Philadelphia Mindfulness Scale

Instructions: Please circle how often you experienced each of the following statements within the past week.

1- I am aware of what thoughts are passing through my mind.
2- I try to distract myself when I feel unpleasant emotions.
3- When talking with other people, I am aware of their facial and body expressions.
4- There are aspects of myself I don't want to think about.
5- When I shower, I am aware of how the water is running over my body.
6- I try to stay busy to keep thoughts or feelings from coming to mind.
7- When I am startled, I notice what is going on inside my body.
8- I wish I could control my emotions more easily.
9- When I walk outside, I am aware of smells or how the air feels against my face.
10- I tell myself that I shouldn't have certain thoughts.
11- When someone asks how I am feeling, I can identify my emotions easily.
12- There are things I try not to think about.
13- I am aware of thoughts I'm having when my mood changes.
14- I tell myself that I shouldn't feel sad.
15- I notice changes inside my body, like my heart beating faster or my muscles getting tense.
16- If there is something I don't want to think about, I'll try many things to get it out of my mind.
17- Whenever my emotions change, I am conscious of them immediately.
18- I try to put my problems out of mind.
19- When talking with other people, I am aware of the emotions I am experiencing.
20- When I have a bad memory, I try to distract myself to make it go away.

Patient Health Questionnaire-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1- Little interest or pleasure in doing things
2- Feeling down, depressed, or hopeless
3- Trouble falling or staying asleep, or sleeping too much
4- Feeling tired or having little energy
5- Poor appetite or overeating

6- Feeling bad about yourself—or that you are a failure or have let yourself or your family down
7- Trouble concentrating on things, such as reading the newspaper or watching television
8- Moving or speaking so slowly that other people could have noticed. Or the opposite— being so fidgety or restless that you have been moving around a lot more than usual
9- Thoughts that you would be better off dead, or of hurting yourself in some way

Chronic Pain Values Inventory

Many people find it difficult to engage in activities that are personally important to them. These people have "VALUES" but they are not living according to their values.

For example, you may want to be a loving partner, a warm and supportive parent, a helpful and reliable friend, a person who keeps physically fit and able, or a person who is always learning new skills, but you may find yourself in circumstances where you are not living that way.

For each of the areas listed below consider how you most want to live your life. Then rate how IMPORTANT each domain is for you. This is NOT about how well you are doing in each area – it is about how important it is to you. Rate the importance you place in each domain using any number on the scale from 0 (not at all important) to 5 (extremely important). Each area need not be important to you - rate an area low if it is not important to you personally.

Consider each area according to your values, the important ways that you most want to live your life in each domain.

1- FAMILY: Participation in your relationships with your parents, children, other close relatives, people you live with, or whoever is your "family."
2- INTIMATE RELATIONS: Being the kind of partner you want to be for your husband/wife or closest partner in life.
3- FRIENDS: Spending time with friends, doing what you need to maintain friendships, or providing help and support for others as a friend.
4- WORK: Engaging in whatever is your occupation, your job, volunteer work, community service, education, or your work around your own home.
5- HEALTH: Keeping yourself fit, physically able, and healthy just as you would most want to do.
6- GROWTH AND LEARNING: Learning new skills or gaining knowledge, or improving yourself as a person as you would most want.

Chronic Pain Values Inventory-Continued

In this section we want you to look at how much SUCCESS you have had in living according to your values. Many times people find it difficult to live their life as they want to live it.

For each of the areas of life listed below consider again how you most want to live your life. Then rate how SUCCESSFUL you have been living according your values during the past two weeks. These questions are not asking how successful you want to be but how successful you have been. Rate your success using any number on the scale from 0 (not at all successful) to 5 (extremely successful).

Consider each area according to your values, the important ways that you most want to live your life in each domain.

1- FAMILY: Participation in your relationships with your parents, children, other close relatives, people you live with, or whoever is your "family."

2- INTIMATE RELATIONS: Being the kind of partner you want to be for your husband/wife or closest partner in life.
3- FRIENDS: Spending time with friends, doing what you need to maintain friendships, or providing help and support for others as a friend.
4- WORK: Engaging in whatever is your occupation, your job, volunteer work, community service, education, or your work around your own home.
5- HEALTH: Keeping yourself fit, physically able, and healthy just as you would most want to do.
6- GROWTH AND LEARNING: Learning new skills or gaining knowledge, or improving yourself as a person as you would most want.

EQ-5D-5L

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Appendix C (Study 3)

The Short Form of the Self-Compassion Scale

Please read each statement carefully before answering; using the scale given below indicate, to the right of each item, how often you behave in the stated manner:

1- when I fail at something important to me I become consumed by feelings of inadequacy
2- I try to be understanding and patient towards those aspects of my personality I don't like
3- when something painful happens I try to take a balanced view of the situation
4- when I'm feeling down, I tend to feel like most other people are probably happier than I am
5- I try to see my failings as part of the human condition
6- when I'm going through a very hard time, I give myself the caring and tenderness I need
7- when something upsets me I try to keep my emotions in balance
8- when I fail at something that's important to me, I tend to feel alone in my failure
9- when I'm feeling down I tend to obsess and fixate on everything that's wrong
10- when I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people
11- I'm disapproving and judgmental about my own flaws and inadequacies
12- I'm intolerant and impatient towards those aspects of my personality I don't like

The Five-Facet Mindfulness Questionnaire

Please rate each of the following statements using the scale provided. Write the number in the blank that best describes your own opinion of what is generally true for you.

1- When I'm walking, I deliberately notice the sensations of my body moving.
2- I'm good at finding words to describe my feelings.
3- I criticize myself for having irrational or inappropriate emotions.
4- I perceive my feelings and emotions without having to react to them.
5- When I do things, my mind wanders off and I'm easily distracted.
6- When I take a shower or bath, I stay alert to the sensations of water on my body.
7- I can easily put my beliefs, opinions, and expectations into words.
8- I don't pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted.
9- I watch my feelings without getting lost in them.
10- I tell myself I shouldn't be feeling the way I'm feeling.
11- I notice how foods and drinks affect my thoughts, bodily sensations, and emotions.
12- It's hard for me to find the words to describe what I'm thinking.
13- I am easily distracted.
14- I believe some of my thoughts are abnormal or bad and I shouldn't think that way.
15- I pay attention to sensations, such as the wind in my hair or sun on my face.
16- I have trouble thinking of the right words to express how I feel about things
17- I make judgments about whether my thoughts are good or bad.
18- I find it difficult to stay focused on what's happening in the present.
19- When I have distressing thoughts or images, I "step back" and am aware of the thought or image without getting taken over by it.
20- I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.
21- In difficult situations, I can pause without immediately reacting.
22- When I have a sensation in my body, it's difficult for me to describe it because I can't find the right words.

23- It seems I am "running on automatic" without much awareness of what I'm doing.

24- When I have distressing thoughts or images, I feel calm soon after.

25- I tell myself that I shouldn't be thinking the way I'm thinking.

26- I notice the smells and aromas of things.

27- Even when I'm feeling terribly upset, I can find a way to put it into words.

28- I rush through activities without being really attentive to them.

29- When I have distressing thoughts or images I am able just to notice them without reacting.

30- I think some of my emotions are bad or inappropriate and I shouldn't feel them.

31- I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadow.

32- My natural tendency is to put my experiences into words.

33- When I have distressing thoughts or images, I just notice them and let them go.

34- I do jobs or tasks automatically without being aware of what I'm doing.

35- When I have distressing thoughts or images, I judge myself as good or bad, depending what the thought/image is about.

36- I pay attention to how my emotions affect my thoughts and behavior.

37- I can usually describe how I feel at the moment in considerable detail.

38- I find myself doing things without paying attention

39- I disapprove of myself when I have irrational ideas.

The Experience of Shame Scale (Please see Appendix A, Study 1).

Appendix D (Study 4)

Pilot Study

Consent Form

Thank you very much for taking time and reading this consent form.

We are currently conducting research on emotions, especially shame. We are interested to find out how you experience shame. You will be asked to fill out a few questionnaires and we will ask you to describe a personal experience of shame.

All data will be strictly anonymous, and will be treated with full confidentiality. There is no way we are able or intend to know your identity. Please try to be as honest as possible. You are free to withdraw from the study at any time. Participation is entirely voluntary. If you feel any discomfort and distress, you are more than welcome to contact Dr Kate Rimes (K.A.Rimes@bath.ac.uk). In addition, if you have any queries about the study, you could contact Professor Bas Verplanken (B.Verplanken@bath.ac.uk).

I wish to participate in this study.

Yes ☐ (please, go to the next page)

No ☐   (you could do whatever you want or you could tell us what you think "shame" is?) – You could write down your answer in the space below or next page.

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Recalling shame

Could you please describe a specific personal experience of shame?

While you are writing, please try to remember how you felt, re-evoking the feelings that you had at the time.

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Now we would like to ask you few questions about your recent thoughts. We are interested to find out what you were thinking about, in the few minutes after writing about your shame memory. Please read each statement and indicate how much you were thinking about these things over the last few minutes, using the scale below:

1= Not at all	2= A little	3= A lot

Please circle a number

	1	2	3
1- I was thinking about good things that had happened in the past	1	2	3
2- I was thinking about normal, everyday things	1	2	3
3-I was daydreaming about what I would like to see happen in the future	1	2	3
4-I was worrying about things that might happen in the future	1	2	3
5-I was thinking about bad or difficult things that had happened in the past	1	2	3
6-I was fantasizing about something pleasant	1	2	3
7-I was thinking about this study or the purpose of this study	1	2	3
8-I had negative thoughts about how I am now	1	2	3
9-I engaged in wishful thinking about attaining positive outcomes	1	2	3
10-I was thinking about things that I need to do	1	2	3
11-I was thinking about the shameful event that I had described	1	2	3
12-I had positive thoughts about how I am now	1	2	3
13-I had negative thoughts about the future	1	2	3
14-I pictured myself as a very successful person	1	2	3
15-I was trying not to think about the shameful event that I had described	1	2	3
16-I was not thinking= there was nothing in my mind	1	2	3

If you had other thoughts, could please write them down in the space below?

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1- When you were writing about the shame experience, how much shame did you feel?

  1= Not at all   2= Slightly   3= Moderately   4= Very   5= Extremely

2- How much shame do you feel at this moment?

  1= Not at all   2= Slightly   3= Moderately   4= Very   5= Extremely

Experimental Manipulation

<u>Shame or pride condition</u>

Emotions define us as humans and we do 'feel' when we have emotions.

A day without feeling emotions would be impossible to imagine. Each day we feel dozens of emotions; the excitement of going on holidays, the fear of flying, or the grief of losing a family member. Humans use emotions to make meaning of life experiences and give colour to their lives. Emotions define how we and the people around us feel and act.

In this study, we are interested in evoking the feeling of shame/pride. The experience of shame is common among all human beings and everyone, throughout life, has shame experiences. In this study, our main emphasis is on evoking the feeling of shame. We want to know how strongly people are able to re-experience emotional memories of shame.

Please take few seconds and think about shame and then click on "continue" to go to the next page.

<u>Personal Memory Task</u>

Now, we would like to ask you to recall a personal experience in which you felt a strong sense of shame/pride as vividly as possible.

Please try to think about this event in detail. For example, you could think about:

1-What was the emotional event?

2-Why did that happen?

3-How did you feel then?

4-What was the consequence of that event?

Most importantly, try to remember how you felt, re-evoking (re-experiencing) the feelings you had at the time.

It might help you if you take a few moments to close your eyes and try to remember exactly what was happening. There is no rush - take as long as you need, to bring the memory and emotion vividly to mind. Please try to evoke the feelings you had at the time.

When you are done, please go to the next page.

Some may find this task upsetting, please bear in mind that you are free to withdraw at any time.

<u>Describing Personal Memory</u>

In this part, please write 2 to 4 paragraphs about the event in which you felt a strong sense of shame/pride as vividly as possible. You could answer the following questions: 1-What was the emotional event? 2-Why did that happen? 3-How did you feel then? 4-What was the consequence of that event? ---Please try to evoke the feeling you had at the time. There is no rush - take as long as you need. Please bear in mind that we are more interested in evoking the feeling of pride rather than your description of the event.

<u>Control condition</u>

In this study, we are interested in personal memories. We want to know how people re-experience or recall personal memories.

We would like to ask you to recall what you had last night for dinner as vividly as possible. For example, you could think about:

1-What did you had last night for dinner?

2-Why did you have that?

3-How did you prepare it? (or where did you buy it)

4-How long did it take to prepare (or buy) that meal?

It might help you if you take a few moments to close your eyes and try to remember exactly what was happening. There is no rush - take as long as you need.

When you are done, please go to the next page.

In this part, please write 2 to 4 paragraphs about what you had last night for dinner as vividly as possible. You could answer the followings questions: 1-What did you had last night for dinner? 2-Why did you have that? 3-How did you prepare it? (or where did you buy it) 4-How long did it take to prepare (or buy) that meal?

There is no rush - take as long as you need.

Reading Task

In this section of the study, we would like to ask you to read a few pages.

Please read each page and then click "continue" to go to the next page.

Page 1:

A river may have its source in a spring, lake, from damp, boggy landscapes where the soil is waterlogged, from glacial melt, or from surface runoff of precipitation. Almost all rivers are joined by other rivers and streams termed tributaries, the highest of which are known as headwaters. Water may also originate from groundwater sources. Throughout the course of the river, the total volume transported downstream will often be a combination of the free water flow together with a substantial contribution flowing through sub-surface rocks and gravels that underlie the river and its floodplain. For many rivers in large valleys, this unseen component of flow may greatly exceed the visible flow.

From their source, rivers flow downhill, typically terminating in a sea or in a lake, through a confluence. In dry areas rivers sometimes end by losing water to evaporation. River water may also soak into the soil or pervious rock, where it becomes groundwater. Excessive use of this water for industry, irrigation, etc., can also cause a river to dry before reaching its natural end.

The mouth, or lower end, of a river is known as its base level. The area drained by a river and its canals is called catchment, catchment basin, drainage basin or watershed. The term "watershed" is also used to mean a boundary between catchments, which is also called a water divide, or in some, continental divide.

The water in a river is usually confined to a channel, made up of a stream bed between banks. In larger rivers there is also a wider floodplain shaped by flood-waters over-topping the channel. Flood plains may be very wide in relation to the size of the river channel. This

distinction between river channel and floodplain can be blurred especially in urban areas where the floodplain of a river channel can become greatly developed by housing and industry.

The term upriver, is referred to as the beginning or source of the river flow regardless of the direction of flow. Therefore, the term down river, is referring to the direction of flow that the river continues in.

Page 2:

The river channel typically contains a single stream of water, but some rivers flow as several interconnecting streams of water, producing a braided river. Extensive braided rivers are found in only a few regions worldwide, such as the South Island of New Zealand.

A river flowing in its channel is a source of energy which acts on the river channel to change its shape and form. According to Brahm's law (sometimes called Airy's law), the mass of objects that may be flown away by a river is proportional to the sixth power of the river flow speed. Thus, when the speed of flow increases two times, it can transport more massive objects. In mountainous torrential zones this can be seen as erosion channels through hard rocks and the creation of sands and gravels from the destruction of larger rocks.

Rivers that carry large amounts of sediment may develop conspicuous deltas at their mouths, if conditions permit. Rivers whose mouths are in salty waters may form estuaries.

Most rivers flow on the surface; however subterranean rivers flow underground in caves or caverns. Such rivers are frequently found in remote regions with limestone geologic formations. An intermittent river only flows occasionally and can be dry for several years at a time. These rivers are found in regions with limited rainfall.

Rivers have been used as a source of water, for food, for transport, as a defensive barrier, as a source of power to drive machinery, and as a means of disposing of waste. For thousands of years rivers have been used for navigation.

Canals are artificial channels for water. There are two types of canals: water conveyance canals, which are used for the conveyance and delivery of water, and waterways, which are used for passage of goods and people, often connected to existing lakes, rivers, or oceans. Some canals are part of an existing waterway. This is usually where a river has been canalised: making it navigable by widening and deepening some parts, and providing locks.

Page 3:

At their simplest, canals consist of a trench filled with water. It may be necessary to line the cut with some form of watertight material such as clay or concrete. When this is done with clay this is known as puddling.

Canals need to be flat, and while small irregularities in the lie of the land can be dealt with through cuttings and embankments for larger deviations, other approaches have been adopted. The most common is the pound lock which consists of a chamber within which the water level can be raised or lowered connecting either two pieces of canal at a different level or the canal with a river or the sea. When there is a hill to be climbed, flights of many locks in short succession may be used.

Canals have various features to tackle the problem of water supply. In some cases such as the Suez Canal the canal is simply open to the sea. Where the canal is not at sea level a number of approaches have been adopted. Taking water from existing rivers or springs was an option in some cases, sometimes supplemented by other methods to deal with seasonal variations in flow. Where such sources were unavailable, reservoirs, either separate from the canal, or built into its

course, and back pumping were used to provide the required water. In other cases water pumped from mines was used to feed the canal.

In Europe, particularly Britain and Ireland, and then in the young United States and the Canadian colonies, inland canals preceded the development of railroads during the earliest phase of the Industrial Revolution. The opening of the Bridgewater Canal in 1761, which halved the price of coal in Manchester, triggered a period of "canal mania" in Britain so that between 1760 and 1820 over one hundred canals were built. In the United States, navigable canals reached into isolated areas and brought them in touch with the world beyond. By 1825 the Erie Canal, 363 miles (584 km) long with 82 locks, opened up a connection from the populated Northeast to the fertile Great Plains.

Memory Test

In this part, we would like to ask you few questions about the text that you were reading before (i.e. the text about rivers).

Please read each questions carefully and choose the most appropriate answer.

According to the text, which of the following is Not correct? (Correct answer is 2)

1- Intermittent rivers are found in regions with limited rainfall
2- It is easy to distinguish river channels from floodplains in urban areas
3- The term down river, is referring to the direction of flow that river continues in
4- The mouth, or lower end, of a river is known as its base level

Which of the following about rivers was Not mentioned in the text? (Correct answer is 2)

1- Subterranean rivers flow underground in caves or caverns
2- Subterranean rivers are found in dry areas
3- Most rivers flow on the surface
4- Subterranean rivers are found in remote regions with limestone geologic formations

According to the text, extensive braided rivers are found in only a few regions worldwide, such as (Correct answer is 2)

1- The South Africa
2- The South Island of New Zealand
3- Latin America
4- East Asia

According to the text, which of the following about canals is Not correct? (Correct answer is 2)

1- Canals are artificial channels for water
2- There are three types of canals
3- Canals need to be flat
4- Some canals are open to the sea

Which of the following was Not mentioned in the text as a way of tackling the problem of water supply in canals? (Correct answer is 4)

1- Taking water from existing rivers and springs
2- Taking water from reservoirs
3- Pumping water from mines
4- Taking water from artificial pounds

According to the text, the period of "canal mania" in Britain was: (Correct answer is 1)

1- Between 1760-1820
2- Between 1825-1850
3- Between 1860-1900
4- Between 1950-1970

The Experience of Shame Scale (see Appendix A, Study 1)

The Short Form of Self-compassion Scale (see Appendix C, Study 3)