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Relationship of attachment security to shame in young adults

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RELATIONSHIP OF ATTACHMENT SECURITY TO SHAME IN YOUNG ADULTS

A Thesis

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ABSTRACT

The purpose of this study was to examine the relationship between early maternal attachment security and shame in young adults. Although there is much literature written about both subjects, little to no research has examined the relationship between the two. It was hypothesized that shame would be negatively and significantly correlated with attachment. Participants were 172 young adults (149 females, 23 males), (M = 21.2 yrs.) who completed a questionnaire comprised of two attachment measures (The Parental Attachment Questionnaire [Kenny, 1990] and the maternal scale from the Inventory of Parent and Peer Attachment scale [Armsden & Greenberg, 1987]); a shame scale (Experience of Shame Scale; Andrews & Hunter, 1997); and a demographic information form. The findings showed that shame was significantly and inversely correlated with attachment. Overall, we found that attachment security was inversely related to shame. Specifically, the affective quality of the parent-child relationship, parents as facilitators of independence, trust, and communication were negatively correlated to shame. Conversely, we found that alienation was positively

correlated with shame. There was a lack of a relationship between the mothers' availability as a source of support during stressful times and shame, and a lack of a relationship between communicative and bodily shame. Findings are discussed in light of other studies, which have found that maternal warmth and empathy create in the child a sense that they are worthy, and valued.

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CHAPTER ONE

LITERATURE REVIEW

Shame is a relatively new concept in the clinical psychology and child development literatures. It is a potentially devastating emotion, and while some research suggests that it is part of our innate construct, others posit that shame stems from such outside influences as family, peers, educators, and work environments. The purpose of this study is to examine the impact of early attachment security on the development of shame in young adults.

Shame

Shame refers to a predominantly intense and often incapacitating negative emotion involving feelings of inferiority, powerlessness, and self-consciousness along with the desire to conceal an individual's perceived deficiencies (Tangney, Miller, Flicker, & Barlow, 1996; Wicker, Payne, & Morgan, 1983). According to Tangney (1990), shame involves a global negative self-evaluation associated with a sense of helplessness or passivity in correcting the perceived fault. For the purpose of this

paper, shame will be defined as a negative affective state regarding a person's entire identity stemming from internal and constant self-attributions (Tangney, 1991).

Shame involves a focus on the self as defective or unworthy, beyond the specifics of one's behavior. A shame-prone individual feels as though he has done a horrible thing, and that he is therefore a horrible person. This negative evaluation is often associated with a sense of shrinking and feeling small, as well as a desire to hide or disappear (Britt & Heise, 2000; Gilbert, Allan, & Goss, 1996). These thoughts leave one feeling inadequate, and can contribute to an individual feeling shame and hopeless about their life (Fisher, 1985; Kaufman, 1989). Thus, shame may affect mood and personal identity, and lead to self-blame, all of which can cause a person to feel inadequate about his or her ability to perform what some people would consider simple everyday tasks.

Recent empirical research indicates that shame results from both environmental situations such as public settings, e.g., school and work, and family interaction patterns, as well as from internal experiences such as when one is alone and feels as if they are a shameful person (Janoff-Bulman, 1979; Lewis, 1992; Miller & Tangney, 1994).

Some individuals may feel shame because of their belief that they have done something wrong to others or to themselves, which may be real or imagined. Whether the shame the individual feels is warranted or not, the individual may feel as though they have been socially rejected even though the rejection never occurred (Lutwak, Razzino, Ferrari, 1998). Individuals who suffer from internal shame may be afflicted by a perceived false sense of social persecution, believing that others consider them a shameful person, leaving the individual highly sensitive to feeling shame due to their perceived social evaluation (Benedict, 1946; Lewis, 1971; Lutwak & Ferrari, 1997).

Shame has also been described as a self-conscious emotion that can result from the normative experience of early adolescence, and related to such key developmental milestones as bodily changes during puberty (Rodin, 1992) and the emergence of sexuality (Tangney, 1990). In fact, the majority of studies on shame have focused on age-related increases in shame during this period due to the general changes in the development of secondary sexual characteristics in males and females as well as bodily change that may lead to either physical attractiveness or lack of appeal. This period can lead to a child feeling

he/she is socially accepted or displaced by peers, depending on his/her own level of shame and how he/she changes developmentally during puberty (DeLamater, 2004).

Finally, throughout the research literature there has been a distinction made between shame and guilt. Shame and guilt have generated considerable interest in the literature as self-conscious emotions that shape positive developmental processes (Erikson, 1950; Jordan, 1989; Lynd, 1958), including the development of conscience, responsibility, empathy, identity, self-awareness, and maintenance of relational bonds (Kaufman, 1989; Kohut, 1971; Lewis, 1987; Tangney, 1991/1995). Both are believed to be a form of sociopsychological functioning that may regulate human behavior (Gilbert, 1997). The psychological implications of shame and guilt have been explored in both the theoretical and empirical literature, and important differences in the experience of these two moral affects have emerged (Tangney & Fischer, 1995). These two overlapping but distinct negative self-conscious affects have differential consequences in terms of pathology, adjustment, and interpersonal relatedness (Tangney, 1993/1995; Tangney, Miller, Flicker & Barlow, 1996). While the literature posits that shame and guilt may both be

thought of as negative emotions, they are distinct emotions and they differ in their subjective interpretation (Lewis, 1971/1987; Lindsay-Hartz, 1984; Tangney, 1995; Woien, Ernst, Patock-Peckham, Nagoshi, 2001). While guilt is positively correlated with empathy, shame is not (Tangney, 1991). Shame is typically seen as a universal self-evaluative experience that involves the entire self-system, whereas guilt is specific to offensive acts committed.

Behavioral and Psychological Consequences of Shame

While shame has been described as a beneficial emotion that keeps us in check when we have gone outside of what is deemed a social norm (Bowles & Gintis, 2002), it becomes detrimental to one's well-being when it results in such negative behavioral and psychological consequences as social anxiety, depression, addiction, eating disorders, narcissism, self-blame, anger, and codependency.

Social Anxiety

Research has found that shame-prone individuals have a higher level of social anxiety (Harder & Lewis, 1987; Harder & Zalma, 1990; Lewis, 1987; Lutwak & Ferrari, 1996). They tend to fear social settings because they fear that others will negatively evaluate them (Benedict, 1946; Buss,

1980; Lewis, 1971; Lutwak & Ferrari, 1997; Tangney, Burggraf, & Wagner, 1995). Studies have found that shame is associated with social withdrawal, interaction anxiety, and a sense of helplessness from not being able to resolve a negative action (Lutwak & Ferrari, 1997; Miller & Tangney, 1994). Social withdrawal is a product of social anxiety due to shame, particularly when the emphasis is on the defects and attributions of the self-blaming individual (Lewis, 1971; Lewis, 1992). This leads the individual to feel they need to make amends for their negative actions, which may force them to want to withdraw from social settings (Lutwak & Ferrari, 1997; Miller & Tangney, 1994).

Social withdrawal caused by shame also occurs in non-western cultures. In a study of Japan, for example, researchers found that shame and the individual's choice to withdraw from social situations stemmed from his/her perceived public humiliation due to a trivial social transgression (Benedict, 1946). Japanese psychologists have also linked shame, i.e., "haji", to various forms of psychopathology such as taijin kyohfu (social phobia or anxiety) in adults and school refusal and social withdrawal in children (Miyake & Yamazaki, 1995).

Research has also shown that individuals who have a greater degree of social anxiety and withdrawal due to shame tend to be more socially compliant and have higher levels of depression (Gilbert, 2000). This in turn supports research showing strong intercorrelations among shame, social anxiety, social withdrawal, and personal self-blaming attributions (Feiring, Taska, & Lewis, 1998).

Most individuals who suffer from shame-induced social anxiety also tend to perceive their social rank as being below that of their peers, and they tend to have a skewed perception of how they fit into society (Benn, Harvey, Gilbert, & Irons, 2005). Individuals who allow themselves to stay within their perceived lower social rank may have inferior social interactions due to their belief that they deserve this lower position. These are some of the reasons why shame has been found to have a profound influence on how individuals interact with one another.

Depression

Shame is a source of depression, which encompasses an array of symptoms, e.g., feeling worthless (i.e., where the individual feels she/he has no true place in society); feeling an overall loss of interest in all aspects of life (including not feeling any pleasure from situations that

should normally bring enjoyment); and suffering from such somatic problems as eating disorders, conversion disorder, pain disorder, body dysmorphic disorder, and hypochondriasis (e.g., Ahmed & Braithwaite, 2004; American Psychiatric Association, 2000; Andrews, Qian, & Valentine, 2002; Harder & Zalma, 1990; Harder, Cutler, & Rockart, 1992; Hoblitzelle, 1987; Karen, 1992/1998; Kaufman, 1992; Kohut, 1985; Lewis, 1971/1987; Lutwak & Ferrari, 1996; Lutwak, Ferrari, & Cheek, 1998; Piers & Singer, 1971; Tangney, Wagner, & Gramzow, 1992; Wright, O'Leary, & Balkin, 1989).

Shame-induced depression can in turn transform an individual's life routines: it may cause the individual to feel overwhelmed with the most basic aspects of life (e.g., getting up in the morning and preparing for one's day), leaving them with a profound sense of lethargy. Other symptoms that may plague the depressed individual include a change in sleeping pattern, a loss of appetite, and a change in physical weight (American Psychiatric Association, 2000; Gilbert & Irons, 2005).

Addiction (Alcohol and Drugs)

Studies have also found that shame is a leading contributor to an individual becoming addicted to drugs and

alcohol (Bennett, 1995; Dearing, Stuewig & Tangney, 2005; Karen, 1992). When compared to their non-addicted counterparts, individuals with drug and alcohol addictions have higher levels of shame (O'Connor, Berry, & Weiss 1999).

Shame is thought to contribute to addiction because alcohol and drugs are known shame-relieving substances used as negative reinforcements (Dearing, Stuewig & Tangney, 2005). Thus, individuals use alcohol or drugs as a tool to escape from the shame they feel, even though the alcohol or drug is only a short-term method of relieving the shame. After the effects of the alcohol or drug have worn off, the individual is once again back in their shame-filled state, only to be driven to again self-medicate to relieve the shame, leading to a vicious cycle of addiction (Bennett, 1995).

Eating Disorders

Shame has also been implicated in the development of eating disorders, e.g., anorexia nervosa and bulimia, as an etiology mechanism of the eating disorder conceptualized to be based within the family (Cooper, Rose, & Turner, 2004; Murray, Waller & Legg, 2000; Teusch, 1988). Shame can begin as early as toddlerhood, setting the stage for an

eating disorder by the parents, creating a shame-filled child who believes that he/she is flawed (Murray, Waller & Legg, 2000). The individual may use the eating disorder as a form of comfort to remove the shameful feelings that have been placed upon them by their family. When an individual has been shamed within their family, she/he may feel the need to disappear or hide: thus, the individual uses the eating disorder as a way to escape or disappear from their shameful feelings. The Anorexic and bulimic individuals feel they are socially unacceptable and may attempt to remove the shameful feelings by denying themselves food, all the while feeling as if it is the food itself, and not the family, that is the destructive force leading to her shameful feelings (Murray, Waller & Legg, 2000; Teusch, 1988; Cooper, Rose, & Turner, 2004).

A common hypothesis that frequently appears in the eating disorder literature is that shame originates within a dysfunctional family. Through abnormal family functioning, a sense of shame is formed due to the constant ridicule and social scorn that the individual receives from the parents. This leaves the individual feeling lost and alone, forcing her to create new schemas, e.g., the need to disappear and hide from their shameful feelings (Cooper,

Rose, & Turner, 2004; Murray, Waller & Legg, 2000; Teusch, 1988). The internalized shame that individuals who suffer from eating disorders feel may lead them to believe that they are worthless and void of being loved. These individuals may try to hide from this shame-induced negative feeling of emptiness. The denial of food or purging oneself of food allows the shamed individual to feel that they are eliminating these feelings of worthlessness. The individual feels that their weight loss is aiding them in their desire to become "invisible" to everyone around them, when in reality the individual has been engulfed by the eating disorder, which in turn reinforces their shameful feelings (Cooper, Rose, & Turner, 2004).

Narcissism

Narcissism is a pervasive pattern of grandiosity where the individual has a need for admiration but lacks empathy and tends to have arrogant, haughty behaviors and attitudes. The individual believes that she/he is unique and feels that they should only associate with high-status people; they also require excessive admiration as well as the need to take advantage of others to achieve his or her own goals (American Psychiatric Association, 2000).

How does shame contribute to the development of narcissism? Shame can lead to narcissism through two different forms of parenting. First, a primary caregiver's lack of sensitive parenting or dysfunctional parenting may lead the individual into a shame-filled state of narcissism. This is caused by the individual's lack of coping strategies to shame-inducing situations. Due to a lack of quality parenting, the child has no support base to turn to for defense against shame-inducing situations, so the individual creates coping strategies that help them to avoid the shameful feelings. These new strategies may lead the individual into a state of narcissism. Second, daily ridicule by a parent may lead a child to feel shamed, driving the individual to manifest a narcissistic personality as a defense mechanism against his or her shameful feelings (Belsky & Fearon, 2002; Campbell, Brunell & Foster, in press). The outcome of the defense mechanism is that the individual creates an "opposite" self or a self that conceals the shame-filled self, leading one to feel she/he is superior to others (Belsky & Fearon, 2002; Campbell, Brunell & Foster, in press).

Self-Blame

Self-blame is also caused by shame, making the individual feel that they are at fault for any injustice perpetuated against them especially whenever a situation does not go the way that they had hoped it would, although the circumstances may not be their fault. Self-blame due to shame can be categorized into two separate attribution tendencies, *characterological self-blame* vs. *behavioral self-blame* (Janoff-Bulman, 1979). Characterological self-blame involves blaming one's character in self-deprecating, maladaptive ways because one views their offensive behavior as an extension of one's self-concept. These character flaws are believed by the person to be relatively constant, large-scale, and fixed (Janoff-Bulman, 1979). By contrast, behavioral self-blame is an unstable, internal attribution in which the individual has control over behaviors such as believing that he has done something to cause the shame. An example would be someone who blames himself for not getting a job because he forgot to set his alarm clock, thus being late for the appointment. This form of blame is less complicated to deal with compared to characterological self-blame, which by contrast is due to fluctuations in a person's behaviors and the external control an individual

has over the situation at hand. An example of characterological self-blame would be someone who handles the shameful situation according to how they are feeling at that moment (Janoff-Bulman, 1979). Behavioral self-blame differs from characterological self-blame in that it involves the belief that one's inappropriate behavior can be modified and the transgression corrected. As a result, behavioral self-blamers focus on specific shameful conduct (Janoff-Bulman, 1979), and may attempt to rectify a situation when a personal failure occurs.

Anger

Anger is another possible consequence of shame. Individuals who suffer from a sense of shame may feel resentment towards others, which may in turn lead them to harmful actions including aggression against others and/or self-harm (Harper & Arias, 2004). For example, Frank, Schettini, and Lower (2002) found that children as well as adults have a higher level of anger-related antisocial behavior if their relationship with their parents was shame inducing, often leading these individuals to find destructive ways to deal with their anger-laden shame.

Anger Directed Towards Others. Shame is highly correlated with anger, especially when the shame is

directed toward others (Ahmed & Braithwaite, 2004; Frank, Schettini & Lower, 2002; Millagan & Andrews, 2005). Research shows that shame and anger are common causes of bullying during middle school and adolescence (Ahmed & Braithwaite, 2004). The anger arises in an individual because of their shameful feelings, but the individual is unaware of the cause of these feelings. One form of anger the individual uses on others is bullying. A form of shame that leads to bullying, i.e., *unacknowledged shame*, occurs when children are unaware that they feel shame and they make excuses for their anger and the bullying of others by blaming their victim (Ahmed & Braithwaite, 2004; Tangney, Wagner, & Gramzow, 1992). Ahmed and Braithwaite (2004) found that this type of bullying might be a defense mechanism that allows the bully to rationalize their anger.

Anger Directed Towards One's Self. By contrast, when individuals do acknowledge their own shame, they tend to turn it inward, which is known as *shame acknowledgement* (Ahmed & Braithwaite, 2004; Tangney, Wagner, & Gramzow, 1992). Shame acknowledgement is both a crucial as well as devastating state for the individual. It is, for example, crucial for keeping within social norms by allowing the individual to maintain self-control over his/her anger that

would otherwise be directed towards others. On the other hand, it is devastating for the individual when he turns his shame and anger inward upon himself. The shame-acknowledged individual becomes driven by internal anger, but unlike the person with unacknowledged shame, the shame-acknowledged individual is aware of his internal anger and feels that he must take this anger out on the source of his shame, i.e., himself. Because these individuals believe that they are defective and because they feel that they are the source of their anger, they are more likely to cause self-induced bodily harm or even commit suicide to overcome the internal pain they feel from his/her shame (Ahmed & Braithwaite, 2004; Milligan & Andrews, 2005).

Milligan and Andrews (2005) found that shame and anger are highly correlated in women who cause self-harm and either attempt or commit suicide. Shame and suicide tend to be equally correlated in both men and women, although women tend to have higher levels of acknowledged shame-induced anger. The self-harm that these individuals inflict upon themselves tends to allow the shame-prone and hence anger-prone individual the ability to reduce their feelings of shame, anger, lack of self-worth, and anxiety. This comes about because the self-harm makes the individual

feel that they are "alive" since the pain they induce upon themselves helps them feel more than the emptiness and apathy they feel from their shame. The individuals feel that the harm imposed upon them is filling the empty void caused by shame, but in reality, it is creating more anger, emptiness, and apathy, and once again reinforcing their shame (Milligan & Andrews, 2005).

Codependency

Codependency refers to a pervasive and excessive need to be taken care of, leading to submissive and clinging behavior as well as fear of separation. It includes difficulty making everyday decisions without the reassurance from others, difficulty expressing disagreement with others, going to excessive lengths to obtain nurturance and support from others, feeling uncomfortable or helpless when alone, and being unrealistically preoccupied with fears of being left to take care of one's self (American Psychiatric Association, 2000).

Shame can result in dysfunctional codependent relationships with others who are similar to their original source of shame, i.e., their parents. This happens when individuals are shamed by their parents (Beattie, 1987/1989; Bradshaw, 1988; Frank & Golden 1992;

Wegscheider-Cruse, 1990; Whitfield, 1987). According to Whitfield (1987), a shame-filled individual has lost connection with her true self and subconsciously replaces the old self with a new "false self", i.e., a creation of what the individual desires or pretends to be. It is similar to wearing a mask; the individual portrays someone who she believes others will like, while in truth, the true shame-filled self rages behind the mask, reminding her that she is unlovable and undesirable. Individuals who have a false self tend to be described as other-oriented, over-conforming, and shame-filled (American Psychiatric Association, 2000). Whitfield (1987) described the codependent individual as feeling bad about their true selves, i.e., as being defective or intrinsically inadequate.

Karen (1992/1998) notes that many clinicians overlook the place of shame in codependency and although a client may come to the therapist in search of help for their shame-inducing disorder, the therapist may try to heal the codependent behavior while missing the source of the syndrome, i.e., shame.

Origins of Shame

Theorists have disagreed about the origins of shame for decades (Karen 1992/1998). Although some researchers propose that shame may be wired in from birth, others believe that shame is an environmentally-induced emotion (e.g., Lewis, 1987).

Biological Origins of Shame

Many theorists feel that shame is an innate, biologically-based "device" used to "connect" the child to the primary caregiver. Helen Block Lewis (1987), a pioneer in the field of shame, believed that shame was biologically built into our emotional system to help maintain close proximity for the purpose of aiding in the survival of the infant. In her view, this innate shame device acts as an internal safety detector for the child in that it helps the child stay close to the parent by making the child feel "shamed" if the child wanders away from the parent. Lewis (1987) contends that the child does not consciously know why she feels this internal shame whenever she wanders too far away from her parent, but in reality, she is instinctively drawn back to her place of security, i.e., the parent, which helps to ensure the child's survival.

Environmental Origins of Shame

The majority of research on shame is based on the belief that it originates within the family of origin, specifically the individual's relationship with their primary caregiver during the first few years of life (Ainsworth, Blehar, Waters, and Wall 1978; Bowlby, 1988; Campbell, Brunell & Foster, in press; Karen, 1992).

Parenting. Parents promote shame within the child in several ways: a void of parental love and "quality" parenting, a lack of communication between the child and the parent, and parents making the child feel he/she is inadequate. First, a parent's lack of love, affection, and "quality" parenting towards his/her child can result in feelings of shame in the child. Consistent insensitive and unresponsive parenting leads to feelings of inadequacy and worthlessness in the child, which in turn leads a child to feel shame (Ainsworth et al., 1978; Bowlby, 1988; Bradshaw, 1988; Fossum & Mason, 1986; Karen, 1992; Morrison, 1989). According to theorists, a child who is not shown love and affection by a parent may wonder why his parent does not love him, leading him to feel that he is not deserving of that parent's love (Fossum & Mason, 1986; Karen, 1992; Morrison, 1989). This may be due in part to the child's

cognitive egocentrism which makes the child feel he/she is some how "flawed". This creates feelings of inadequacy, which in turn leads to feelings of shame (Ainsworth et al., 1978; Bowlby, 1988; Karen, 1992; Piaget, 1962).

In addition, parenting that is inconsistent, e.g., a parent whose parenting expectations change from day to day, creates confusion in the child as to whether his parent loves him. This can then activate internal shame by making the child feel that he is the cause of his parent's inconsistent parenting again, likely due to the child's cognitive egocentrism (Ainsworth et al., 1978; Bowlby, 1988; Karen, 1992; Piaget, 1962). One form of inconsistent parenting happens when the parent shows the child love and nurturance but does not set rules or consequences for the child. Because of this contradictory parenting, the child experiences a state of disequilibrium and begins to feel emotionally unbalanced (Piaget, 1962). This imbalance within the child's cognitive-emotive processes results in the child feeling shame (Ainsworth et al., 1978; Baumrind, 1967/1971/2005; Bowlby, 1988; Campbell, Brunell & Foster, in press; Karen, 1992; Lewis 1987).

Second, shame also results from a lack of emotive-based communication between the parent and the child (e.g.,

Bradshaw, 1988; Lutwak & Ferrari, 1997; Miller & Tangney, 1994). This lack of communication may take one of two forms: first, a parent may engage primarily in "impersonal" communications with the child, e.g., telling the child when dinner is, discussing with the child what they are having for dinner, or to inform the child that it is time to go somewhere as opposed to primarily focusing on recognizing and validating the child's feelings (Karen, 1992/1998). The second form of "emotionless" communication results from conversations between the parent and child that are completely one-sided, usually favoring the parent. In this type of communication, the parent does not consider or recognize the child's feelings. Instead, the parent uses directives, making verbal demands of the child and then walking away, completely ignoring the child's needs (Karen, 1992). Both of these forms of communication lack intimacy and recognition of the child's feelings. According to various researchers (e.g., Bradshaw, 1988; Lutwak & Ferrari, 1997; Miller & Tangney, 1994), this lack of emotive communication causes the child to begin to question her parent's love, leading her to feel shame: because of her own egocentrism, she feels that she is responsible for

the apathy that her parent shows towards her, while in reality she is not (Karen, 1992/1998; Piaget, 1962).

A third way a parent produces shame in the child is by making the child feel that he is inadequate by blaming the child for any negative outcome the child is involved in, e.g., accidentally spilling a glass of milk, or being bullied at school (Bradshaw, 1988; Janoff-Bulman, 1979; Karen, 1992; Lewis 1971/1992). Combined with young children's egocentric thought processes, this can lead to feelings of inadequacy and shame in young children (Piaget, 1962). This inadequacy in turn leads the child to feeling that anything negative that happens to him is created through his own actions, and he starts to feel personally responsible for his failures, which leads to further feelings of shame (Lewis 1971; Lewis, 1992). Over time, this child may willingly accept the blame for situations he may or may not have caused because internally he believes that he deserves to be blamed and punished (Bradshaw, 1988; Janoff-Bulman, 1979; Karen, 1992; Lewis 1971; Lewis, 1992).

Peers, Teachers, and Workplace Setting. Studies have shown that after the child leaves the care of the parent, i.e., when they enter into school, the child's level of pre-existing shame is put to the test (Ahmed & Braithwaite,

2004; Benn, Harvey, Gilbert, & Irons, 2005; DeLamater, 2004; Miyake & Yamazaki, 1995). If the child comes from a household that has induced shame into the child prior to entering school, he has a greater chance of suffering the ill effects of shame encountered from peers and teachers. Peers who use shame to control or manipulate (which is most likely learned from the manipulator's own parents) will now reinforce the shame-filled child's feelings. Teachers are also guilty of triggering shame in children by pitting children against each other, e.g., by creating a highly competitive grade-influenced classrooms, and in the way they talk to children (e.g., Ahmed & Braithwaite, 2004; DeLamater, 2004; Miyake & Yamazaki, 1995).

Attachment

Defining Attachment

Attachment is referred to as the evolutionary bond that occurs between the primary caregiver and the infant to ensure the survival of the infant (Broberg, 2000). There are four classifications of attachment styles, with the paramount style being securely attached. The other attachment styles are insecurely attached, which includes the ambivalent/resistant attachment and avoidant attachment

(Ainsworth, Blehar, Waters & Wall, 1978), and the fourth style of attachment is labeled disorganized (Main & Solomon, 1990).

Schaffer and Emerson (1964) examined the ethological observations of mothers and babies, which led to negation of the bond between the child and the primary caregiver. They discovered that the bond that forms is a result of the quality of interaction between the primary caregiver and the child. This contradicts what was previously believed, i.e., that the bond between the child and mother was due to the primary caregiver providing the baby its basic needs, i.e., food and water, but what Bowlby discovered was that babies are social creatures who tend to respond better to those who are sensitive, warm, and caring (Schaffer & Emerson, 1964).

Bowlby (1988) was also looking at the relationship between the infant and their primary caregiver in the same way as Schaffer and Emerson (1964). According to Bowlby (1988), there are three integral criteria, which are necessary for the attachment relationship to form: there needs to be proximity maintenance, a secure base, and a safe haven between the primary caregiver and the child. Proximity maintenance is what happens when the child makes

an effort to stay within proximity to the primary caregiver using the caregiver as a secure base in order to engage in investigative behavior such as exploration of the surrounding environment. The child will find comfort and a safe haven from their primary caregiver and they will use the primary caregiver as a place of support when she/he feels frightened or distressed. From their relationship with the primary caregiver, the child learns that she/he can depend on the primary caregiver and that she/he can trust the availability of the primary caregiver (Blatt 1990; Hazan & Shaver, 1994; Sloman, Atkinson, Milligan & Liotti, 2002).

Building off the works of Bowlby (1973), Schaffer, and Emerson (1964), Mary Ainsworth introduced the concept of attachment classifications to the world of psychology. From this research, Ainsworth devised the Strange Situation, i.e., an experiment used to create a stress-inducing situation by placing the child and the mother in a room. It then involves the introduction of a stranger and the departure and reintroduction of the mother. Through these series of episodes, Ainsworth found that she could classify children into one of three different categories:

securely attached, avoidant insecure, and ambivalent insecure (Ainsworth et al., 1978).

The securely attached child's parent is warm, sensitive, and responsive to the child's needs. The insecurely attached classification is represented by two subgroups, the avoidant and the ambivalent/resistant attachment classification. The avoidant child is characterized as feeling her primary caregiver provides an unstable environment where there is a more stressful environment. The ambivalent/resistant child has an environment that is also unstable and stressful, but the parents of these children are not as rejecting of the child; instead, they may be merely insensitive to the child's needs (Ainsworth et al., 1978; Bolen, 2000).

From Bowlby's and Ainsworth's work, Mary Main and Judith Solomon identified a fourth style of attachment classification, which they labeled as disorganized (Main & Solomon, 1990). The disorganized child's environment is chaotic and there is false stability. The disorganized child may show contradictory emotions towards the primary caregiver. This may be due to the parents not showing the child any affection, causing the child to become apathetic (Bolen, 2000; Main & Solomon, 1990). The disorganized

child does not know how to interpret the parent's affect or emotions and may live in constant fear of the parent, therefore the child will attempt to avoid or resist the parent. It has been hypothesized that if the child perceives the parent as someone to fear then it is more likely that the child will have a disorganized attachment relationship with the parent (Main & Hesse, 1990).

Research has shown that there is a higher incidence of disorganized attachment in children whose mothers report high levels of violence perpetrated on them by a partner (Steiner, Zeanah, Stuber, Ash & Angell, 1994), or have been identified as abusing alcohol and other illegal substances (Lyons-Ruth & Jacobinism, 1999), and in children who have been mistreated (Lyons-Ruth, Connell, Zoll & Stahl, 1987).

Consequences and Benefits of Attachment

Attachment theory has shown that the relationship one has with their primary caregiver sets the basis for that individual's future social interactions and will affect relationships that the individual has with others. The securely attached child has a better conception of what a healthy relationship is and has better coping strategies when confronted with a shame-inducing situation (such as

anxiety) compared to his insecurely attached counterpart. An individual's attachment classification determines their ability or incapacity to have a healthy way of adjusting to an anxiety-producing episode (Warren, Huston, Egeland, & Sroufe 1997).

Bowlby (1973) felt that the early years with our primary caregiver either provides us with or denies us the tools needed to adjust to anxiety-producing situations. As with Ainsworth's (1978) Strange Situations, the infant is placed in an anxiety-inducing environment and it is the child's attachment classification that determines how the infant handles this situation upon being reunited with their primary caregiver.

Researchers have established that adults who have been classified as insecurely attached as children will have greater feelings of affective distress, including depression and anxiety (Armsden, McCauley, Greenberg, Burke & Mitchell, 1990; Kobak, & Sceery, 1988; Kobak, Sudler, & Gamble, 1991). The securely attached individual, as a child, learns to manage distress and anxiety by using the strategies that were reinforced by their relationship with their primary caregiver (Bowlby, 1988; Mikulincer & Florian, 1998), whereas the insecurely attached individual

learns from their primary caregiver that they do not have the tools to overcome certain anxiety ridden situations (Bowlby, 1988).

Research has shown that individuals who have been classified as insecurely attached, both avoidant and the ambivalent/resistant classifications are more prone to depression (Beatson & Taryan, 2003; Scott & Cordova, 2002; Strodl & Noller, 2003), which is due to the lack of strategies that the individual has to use to cope with situations that cause depression. Subsequently, the primary caregiver becomes the source of the depression and/or anxiety, causing the individual to enter into adulthood with these negative feelings (Ainsworth, Blehar, Waters, & Wall, 1978; Beatson & Taryan, 2003; Bowlby, 1969; Scott & Cordova, 2002; Strodl & Noller, 2003).

In contrary to the insecurely attached child, the securely attached child has lower levels of depression and anxiety due to secure attachment styles acting as a buffer (Beatson & Taryan, 2003; Ciechanowski, Sullivan, Jensen, Romano, and Summers, 2003; Haaga, Yarmus, Hubbard, Brody, Solomon, Kirk, and Chamberlain, 2002; Wayment & Vierthaler, 2002). A relationship of warmth, caring, and sensitivity leads the securely attached individual to learn from their

primary caregiver strategies that help combat against shame-inducing psychological consequences. The primary bond between the child and the primary caregiver helps cushion the securely attached individual from childhood into adulthood.

Shame and Attachment

Research has shown that like insecure attachment, one factor that leads to creating a shame-prone individual is an unstable, persevering, and indifferent relationship between the child and the primary caregiver. Bowlby (1969) showed in his research that the relationships that we have as children become our Internal Working Models or guides as to how other relationships will be throughout our life. Ainsworth et al. (1978) reinforced Bowlby's (1969) findings and stated that the child-parent dyad is a persistent relationship that builds our repertoire of tools that we use to combat such angst provoking situations i.e., shame, depression, and anxiety. The insecure individual is most likely to be a shame-prone individual due to a lack of warmth and sensitivity in the parent-child relationship and is thus more likely to experience social rejection, depression, and anxiety.

Summary and Purpose of the Study

A child's parents appear to be a significant influence on the development of feelings of shame in children. Research suggests, for example, that parenting characterized as unresponsive, inconsistent, and void of sensitive attunement to the child's feelings is a leading cause of a child's shame (e.g., Ainsworth et al., 1978; Bowlby, 1988; Bradshaw, 1988; Fossum & Mason, 1986; Karen, 1992; Morrison, 1989). These shame-inducing parenting characteristics are very similar to those that foster an insecure attachment in young children, e.g., lack of love, insensitivity, and unresponsiveness. Conversely, parenting qualities that protect children against shame are parental love, sensitivity, warmth, and responsiveness, i.e., the same qualities that lead to a secure attachment between parent and child (e.g., Karen, 1992).

It was hypothesized that attachment security would be inversely related to shame, i.e., the more securely attached an individual, the less likely they will be to report feelings of shame.

CHAPTER TWO

METHOD

Participants

The participants were 172 volunteers (23 males, 149 females) from a medium-sized southwestern university who ranged in age from 18 to 25 years (M = 21.2 yrs.). Participants were ethnically diverse and predominantly Hispanic 44.8% (Caucasian 29.1, African American 8.7%, Asian 8.7%, and other 8.7%). Participants were from a wide range of social class backgrounds (based on father's educational level) with the highest percentage (44.2%) having a high school education or less. Of the remaining, 30.8% had some college or trade school experience, 15.7% had graduated college, 6.4% had completed postgraduate school, and 2.9% other.

Participants were recruited through in-class announcements and were given a brief introduction to the study. They were asked to complete and return the questionnaire to the experimenter to receive extra credit for their participation.

Measures

A questionnaire comprised of two attachment measures, a shame scale, and demographic information was distributed.

The Parental Attachment Questionnaire

The Parental Attachment Questionnaire (PAQ; Kenny, 1990) is a 55-item self-report measure designed to assess young adult's perceptions of their maternal relationships (Appendix A). The questionnaire uses a 5- point Likert scale (1= *not at all,* 5= *very much*) and allows for separate ratings of each parent, their relationship with that parent, and their feelings and experiences. The PAQ contains three scales derived by factor analysis: Affective Quality of Attachment, which assesses the individual's perceptions of parent availability, understanding, and acceptance and affect towards his/her parents (27 items); Parental Fostering of Autonomy, which assesses the individual's perceptions of the level of parental control, parental respect for individuality, and how the parent facilitates the individual's independence (14 items); and Parental Role in Providing Emotional Support, which assesses the individual's help-seeking behaviors during periods of stress, their degree of satisfaction concerning assistance obtained from parent(s), and their perceived

degree of parental support and protection (13 items). Internal consistency coefficients (Cronbach's alpha) for each of the derived factors are as follows: the Affective Quality of Attachment scale, .96; and both the Parental Fostering of Autonomy and Parental Role in Providing Emotional Support scales, .88 (Kenny & Hart, 1992). Test-retest reliability was reported at .92 for the PAQ measure over a two-week interval (Kenny & Hart, 1992). Since the focus was on the primary caregiver in the current study, the word "parents" was replaced with the word "mother".

Inventory of Parent and Peer Attachment Scale

The maternal scale from the Inventory of Parent and Peer Attachment (IPPA) scale (Appendix B) (Armsden & Greenberg, 1987) was also used to assess maternal attachment security as conceptualized by Bowlby (e.g., Ainsworth et al., 1978; Bowlby, 1988). The 25-item scale yields three subscales including Trust (i.e., mothers respect for individual's feelings and acceptance of the individual), Communication (i.e., the individual's level to communicate openly and without bias with their mother, how receptive the mother is to the child's feelings, and the mother's ability to empathize during conversations), and Alienation (i.e., individual's feelings of being alienated,

angered and isolated by their mother). The authors reported that the test-retest reliability for the maternal scale was .93; item-total correlations range from .53 to .80 (Armsden & Greenberg, 1987). The authors also reported excellent concurrent validity.

Experience of Shame Scale

The Experience of Shame Scale (Andrews & Hunter, 1997) (Appendix C) is a 25-item scale assessing characterological shame (i.e., the individual's feeling that there is something inherently wrong with them (12 items), behavioral shame (i.e., the individual's feeling that their shame is created through their own action (4 items), and bodily shame (i.e., the individual's undue preoccupation with their body shape and image, as well as their dread of becoming overweight)(9 items). These three subscales can also be combined to yield a total shame score. Participants respond to each Likert-type item (1 = not at all, 4 = very much) according to how they have felt in the past year, yielding total scores ranging from 25-100. The total scale shows high internal consistency (Cronbach's alpha = .92), with .83 test-retest reliability over 11 weeks. The internal consistency for the subscales was .90,

.87, and .86 (Cronbach's alpha) (Andrews, Qian & Valentine, 2002).

Demographics

Participants were asked to complete demographic questions regarding their age, social-economic status, and marital status (Appendix D).

Procedure

Questionnaires were handed out to participants in their classes. Participants completed the questionnaires and returned them for extra credit.

CHAPTER THREE

RESULTS

The purpose of this study was to examine the relationship between maternal attachment security and subsequent shame in young adulthood. Specifically, it was hypothesized that attachment security would be inversely related to shame.

Preliminary Analyses

The definitions, means, and standard deviations for the variables used in the study are shown below (see Table 1).

Table 1. Definitions, Means, and Standard Deviations for the Attachment and Shame Scales

Scale	Subscale	Definition	X	SD
Attachment:				
1. Inventory of Peer and Parent Attachment (IPPA)		Maternal attachment security (global score)	95.6	21.9
	Trust	Mother's respect for individual's feelings, and acceptance of the individual	39.5	8.7

Scale	Subscale	Definition	X	S
	Communication	Capacity to communicate openly and without bias with their mother; how receptive the mother is to the child's feelings; mother's ability to empathize during conversations	33.2	8.7
	Alienation	Feelings of being alienated, angered, and isolated by their mother	13.1	5.8
2. Parental Attachment Questionnaire (PAQ)		Parental attachment security (global scale)	155.6	15.9
	Affective Quality of Relationships	Feels that parents understand and accept them	108.7	21.0
	Parents as Facilitators of Independence	Feels that parents encourage and support their autonomy	50.4	10.4
	Parents as Source of Support	Feels that parents are available during times of stress and difficulty with decision making	38.9	8.5
Shame: 3. Experience of Shame Scale (ESS)		Shame (global scale)	52.7	1.3
	Characterological Shame	Feeling that there is something inherently wrong with them	22.6	8.7
	Behavioral Shame	Feeling that their shame is created through their own action	22.0	6.3

Scale	Subscale	Definition	X	S
	Bodily Shame	Undue preoccupation with their body shape and image, as well as their dread of becoming overweight	9.2	3.8

Next, to determine whether the shame scores were influenced by ethnicity, SES, or gender, a one-way ANOVA was used to compare the mean scores of the four ethnic groups (i.e., Hispanic, Caucasian, Asian, and African American); t-tests were then computed to compare "higher" versus "lower" SES groupings (based on whether the father had completed any higher education) and the two gender groups. No significant differences were found in any of the analyses, so all participants were combined for the final analyses.

Analyses

To test the relationship between attachment security and shame, a Pearson correlation was first computed. Results are shown in Table 2, and illustrate that, overall, the data support the hypothesis: the shame and attachment

security measures were significantly and inversely correlated in the expected direction.

Table 2. Correlation between Maternal Attachment Security and Shame

	Shame			
	Characterological	Behavioral	Bodily	Global Score
Attachment:				
Global Score (IPPA)	-.32***	-.25***	-.17*	-.30***
Trust (IPPA)	-.29***	-.21**	-.16*	-.27***
Communication (IPPA)	-.25***	-.20**	-.10	-.23**
Alienation (IPPA)	.41***	.31***	.27***	.40***
Affective Quality of Relationships (PAQ)	-.25***	-.17*	-.20**	-.24**
Parents as Facilitators of Independence (PAQ)	-.33***	-.23**	-.19*	-.30***
Parents as Source of Support (PAQ)	-.11	-.04	-.05	-.09

*$p \leq .05$
**$p \leq .01$
***$p \leq .001$

Overall, the results generally show that maternal trust, maternal understanding/acceptance, empathetic communication, and facilitation of autonomy are all significantly related to lower levels of shame. By contrast, being angry at and feeling alienated from one's

mother were positively and significantly correlated with shame.

Maternal Trust was negatively and significantly correlated with all three shame subscales, while Communication was negatively and significantly correlated with Characterological and Behavioral shame. In addition, both factors were negatively and significantly correlated with the global shame score, suggesting that mothers' respect for the participants' feelings and having open communication between the mother and participant are related to having less shame. Maternal Alienation, by contrast, was positively and significantly related to shame: i.e., the more an individual is alienated, angered, and isolated by their mother, the higher their level of shame.

The PAQ subscales of Affective Quality of Relationships (i.e., feeling that the parent understands and accepts them) and Parental Fostering of Autonomy (i.e., feeling the parent supports their independence) were both negatively and significantly correlated with all the measures of shame. However, Parental Role in Providing Support was not significantly related to shame; i.e., whether or not an individual feels that their parent is

available during times of stress and helps with difficult decision-making was unrelated to shame.

Finally, there was no relationship between maternal support and the level of shame in the individual.

A stepwise regression analysis was next computed to examine the predictors of (global) shame. The variables entered were Maternal Trust, Maternal Communication, Maternal Alienation, Affective Quality of Relationship, and Mothers as Facilitators of Independence. Results showed that a significant proportion of the variance in shame (R^2=.15) was influenced by Maternal Alienation, F (1, 170) =30.80, p<.000. None of the other variables was significant.

CHAPTER FOUR

CONCLUSIONS AND RECOMMENDATIONS

Discussion

The purpose of the current study was to examine the impact of the quality of maternal attachment on shame. Although research has theorized this connection (e.g., Ainsworth et al., 1978; Bowlby, 1988; Bradshaw, 1988; Fossum & Mason, 1986; Karen, 1992; Morrison, 1989), no study has yet examined this empirically.

Overall, the results of this study supported the hypothesis that attachment security would be inversely related to shame. These findings are consistent with other studies that have postulated that a secure attachment contributes to the child's feeling of self-worth and value by providing warmth, responsiveness, and sensitivity instead of shame-inducing parent-child interactions (e.g., Ainsworth et al., 1978; Bowlby, 1988; Karen, 1992). In addition, a secure attachment can provide children with the ability to defend themselves against other shame-inducing episodes outside the home (Warren, Huston, Egeland, & Sroufe 1997). Conversely, a child who has an insecure attachment with his/her mother will have greater feelings

of affective distress; the lack of warmth, love, and sensitive responsiveness leaves a child feeling unloved and unworthy, resulting in a sense of shame(e.g., Armsden, McCauley, Greenberg, Burke & Mitchell, 1990; Bowlby, 1988; Kobak, & Sceery, 1988; Kobak, Sudler, & Gamble, 1991).

The significant relationship between individuals feeling that they can speak openly, empathetically, and free of criticism with their mother and lower levels of shame is consistent with research that has found that shame is a result of the lack of genuine and empathetic communication between the parent and the child (e.g., Bradshaw, 1988; Lutwak & Ferrari, 1997; Miller & Tangney, 1994). A secure attachment allows the child to feel uninhibited in their ability to explore, not only physically, but also psychologically and emotionally. This freedom allows the child to have a higher sense of self-worth (e.g., Ainsworth et al., 1978; Bowlby, 1988; Karen, 1992).

Maternal respect and acceptance of the child may also prevent the development of feelings of shame from outside sources by creating better management skills against shame by using the strategies that were reinforced by their

secure relationship with their mother (Ahmed & Braithwaite, 2004).

The inverse relationship between maternal understanding/acceptance and shame supports research that maintains that the child's positive affective attachment to their mother, i.e., feeling warmth, caring, and sensitivity from her is vital to their development of a sense of one's self as worthy and valued (e.g., Ainsworth et al., 1978; Bowlby, 1988; Karen, 1992).

In addition, the negative relationship between maternal support of autonomy and shame coincides with current research showing that securely attached individuals have learned to rely on their mother while maintaining their autonomy (e.g., Ainsworth et al., 1978; Bowlby, 1988; Bradshaw, 1988; Fossum & Mason, 1986; Karen, 1992; Morrison, 1989). With a secure attachment, an individual is more likely to explore their environment as they have the reassurance that their mother will be there as a refuge in time of need. This secure relationship gives the individual the freedom of independence without the consequence of shame (e.g., Ainsworth et al., 1978; Bowlby, 1988; Karen, 1992).

The findings of a lack of a relationship between the mothers' availability as a source of support during stressful times and shame may be due to feelings of shame being unrelated to a mother's actual or available support of the individual during stressful times. Since attachment was found to play a role in the child's level of shame, it may be that maternal attachment, which reinforces support in decision-making, would be indirectly but not directly related to support (Ainsworth et al., 1978; Bowlby, 1988; Bradshaw, 1988; Fossum & Mason, 1986; Karen, 1992; Morrison, 1989). Another possibility, which needs further research, is whether the questionnaire items regarding the mother as a source of support are more behavioral than based on participants' perception. Finally, these results may also have been influence by the fact that while the IPPA looks at the mother-child relationship in the past, the PAQ examines the parent-child relationship in the present.

The current study also found that participants' communicative relationship with their mother had no effect on bodily shame (i.e., the preoccupation with one's body shape and image, or the dread of becoming overweight). This may be due to such influences as peers, the media, and

the onset of puberty having more of a direct influence on body image than the quality of communication with parents.

The results of the current study also showed that individuals who feel alienated, angered, and isolated from their mothers have higher levels of shame. This finding is consistent with studies showing that if one's relationship with their mother is fraught with attachment estrangement, then alienation will lead to shame within the child (e.g., Ainsworth et al., 1978; Bowlby, 1988; Karen, 1992). Insecurely attached children have a lower level of self-worth and tend to feel that their mother is not trustworthy or reliable (Ainsworth et al., 1978; Bowlby, 1988; Karen, 1992). If this is compounded with a sense of alienation, anger, and isolation, the child has little sense of self-worth and/or confidence, and this emptiness may turn into feelings of shame (Ainsworth et al., 1978; Bowlby, 1988; Bradshaw, 1988; Fossum & Mason, 1986; Karen, 1992; Morrison, 1989).

Limitations and Future Research

There are a few limitations of the current study, i.e., gender and ethnicity.

First, the majority of the sample pool was female; there were very few males. Future studies could determine whether the outcome would have been different for males. The lack of many male participants in the current study did not give a clear picture as to whether males' experience of shame is similar to that of females, and whether it is related to attachment in the same way as females'.

Second, the majority of the sample was Hispanic; future studies that have equal numbers of participants in various ethnic groups could determine whether ethnicity impacts the relationship between attachment and shame. Various cultures raise their children differently; for example, some cultures use shame as a parenting tool (e.g., the Japanese use of social withdrawal [Miyake & Yamazaki, 1995]).

The present study opens the door to future research in the area of attachment-shame studies. Future studies, for example, might examine longitudinally the developmental consequences of shame and attachment. The evidence that shame and attachment are significantly correlated along with the research demonstrating that shame leads to social anxiety, depression, addiction, eating disorders, narcissism, self-blame, anger, and/or codependency can now

be linked to the importance of a secure attachment relationship between the mother and child.

Another area to examine for future study would be to verify that the maternal alienation scale is qualitatively different from items measuring shame. In addition, further analyses of the regression models could clarify the relationship between the various attachment factors.

Summary and Conclusions

This is the first study to empirically examine the relationship between shame and attachment. The findings of this study have significant implications for parenting, including providing support for the importance of a secure relationship between the mother and child and the developmental consequences of warm, secure caregiving experiences for their child.

Second, this research adds to the current attachment literature in that it extends the consequences of the impact of attachment on development to include shame as yet another psychological correlate of a poor early caregiving environment. The development of a secure attachment with one's child will, theoretically, help build life-long barriers against familial and extra-familial sources of

shame (and the repercussions of shame in terms of many of the psychological disorders reviewed earlier).

Lastly, this study has implications for the field of clinical psychology. Therapists who are treating clients for social anxiety, depression, addiction, eating disorders, narcissism, self-blame, anger, and/or codependency, could benefit from the knowledge that shame may be the underlying cause of the symptoms being treated (e.g., Karen, 1994). Not recognizing underlying shame may result in a greater chance that the client may leave therapy feeling healed, but if their source of shame was never examined, the patient may return to using alcohol to self-medicate due to their subliminal shame. The present study could encourage clinical psychologists to look beyond the presenting disorder and delve deeper into the patient's early relational background.

APPENDIX A

MATERNAL ATTACHMENT QUESTIONNAIRE

Maternal Attachment Questionnaire (Revised PAQ sale)

The following pages contain statements that describe your relationship with your mother and the kinds of feelings and experiences frequently reported by young adults. Please respond to each item by filling in the number on a scale of 1 to 5 that best describes your mother, your relationship with your mother, and your experiences and feelings. Please provide a single rating to describe your mother and your relationship with her.

Not at All	Somewhat	A Moderate Amount	Quite A Bit	Very Much
1	2	3	4	5

In general, my mother...

___1. is a person I can count on to provide emotional support when I feel troubled.
___2. supports my goals and interests.
___3. lives in a different world.
___4. understands my problems and concerns.
___5. respects my privacy.
___6. restricts my freedom or independence.
___7 is available to give me advice or guidance when I want it.
___8. takes my opinions seriously.
___9. encourages me to make my own decisions.
___10. is critical of what I can do.
___11. imposes her ideas and values on me.
___12. has given me as much attention as I have wanted.
___13. is a person to whom I can express differences of opinion on important matters.
___14. has no idea what I am feeling or thinking.
___15. has provided me with the freedom to experiment and learn things on my own.
___16. is too busy or otherwise involved to help me.
___17. has trust and confidence in me.
___18. tries to control my life.

During recent visits or time spent together, my mother was a person. . .

___28. I looked forward to seeing.
___29. with whom I argued.
___30. with whom I felt relaxed and comfortable.
___31. who made me angry.
___32. I wanted to be with all the time.
___33. towards whom I felt cool and distant.
___34 who got on my nerves.
___35. who aroused feelings of guilt and anxiety.
___36. to whom I enjoyed telling about the things I have done and learned.
___37. for whom I felt a feeling of love.
___38. I tried to ignore.
___39. to whom I confided my most personal thoughts and feelings.

Not at All	Somewhat	A Moderate Amount	Quite A Bit	Very Much
1	2	3	4	5

___40. whose company I enjoyed.
___41. I avoided telling about my experiences

Following time spent together, I leave my mother. . .
___42. with warm and positive feelings.
___43. feeling let down and disappointed by my family.

When I have a serious problem or an important decision to make. . .
___44. I look to my mother for support, encouragement, and/or guidance.
___45. I seek help from a professional, such as a therapist, college counselor, or clergy.
___46. I think about how my mother might respond and what she might say.
___47. I work it out on my own, without help or discussion with others.
___48 I discuss the matter with a friend.
___49. I know that my mother will know what to do.
___50. I contact my mother if I am not able to resolve the situation after talking it over with my friends.

When I go to my mother for help. . .
___51. I feel more confident in my ability to handle the problems on my own.
___52. I continue to feel unsure of myself.
___53. I feel that I would have obtained more understanding and comfort from a friend.
___54. I feel confident that things will work out as long as I follow my mother's advice.
___55. I am disappointed with her response.

APPENDIX B

MATERNAL SCALE FROM INVENTORY OF PARENT AND PEER ATTACHMENT SCALE

Maternal Scale from Inventory of Parent and Peer Attachment (IPPA) scale. Each of the statements below asks about your feelings about your **Mother**. Please Read each statement and indicate the response, which best applies to you, **when you were a child** with the appropriate letter. There are no 'right' or 'wrong' answers.

Almost Never or Never True	Not Very Often True	Sometimes True	Often True	Almost Always or Always True
A	B	C	D	E

___1. My mother respected my feelings.
___2. I felt my mother did a good job as my mother.
___3. I wish I had had a different mother.
___4. My mother accepted me as I was.
___5. I liked to get my mother's point of view on things I was concerned about.
___6. I felt it was no use letting my feelings show around my mother.
___7. My mother was able to tell when I was upset about something.
___8. Talking over my problems with my mother made me feel ashamed or foolish.
___9. My mother expected too much from me.
___10. I got easily upset around my mother.
___11. I got upset a lot more than my mother knew about.
___12. When we discussed things, my mother cared about my point of view.
___13. My mother trusted my judgment.
___14. My mother had her own problems, so I did not bother her with mine.
___15. My mother helped me to understand myself better.
___16. I told my mother about my problems and troubles.
___17. I felt angry with my mother.
___18. I did not get much attention from my mother.
___19. My mother helped me to talk about my difficulties.
___20. My mother understood me.
___21. When I got angry about something, my mother tried to be understanding
___22. I trusted my mother.
___23. My mother did not understand what I was going through.
___24. I could count on my mother when I needed to get something off my chest.
___25. If my mother knew something was bothering me, she asked me about it

APPENDIX C

EXPERIENCE OF SHAME SCALE

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**. Please indicate your response, with the appropriate letter. There are no 'right' or 'wrong' answers.

Not At All	A Little	Moderately	Very Much
A	B	C	D

___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 at something, which was important to you?
___20. Have you worried about what other people think of you when you fail?
___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 D

DEMOGRAPHIC INFORMATION

Demographic Information

1. Your Age: _____

2. Your Sex (Check one):Male _____ Female _____

3. Your current marital status (Check one):

____ single
____ married
____ separated/divorced
____ widowed
____ other (_____)

4. What is your ethnic background? (Check one):

____ Asian
____ Black
____ Caucasian
____ Hispanic
____ Other (_____)

5. What was the highest grade in school (or level of education) your mother completed?

____ did not complete high school
____ graduated high school
____ some college or trade school
____ graduated from college
____ Other (_____)

6. What was the highest grade in school (or level of education) your father completed?

____ did not complete high school
____ graduated high school
____ some college or trade school
____ graduated from college
____ Other (_____)

7. If your parents were separated/divorced or widowed, how old were you when this occurred? _____

REFERENCES

Ahmed, E. & Braithwaite, V. (2004). What Me ashamed? Shame management and bullying. *Journal of Research in Crime and Delinquency, 4,* 269-294.

Ainsworth, M., Blehar, M. C., Waters, E., and S. Wall. (1978). *Patterns of Attachment: A Psychological Study of the Strange Situation.* Hillsdale, NJ: Erlbaum.

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV.* 4th ed., text revision. Washington.

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

Andrews, B., Qian, M. & Valentine, J.D. (2002). Predicting depressive symptoms with a new measure of shame: The Experience of Shame Scale. *British Journal of Clinical Psychology, 41,* 29-42.

Armsden, G., & Greenberg, M. (1987). The inventory of parent and peer attachment: Individual differences and their relationship to psychological well-being in adolescence. *Journal of Youth and Adolescence, 16,* 427-454.

Armsden, G. C., McCauley, E., Greenberg, M. T., Burke, P. M., & Mitchell, J. R. (1990). Parent and peer attachment in early adolescent depression. Journal of Abnormal Child Psychology, 18, 683-697.

Baumrind, D. (1967). Childcare practices anteceding three patterns of preschool behavior. *Genetic Psychology Monograph, 75,* 43-88.

Baumrind, D. (1971). Current patterns of parental authority. *Developmental Psychology Monograph, Part 2, 4(1),* 1-103.

Baumrind, D. (2005). Taking a stand in a morally pluralistic society: Constructive obedience and responsible dissent in moral/character education. In L. Nucci (Ed.), *Conflict, contradiction, and contrarian elements in moral development and education* (pp. 21-50). New Jersey: Erlbaum.

Beatson, J. & Taryan, S. (2003). Predisposition to depression: the role of attachment. Australian & New Zealand J Psychiatry 37: 219-225.

Beattie, M. (1987). *Co-dependent no more.* New York: Harper & Row.

Beattie, M. (1989). *Beyond codependency and getting better all the time.* San Francisco: Harper & Row.

Belsky, J. & Fearon, R. M. (2002). Early attachment security, subsequent maternal sensitivity, and later child development: Does continuity in development depend upon continuity of care giving? *Attachment & Human Development, 4,* 361-388.

Benedict, Ruth. (1946). *The Chrysanthemum and the Sword: Patterns of Japanese Culture*. Boston: Houghton Mifflin.

Benn, L., Harvey, J.E., Gilbert, P., & Irons, C. (2005). Social rank, interpersonal trust and recall of parental rearing in relation to homesickness. *Personality and Individual Differences, 38,* 1813-1822.

Bennett, L. (1995). Substance abuse and the domestic assault

of women. *Social Work, 40 (6),* 760-771.

Blatt, S.J. (1990). Interpersonal relatedness and self-definition: Two personality configurations and their implications for psychopathology and psychotherapy. In: J.L. Singer, Editor, *Repression and dissociation: Implications for personality theory, psychopathology & health*, University of Chicago Press, Chicago 299-335.

Bolen, R. M. (2000). Validity of attachment theory. *Trauma, Violence, and Abuse, 1,* 128-153.

Bowlby, J. (1969). *Attachment and Loss, Vol. 1: Attachment.* New York: Basic Books.

Bowlby, J. (1973). Separation: Anxiety & Anger. *Vol. 2 of Attachment and loss* London: Hogarth Press; New York: Basic Books; Harmondsworth: Penguin

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development.* New York: Basic Books.

Bowles, S. & Gintis, H. (2002). The Inheritance of Inequality. *Journal of Economic Perspectives, 26,* 3-30

Bradshaw, J. (1988). *The Family: A Revolutionary Way of Self-Discovery.* Deerfield Beach, FL: Health Communications.

Britt, L. & Heise, D. R. (2000). "From shame to pride in identity politics." Pp. 252-268 in *Self, Identity, and Social Movements,* edited by Sheldon Stryker, Timothy J. Owens, and Robert W. White. Minneapolis: University of Minnesota Press.

Broberg, A. G. (2000). A review of interventions in the parent-child relationship informed by attachment theory. *Acta Pedeatric, 89,* 37-42.

Buss, A.H. (1980). *Self-consciousness and social anxiety.* San Francisco: Freeman Campbell, W.K., Brunell, A. B., & Foster, J. D. (in press). *Sitting here in limbo: Ego-shock and posttraumatic growth.*

Campbell, W.K., Brunell, A. B., & Foster, J. D. (in press). *Sitting here in limbo: Ego-shock and posttraumatic growth.*

Ciechanowski P, Sullivan M, Jensen M, Romano J, Summers H. (2003). The relationship of attachment style to depression, catastrophizing and health care utilization in patients with chronic pain. *Pain, 104,* 627-37.

Cooper, M.J., Rose, K.S. & Turner, H. (2004). Core beliefs and the presence or absence of eating disorder symptoms and depressive symptoms in adolescent girls. *International Journal of Eating Disorders.*

Dearing, R. L., Stuewig, J., & Tangney, J. P. (2005). On the importance of distinguishing shame from guilt: Relations to problematic alcohol and drug use. *Addictive Behaviors, 30,* 1392-1404.

DeLamater, J. (2004). *Handbook of Social Psychology.* New York: Kluwer-Plenum. Erikson, E. (1950). *Childhood and Society.* NY: WW Norton & Company.

Erikson, E. (1950). *Childhood and society*. New York: Norton.

Feiring, C., Taska, L.S, & Lewis, M. (1998). The role of shame and attribution style in children's and adolescents' adaptation to sexual abuse. *Child Maltreatment, 3,* 129-142.

Fisher, S.F. (1985). Identity of two: The phenomenology of shame in borderline development and treatment. *Psychotherapy, 22,* 101-109.

Fossum, M.A. & Mason, M.J. (1986). *Facing Shame: Families in Recovery*. New York: WW Norton & Company.

Frank, P., & Golden, G. (1992). Blaming by naming. *Social Work, 37,* 5-6.

Frank, S.J., Schettini, A. M., & Lower, R. J. (2002). The role of separation-individuation experiences and personality in predicting externalizing and internalizing dimensions of functional impairment in early adolescence. *Journal of Clinical Child & Adolescent Psychology, 31,* 431-442.

Gilbert, P., Allan, S., & Goss, K. (1996). Parental representations, shame, interpersonal problems and vulnerability to psychopathology. *Clinical Psychology and Psychotherapy, 3,* 23-34.

Gilbert, P. (1997). The evolution of social interactions. *British Journal of Medical Psychology, 70,* 113-147.

Gilbert, P. (2000). Stigmatization as a survival strategy: 'Skeletons in the cupboard' and the role of shame. *Every Family in the Land, tackling the prejudice and discrimination against people with mental illness* (ed. A. H. Crisp), www.stigma.org.

Gilbert, P. & Irons, C. (2005). Therapies for shame and self-attacking, using cognitive, behavioural, emotional imagery, and compassionate mind training. In P. Gilbert (Ed) *Compassion: Conceptualisations research and use in psychotherapy.* London: Brunner-Routledge.

Haaga, D. A. F., Yarmus, M., Hubbard, S., Brody, C., Solomon, A., Kirk, L., & Chamberlain, J. (2002). Mood dependency of self-rated attachment style. *Cognitive Therapy and Research, 26,* 57-71.

Harder, D., & Lewis, S. (1987). The assessment of shame and guilt, in C. Spielberger & J. Butcher (Eds.) *Advances in Personality Assessment, (Vol. 6),* Hillsdale, NJ: Lawrence Erlbaum, 91-114.

Harder, D. W., Cutler, L., & Rockart, L. (1992). Assessment of shame and guilt and their relationships to

psychopathology. *Journal of Personality Assessment, 59,* 584-604.

Harder, D. W., & Zalma, A. (1990). Two promising shame and guilt scales: A construct validity comparison. *Journal of Personality Assessment, 55,* 729-745.

Harper, F. W. K., & Arias, I. (2004). The role of shame in predicting adult anger and depressive symptoms among victims of child psychological maltreatment. *Journal of Family Violence.*

Hazan, C., & Shaver, P. R. (1994). Attachment as an organizational framework for research on close relationships. *Psychological Inquiry, 5,* 1-22.

Hoblitzelle, W. (1987). Differentiating and measuring shame and guilt: The relation between shame and depression. In H. B. Lewis (Ed.), *The role of shame in symptom formation* (pp. 207-235). Hillsdale, NJ: Erlbaum.

Janoff-Bulman, R. (1979). Characterological versus behavioral self-blame: Inquiries into depression and rape. *Journal of Personality and Social Psychology, 37,* 1798-1809.

Jordan, J. (1989). *Relational development: Therapeutic implications of empathy and shame,* Wellesley, MA: The Stone Center.

Karen, R. (1992). Shame. *The Atlantic Monthly*. 40-70.

Karen, R. (1998). *Becoming attached: First relationships and how they shape our capacity to love*. New York: Oxford University Press.

Kaufman, G. (1989). *Psychology of shame: Theory and treatment of shame-based syndromes*. New York: Springer.

Kaufman, G. (1992). *Shame, the power of caring*. 3rd Rev. Ed. Rochester, VT: Schenkman.

Kenny, M. (1990). College seniors' perceptions of parental attachments: The value and stability of family ties. *Journal of College Student Development, 31,* 39-46.

Kenny, M. E. & Donaldson, G. (1991). Contributions of parental attachment and family structure to the social and psychological functioning of first-year college students. *Journal of Counseling Psychology, 38,* 479-486.

Kenny, M. E. & Hart, K. (1992). Relationship between parental attachment and eating disorder symptoms in an inpatient and a college sample. *Journal of Counseling Psychology, 39,* 521-526.

Kohut, H. (1971). *The Analysis of the Self. A Systematic Approach to the Psychoanalytic Treatment of*

Narcissistic Personality Disorders., New York: Int. Univ. Press.

Kobak, R. R., & Sceery, A. (1988). Attachment in late adolescence: Working models, affect regulation, and working representations of self and others. Child Development, 59, 135-146.

Kobak, R., Sudler, N. & Gamble, W. (1991). Attachment and depressive symptoms during adolescence: A developmental pathways analysis. Development and Psychopathology, 3, 461-474.

Kohut, H. (1985). *Self Psychology and the Humanities: Reflections on a New Psychoanalytic Approach.*, New York & London: W. W. Norton.

Lewis, H. B. (1971). *Shame and guilt in neurosis.* New York: International Universities Press.

Lewis, H. B. (1987). *The Role of Shame in Symptom Formation.* Hillsdale NJ: Erlbaum.

Lewis, M. (1992). *Shame: The exposed self.* New York: The Free Press.

Lindsay-Hartz, J. (1984). Contrasting experiences of shame and guilt. *American Behavioral Scientist, 27,* 689-704.

Lutwak, N. & Ferrari, J. (1996). Moral affect and cognitive processes: Differentiating shame from guilt among men

and women. *Personality and Individual Differences, 21,* 1-6.

Lutwak, N. & Ferrari, J. (1997): Understanding Shame in Adults: Retrospective Perceptions of Parental-Bonding during Childhood. Journal *of Nervous & Mental Disease, 185,* 595-598.

Lutwak, N., Ferrari, J., & Cheek, J. M. (1998). Shame, guilt, and identity in men and women: The role of identity orientation and processing style in moral affects. *Personality and Individual Differences, 25,* 1027-1036.

Lutwak, N., Razzino, B.E., & Ferrari, J.R. (1998). Self-perceptions and moral affect: An exploratory analysis of subcultural diversity in guilt and shame emotions. *Journal of Social Behavior and Personality, 13,* 333-348.

Lynd, H. (1958). *On Shame and the Search for Identity. New York: Harcourt.* New York: Plenum.

Lyons-Ruth, K., Connell, D., Zoll, D., & Stahl, J. (1987). Infants at social risk: Relations among infant maltreatment, maternal behavior, and infant attachment behavior. *Developmental* Psychology, 23, 223-232.

Lyons-Ruth, K. & Jacobvitz, D. (1999). Attachment disorganization: unresolved loss, relational violence, and lapses in behavioral and attentional strategies. In J. Cassidy & P. R. Shaver Eds.). *Handbook of attachment: Theory, research, and clinical applications* (pp. 520-554). NY: The Guilford Press.

Main, M., & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism? In M. Greenberg, D. Cicchetti, & E.M. Cummings (Eds.), *Attachment in the preschool years: Theory, research and intervention* (pp. 161-184). Chicago: University of Chicago Press.

Main, M. & Solomon, J. (1990). Procedures for identifying infants as disorganized-disoriented during the Ainsworth Strange Situation. In M. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the Preschool Years: Theory, Research and Intervention.* (p. 121-160). Chicago: University of Chicago Press.

Miller, R. S., & Tangney, J. P. (1994). Differentiating embarrassment and shame. *Journal of Social and Clinical Psychology, 13,* 273-287.

Milligan, R. J. & Andrews, B. (2005). Suicidal and other self-harming behavior in offender women: The role of shame, anger and childhood abuse. *Legal and Criminological Psychology, 10,* 13-25.

Miyake, K., & Yamazaki, K. (1995). Self-conscious emotions, child rearing, and child psychopathology in Japanese culture. In J. P. Tangney & K. W. Fischer (Hg.), *Self-conscious emotions: The psychology of shame, guilt, embarrassment, and pride* (488-504). New York: Guilford.

Morrison, A. P. (1989). *Shame: the underside of narcissism.* Hillsdale, NJ: Analytic Press.

Mikulincer, M., & Florian, V. (1998). The relationship between adult attachment styles and emotional and cognitive reactions to stressful events. In J. A. Simpson & W. S. Rholes (Eds.), *Attachment theory and close relationships* (pp. 143-165). New York: Guilford Press.

Murray, C., Waller, G., & Legg, C. (2000). Family dysfunction and bulimic psychopathology: The mediating role of shame. *International Journal of Eating Disorders, 28,* 84-89.

O'Connor, L.E., Berry, J.W., & Weiss, J. (1999). Interpersonal guilt, shame, and psychological problems. *Journal of Social and Clinical Psychology*, 18, 181-203. Piaget, J. (1962). *Play, Dreams and Imitation in Childhood*. New York: Norton.

Piers G. & Singer M. (1971). *Shame and Guilt: A Psychoanalytic and a Cultural Study*. W. W. Norton, New York

Rodin, J. (1992). *Body traps: Breaking the binds that keep you from feeling good about your body*. New York: William Morrow and Company.

Schaffer, H.R. & Emerson, P.E (1964). The development of attachment in infancy. *Monographs of the Society for Research in Child Development, 94*.

Scott, R., & Cordova, J. V. (2002). The influence of adult attachment styles on the association between marital adjustment and depressive symptoms. *Journal of Family Psychology, 16,* 199-208.

Sloman, L., Akinson, L., Milligan, K. and Liotti, G. (2002). Attachment, social rank and affect regulation: speculations on an ethological approach to family interaction. *Family Process, 41*, 313-327.

Steiner, H., Zeanah. C. H., Stuber, M. Ash, P., and Angell, R. (1994). The hidden faces of trauma: An update on child psychiatric traumatology. *Scientific Proceedings of the Annual Meeting of the American Academy of Child and Adolescent Psychiatry. 3.*

Strodl, E., & Noller, P. (2003). The Relationship between Attachment, Depression and Panic Disorder with Agoraphobia. *Personal Relationships, 10,* 171-185.

Tangney, J. P. (1990). Assessing individual differences in proneness to shame and guilt: Development of the self-conscious affect and attribution inventory. *Journal of Personality and Social Psychology, 59,* 102-111.

Tangney, J. P. (1991). Moral affect: The good, the bad and the ugly. *Journal of Personality and Social Psychology, 61,* 598-607.

Tangney, J.P. (1993). Shame and guilt. In C.G. Costello (Ed.), *Symptoms of depression* (pp. 161-180). New York: Wiley.

Tangney, J.P. (1995). Recent advances in the empirical study of shame and guilt. *American Behavioral Scientist, 38,* 1132-1145.

Tangney, J.P., Burggraf S.A. & Wagner P.E. (1995). Shame proneness, guilt- proneness and psychological

symptoms. In J. P. Tangney and K.W. Fisher (eds.) *Self-conscious emotions: The psychology of shame, guilt, embarrassment and pride.* New York: Guilford, pp. 343-367.

Tangney, J. P. & Fischer, K. W. (1995). *Self-conscious emotions: Shame, guilt, embarrassment and pride.* New York: Guilford Press.

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

Tangney, J. P., Wagner, P. E., & Gramzow, R. (1992). Proneness to shame, proneness to guilt, and psychopathology. *Journal of Personality and Social Psychology, 62,* 669-675.

Teusch, R. (1988). Level of ego development and bulimics' conceptualizations of their disorder. *International Journal of Eating Disorders,* 7, 607-615.

Warren, S. L., Huston, L., Egeland, B., Sroufe, A. (1997). Child and adolescent anxiety disorders and early attachment. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 637 - 645.

Wayment, H.A., & Vierthaler, J. (2002). Attachment style and bereavement reactions. *Journal of Loss and Trauma, 7, 129-149.*

Wegscheider-Cruse, S. (1990). *Understanding Codependency.* Pompano Beach, FA: Health Communication.

Wicker, F. W., Payne, G. D. & Morgan, R. D. (1983). Participant Descriptions of Guilt and Shame. *Motivation and Emotion, 7,* 25-39.

Whitfield, C. (1987). *Healing the child within.* Deerfield Beach, Fla.: Health Communications, Inc.

Woien, S. L., Ernst, A. H., Patock-Peckman, J. A., & Nagoshi, T. (2001). Validation of the TOSCA to measure shame and guilt. *Personality and Individual differences, 35,* 313-326.

Wright, F, O'Leary, J. & Balkin, J. (1989). Shame, Guilt, Narcissisism, and Depression: Correlates and Sex Differences. *Psychoanalytic Psychology 6,* 217-230.