

I'm Upset, not Ashamed: An Investigation into Adolescent Shame Acknowledgement

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ABSTRACT: Shame is a powerful and acutely painful “master emotion” that is strongly correlated with maladaptive behaviors and a host of psychological symptoms. Concerningly, the affect remains under-researched and difficult to identify or address in a clinical setting. This may be caused, at least in part, by shame’s intrinsically hidden nature, which drives people to deny the emotion and express it through other means. This study aimed to understand the degree to which people fail to acknowledge their own shame and the psychological and behavioral implications of this shame. Participants completed both a self-report measure of shame and an empirical assessment of internalized shame, as well as measures of shame coping methods and emotional regulation. As expected, results showed no significant correlation between participants’ self-rated shame and measured shame. We also saw a significant correlation between assessed internalized shame and use of shame-coping methods as well as difficulty in emotion regulation – specifically, difficulty with clarity of emotion, acceptance of emotions, and strategies for coping with emotions. These findings indicate that people struggle to acknowledge their own shame and also speak to the maladaptive, dysregulated ways people manage their shame. Recognizing shame as a powerful emotion with implications in psychiatric disorders and understanding the factors that prevent people from acknowledging their own shame may help improve treatment for those who struggle with the emotion and reduce the likelihood that they will engage in maladaptive coping behaviors.

INTRODUCTION

Shame is one of the most under-researched emotions. Whereas emotions like sadness, anger, and nervousness have undergone decades of psychological research and have come to be seen as the underlying feelings behind widespread clinical diagnoses like Anxiety or Depression, shame research within the field of psychology was virtually nonexistent until the last two decades and remains remarkably limited today. This lack of research is particularly troubling when it comes to shame because the affect is highly maladaptive. Unsurprisingly, as a result, it is highly correlated with addiction, depression, violence, aggression, bullying, suicide, and eating disorders. In recent years, it has also become an emerging component of PTSD (Taylor, 2015).

A Brief History of Shame Conceptualization

One especially influential early premise for defining shame, and differentiating it from guilt, is early anthropologists’ focus on public vs. private transgressions (e.g., Benedict, 1946). Anthropologists commonly distinguished shame based on the situations they believed elicited it. More specifically, shame was conceived as a “public” emotion, arising from public exposure and disapproval of some transgression in societal rules and norms. Guilt, on the other hand, was described as a more “pri-

vate” experience arising from self-inflicted criticism and regret. However, more recent empirical research has failed to support this public/private distinction (Tangney, Marschall, Rosenberg, Barlow & Wagner, 1994; Tangney, Miller, Flicker & Barlow, 1996). One such example is a study conducted in 1992 asking participants to describe three guilt-inducing events and three shame-inducing events. A systematic analysis of the social context of these events found that shame and guilt are equally likely to be experienced in the presence of others (Tangney, et al., 1992). “Solitary” shame experiences were equally as common as “solitary” guilt experiences. Even more to the point, “the frequency with which others were *aware* of the respondents’ behavior did not vary as a function of shame and guilt” (Tracy, 2011).

This led to a new conceptualization of shame which remains today: shame as holistic negative self-concept. Helen Block Lewis, renowned psychologist and pioneer of this shame-understanding, asserted that while guilt involves a negative evaluation of a specific behavior, shame involves a negative evaluation of the global self (“I did something bad” vs. “I am bad”) (1971).

Though the distinction may appear inconsequential, this contrasting emphasis on the self “sets the stage for very different emotional experiences and very different patterns of motivation and subsequent behavior” (Tracy, 2011). The two emotions, for instance, produce distinct

“action tendencies.” Shame is commonly accompanied by attempts to deny, hide from, or escape the experiences that elicit shame, while guilt typically leads to “reparative action” – confessing, apologizing, undoing.

This difference in internal conceptualization of the self and subsequent “action tendencies” is part of what ultimately makes shame maladaptive. While guilt can be painful and overwhelming, it is generally limited to the guilt-inducing action or experience. Shame consumes the entire self, leaving experiencers with a globally-negative self-conception (“I am a terrible person”). This negative self-concept is not only painful and distressing, but it also feels irreparable. A person can correct a behavior, but one’s fundamental essence seems permanent. This sense of futility drives much of shame’s maladaptivity. Rather than embracing adaptive behaviors like apologies or changes in behavior, which increase psychosocial success, shame-experiencers tend to recede and hide from the shame-inducing event. Often, this leads people to isolate themselves socially, withdraw from activities that potentially remind them of the shame, and engage in anhedonic-behaviors. In other cases, this avoidance manifests as anger or hostility, as experiencers attempt to “turn the tables” on others to avoid their own shame, or as risky behavior (i.e. substance abuse) which many use a distraction from their shame (Ellison, 2006).

In instances where shame-experiencers have in fact committed some wrongdoing (the determination of which is of course subjective) the failure to take the expected “reparative action” can lead to social conflict (Tangney, Stuewig & Mashek, 2007). For those who experience shame about events for which reparative action is not typically expected (i.e. being the victim of sexual assault, mental illness, minor mistakes or failures), shame can cause dissociation, debilitate people from talking about their experience, and limit much-needed processing of their own emotions and/or trauma (Taylor, 2015). Either way, these maladaptive responses to shame led researchers to “consistently report a positive relationship between proneness to shame and a host of psychological symptoms, including depression, generalized anxiety and social anxiety, low self-esteem, PTSD, eating disorder symptoms, Cluster C personality disorders, suicidal behavior and self-injurious behavior, and substance abuse” (Tracy, 2011).

Shame Acknowledgement

In the context of shame’s maladaptive consequences, the lack of research into the affect becomes dangerous. Without comprehensive research into shame and its implications in psychological disorders, we cannot develop evidence-based treatments for shame-related disorders or, more importantly, adjust treatments for preexisting mental health disorders in which shame plays a more important role than previously-realized.

One roadblock that commonly hinders the development of these treatments or the confrontation of shame within a therapy setting is the fact that shame often goes unacknowledged by the experiencer (McGonigal, 2016). As Terry F. Taylor Ph.D. writes in a review article of peritraumatic shame, “Shame...is a virtually invisible,

ubiquitous part of everyday life. Because the experience of shame is often considered to be painful and disempowering, and because recognition of shame in itself can be felt as shameful... shame remains unacknowledged and is expressed as avoidant behavior” (2015). This instinct to hide one’s shame “makes it difficult to recognize internally when it happens,” let alone acknowledge out loud (Luoma, 2012). Concerningly, this tendency among people not to acknowledge their own shame also makes it difficult to study the affect, as it renders self-report measures unreliable.

Present Study

The consensus that shame characteristically goes unrecognized has never been scientifically reviewed. Further, researchers have not studied whether the degree to which people report their own shame correlates with their mental health in other capacities. Our research attempts to fill this gap. Like most shame-studies before it, we utilize assessments intended to empirically measure participants’ levels of shame. In addition to these assessments, however, we also use an assessment of emotional affect that asks participants to self-rate the frequency with which they experience different emotions, “ashamed” being one them. Comparisons of participants’ scores on the shame assessments and their self-reported level of shame will act as quantified measurements of how well they acknowledge their own shame.

This research will not only test the assumption of shame’s unidentified nature but may also provide some insight into the prevalence of unacknowledged shame and how it affects people’s mental health.

METHODS

Participants and Procedure

The assessments were administered to a sample of 54 adolescent students between the ages of 14 and 17 (58% female, 42% male, $M = 16.3$ years old, $SD = 1.3$, 55% American). Participants were recruited from the student population at Wayland Academy, a small boarding high school with international students. As an incentive for participation, students were offered a small amount of extra credit in their science and math classes. Participants were each given a battery of psychological assessments including the Positive and Negative Affect Scale (PANAS), the Internalized Shame Scale (ISS), the Compass of Shame Scale (CSS), and the Difficulty in Emotion Regulation Scale (DERS). Participants were assured that their responses would be anonymous and confidential. Assessments were given in a quiet, distraction free room.

Assessments

Positive and Negative Affect Scale: (PANAS; Watson and Clarke, 1998) The most commonly used measure of affect in scholarly research, the PANAS is comprised of 10 negative affects (afraid, upset, distressed, jittery, nervous, ashamed, guilty, irritable, hostile) and 10 positive affects (enthusiastic, interested, determined, excited, in-

spired, alert, active, strong, proud, attentive). Participants use a 0-4 Likert scale to rate the frequency with which they tend to experience each affect. For the purposes of this research, the “ashamed” item was used to measure self-rated shame because, unlike empirical assessments of shame, it requires participants to explicitly endorse the word “ashamed.”

Internalized Shame Scale: (ISS; Rosario and White, 2006) The Internalized Shame Scale, a 30-item questionnaire, is the most widely used empirical measure of shame across psychology and sociology research. The assessment has two subscales that are intended to be reported separately: a 24-item shame scale and a 6-item self-esteem scale. The shame scale attempts to tease apart different experiences of shame to create a holistic measure of the affect. Importantly, the ISS does not actually use the word shame, because shame can itself be a shameful thing to admit. There are four identified cutoffs: a score of 50 or higher indicates problematic levels of shame, a score of 60 or higher indicates possible depression and/or other emotional or behavioral problems, a score of 70 or higher indicates a high probability of depression and/or other emotional or behavioral problems.

Compass of Shame Scale: (CSS; Ellison, 2006) Because shame is an emotion that commonly goes unacknowledged both internally and outwardly, it is often expressed through other emotions or behaviors. The Compass of Shame Scale recognizes this tendency and assesses the maladaptive ways people cope with shame. The four coping methods that it identifies are “Attack Self,” “Attack Others,” “Withdraw,” and “Avoid.” This scale is of particular importance because it acknowledges shame as a fundamental source for many other maladaptive, unhealthy behaviors and is the first of its kind to assess and quantify these shame-based behaviors. Additionally, the test questions are situational rather than experiential. Participants cannot always recognize feelings as shame, but they can often identify situations that produce those shame feelings.

Difficulty in Emotional Regulation Scale: (Gratz, 2004) This assessment represents one of the most popular, comprehensive and well-established measures of emotion regulation and is widely used in both clinical and nonclinical settings. The questionnaire assesses five primary components of emotional regulation: emotional awareness, emotional clarity, emotional acceptance, impulse control, ability to engage in goal-directed behavior while experiencing negative emotions, and ability to use situationally appropriate emotion regulation strategies flexibly to modulate emotional responses as desired.

RESULTS

Self-Rated Shame vs. Measured Shame

To investigate the relationship between self-rated shame and measured shame, Pearson correlations were computed between ratings from the PANAS item “ashamed” and scores from the Internalized Shame Scale. As expected, there was no significant correlation between self-rated

shame and assessed “true” shame. The correlation and significance are displayed in Figure 1.

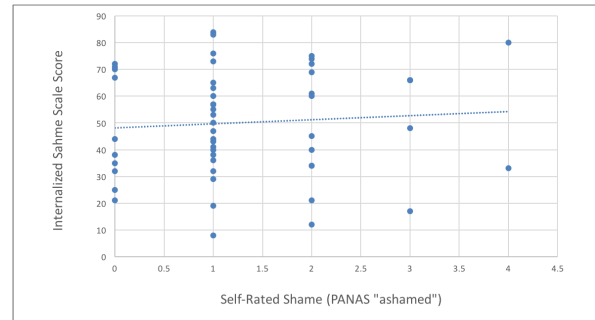


Figure 1. Pearson correlation between PANAS “ashamed” score and Internalized Shame Score. This graph shows the Pearson correlation between PANAS “ashamed” rating and ISS scores, $r = 0.0806$, $p > 0.05$

To visualize how shame acknowledgment relates to shame’s maladaptivity, an ANOVA test for the significance of differences in mean PANAS “ashamed” ratings among internalized shame cutoff groups – shame w/in normal limits, problematic levels of shame, possible indicator of mental health disorders, and likely indicator of depression/mental health disorder -- was performed and is displayed in Figure 2.

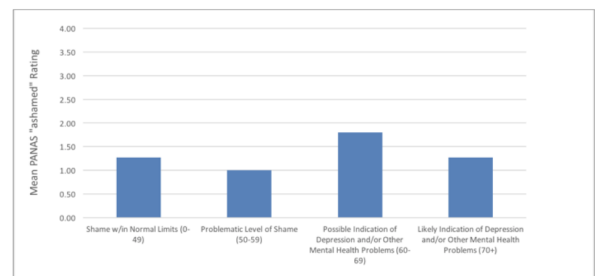


Figure 2. Analysis of Variance test of PANAS “ashamed” score by ISS cutoff groups. This graph shows the mean PANAS ashamed ratings reported by individuals in different ISS cutoff groups, f ratio = 0.903 , $p > 0.05$

As expected, and in line with our other findings, there was no significant difference in self-rated shame (PANAS “ashamed”) between among ISS cutoff groupings (i.e. all participants reported similar levels of sham, no matter how much shame an individual was actually experiencing).

Identifying Shame as Negative Affect

In order to explore whether participants may identify their internalized shame as other negative emotions, Pearson correlations were computed between PANAS Negative Affect item scores and Internalized Shame scale scores. Both are displayed in table 1.

Table 1. Pearson correlations between PANAS negative affect subscores and Internalized Shame Scale score. This table shows the results of Pearson correlations between various PANAS negative affect subscores and ISS score.

Negative Affect	beta-co (r)	sig (p)
Distressed	0.451	0.000
Upset	0.215	0.122
Guilty	0.318	0.021
Scared	0.266	0.114
Hostile	0.217	0.012
Irritable	0.342	0.012
Ashamed	0.081	0.564
Nervous	0.393	0.004
Jittery	0.24	0.083
Afraid	0.380	0.005

There was also a significant positive correlation between PANAS Negative Affect Subscale total score and Internalized Shame score ($r = 0.534$, $p < 0.01$).

Implications of Shame

To investigate shame's relationship with other emotional and behavioral problems, Pearson correlations were computed between ISS scores and scores on the individual Compass of Shame scales and the Difficulty in Emotion Regulation Scale (Figure 3).

Strong correlations between the ISS and the Withdrawal and Attack Self scales were expected and obtained. Both correlations were significantly stronger than the ISS correlations with the Avoidance and Attack Other scales. All correlations were significant.

Category Differences

Male/Female, Age, and Continent of Origin differences were assessed for both the Internalized Shame Scale and the PANAS "ashamed" rating. Women tended to have higher Internalized Shame scores than men ($t = 1.76$, $p < 0.05$). There was no significant difference, however, between men and women for the PANAS "ashamed" rating. There was also no significant correlation between age and Internalized Shame Score or the PANAS "ashamed" rating. Continent of origin did not produce any significant differences in ISS score or PANAS "ashamed."

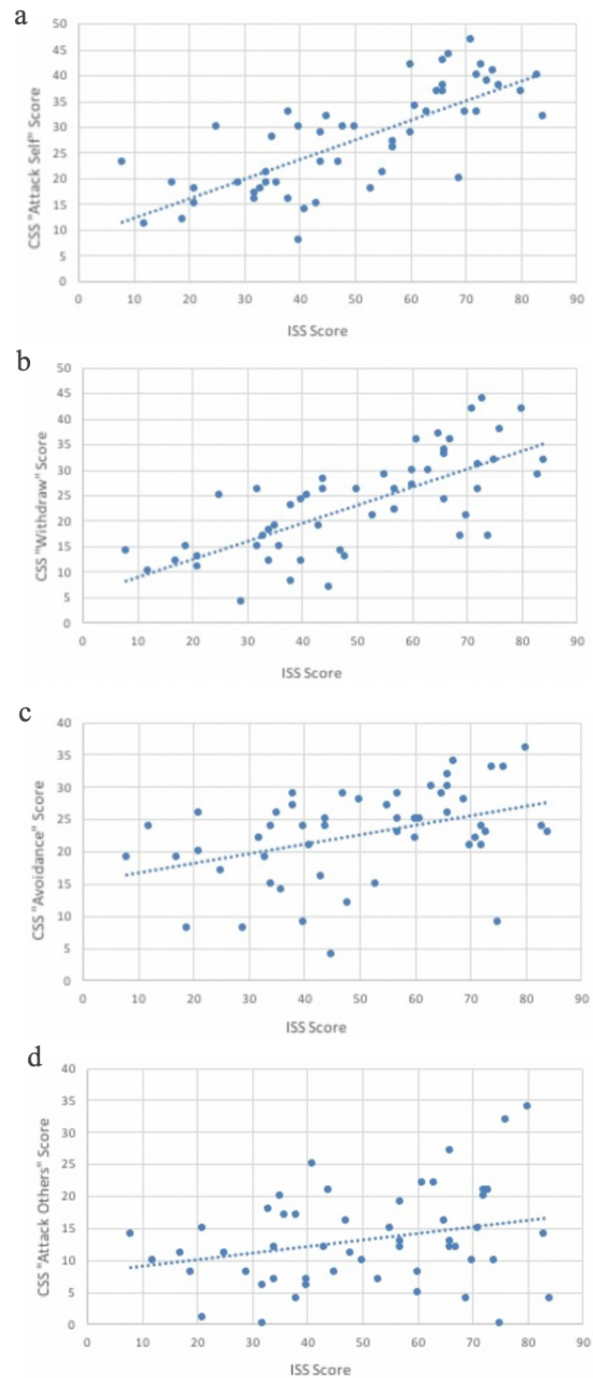


Figure 3. Pearson correlations between CSS subscores and ISS Scores. **a**, Pearson correlation between CSS attack self subscore and ISS score, $r = 0.75$, $p < 0.001$ **b**, Pearson correlation between CSS withdraw subscore and ISS score, $r = 0.72$, $p < 0.001$ **c**, Pearson correlation between CSS avoidance subscore and ISS score, $r = 0.41$, $p < 0.01$ **d**, Pearson correlation between CSS attack others subscore and ISS score, $r = 0.27$, $p < 0.05$

DISCUSSION

The lack of correlation between ISS score and PANAS “ashamed” rating, as displayed in Figure 1, indicates that there is no relationship between self-rated shame and empirically-measured “true” shame. This is further demonstrated by the analysis of variance displayed in Figure 2, which shows that there is no significant difference in self-rated shame between cutoff categories of “true” ISS shame. Essentially, even those who experience shame at an intensity high enough to indicate depression or other mental health disorders tended to describe their experience of shame as “rare.” A paired t-test comparing average ISS shame and PANAS shame affirmed this underreporting phenomenon in individuals, with nearly 74 percent of participants reporting lower self-rated PANAS shame than “true” ISS shame.

Importantly, there was a significant positive correlation between ISS score and PANAS Negative Affect subscale score, suggesting that while people struggle to accurately identify their shame, they may describe it broadly as negative affect. This point is reiterated by the fact that, with the exception of “distressed,” the individual PANAS negative affect items had weak or insignificant correlations with ISS score and none had stronger correlations than the Negative Affect subscale score. This indicates that people are not calling shame by another name, but instead use negative umbrella terms, or a variety of different emotion words, to imprecisely describe the feeling. These results both confirm a common understanding that shame often goes unacknowledged and also underline the difficulty of identifying and properly addressing shame.

This pattern becomes especially meaningful in the context of internalized shame’s negative implications. ISS score was found to have positive correlations with all CSS scales: attack self, withdraw, avoid, and attack others. Given their naturally internalized nature, the “withdraw” and “attack self” coping mechanisms had a stronger relationship with internalized shame than “avoid” or “attack other.” Internalized shame also showed a strong positive relationship with DERS score and with the lack-of-clarity, non-acceptance, and strategies subscales specifically. This fits well with the findings about unacknowledged shame, as clarity and acceptance are both components of emotional acknowledgment, and are necessary for strategic management of one’s emotions.

The male/female differences on the ISS reflect those of previous studies, with women tending to experience more internalized shame than men. Also similar to adult studies, age was not a significant factor in ISS score, suggesting that experience of shame does not change significantly during adolescent development. Given that this comes from a cross-sectional review rather than a longitudinal one, however, the accuracy of this conclusion is limited. Continent of origin, which has never before been studied in relationship to internalized shame, produced no significant difference. The accuracy of this conclusion, however, may be compromised by the small and varying number of participants within each continent group.

CONCLUSION

The comparisons of self-rated shame and empirically measured “real” shame confirm both our hypothesis and a larger long-held public understanding that people hesitate to acknowledge their shame. This finding is important not only because it is the first of its kind to quantitatively validate that informal understanding, but, more significantly, because it speaks to the extent of the disparity. More than one third of participants experienced internalized-shame with a frequency associated with depression and other clinical disorders, yet the great majority of these participants rated their own experience of shame as rare. This is problematic because, if people cannot acknowledge shame as a component of their emotional distress or mental illness, then these problems become much more difficult to address within a clinical or intrapersonal context. This lack of acknowledgment becomes especially concerning if the shame centers around a specific, potentially-traumatic event (i.e. sexual assault). If shame prevents a person from speaking up about and working through such an experience, then symptoms can worsen dramatically. As time goes on, this can also become a self-fulfilling prophecy of sorts because the longer one avoids their shame the more internalized it becomes and, consequently, the more inhibiting it becomes.

Given that shame is a powerful emotion, however, it cannot be entirely ignored or suppressed. In fact, this study’s findings indicate that people may be able to recognize the emotion broadly as emotional distress. However, without specific identification and management, shame is often expressed through maladaptive coping mechanisms. The correlation between internalized shame and each pole of the shame-coping scale suggests that, rather than addressing shame head on, shame-experiencers tend to avoid the emotion through problematic behaviors such as: risk-taking and distraction, which can develop into substance abuse and have been shown to be severely maladaptive; withdrawal from social interaction, often a symptom of depression; excessive self-criticism, also related to mental illness; or attacking others, an instinct associated with aggression and potential violence. Though they vary in commonality, each pole is maladaptive in its own right—an attempt to ignore, hide from, wallow in, or push back one’s shame without ever truly acknowledging it. It is also important to note that these individuals coping mechanisms are not orthogonal and in fact tend to converge.

This tendency to cope with shame is similarly reflected by the significant correlation between internalized shame and difficulty in emotional regulation. Even more to the point, the DERS subscales that had the strongest relationships with shame were lack-of-clarity, non-acceptance, and strategies. This indicates that people with high levels of internalized shame have significant trouble identifying their emotions, acknowledging their emotions without guilt or embarrassment, and coping with their emotions effectively. This not only speaks to the troubling ways people manage their shame but also to the dysregulatory nature of shame itself, which can make it

more difficult for a person to manage any of their emotions.

The implication of these findings is three-fold: tools for shame recognition must be better integrated into both clinical and intrapersonal settings, shame must be better accounted for within diagnostic criteria, and more research into the affect must be conducted. It is imperative that mental health practitioners recognize that patients are unlikely to forthrightly acknowledge or report their shame and that these practitioners are trained in how to identify this underlying shame and address it without causing the patient to shut down or react with anger. It is also an unfortunate truth that, because the perception of shame in others “can also evoke a discomforting emotion in the observer,” it may fail to be addressed in therapy, with the therapist remaining in an “unconscious collusion with the patient” to ignore the shame (Taylor, 2015). Additional shame-specific training and wider acknowledgement of the emotion’s role in psychopathology may help mediate this problem

An important step in helping clinicians (and, in fact, any individual) better identify and work with shame is better accounting for the emotion in diagnostic criteria. Despite the fact that the emotion is strongly correlated with many different mental illnesses and social-emotional problems, shame is rarely listed as a symptom in the DSM IV and is generally relegated to the “associated features” of a disorder. Not only does this lack of representation reinforce shame’s hidden nature, but it also fails to account for the way shame’s role in a disorder can change the way it must be treated.

Perhaps most importantly, more scientific research must be conducted into shame. Since shame’s psychological conceptualization as holistic self-blame was established, only a handful of scientific studies into the affect have been conducted and, even fewer yet have investigated shame’s role in psychiatric disorders. If we are to help people recognize and cope with their internalized shame, we must first understand what prevents that acknowledgment and which tools are the most effective in fostering it.

AUTHOR INFORMATION

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