Psychiatry Research 220 (2014) 490–495

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Do patients with different mental disorders show specific aspects of shame?

Corinna N. Scheel [a,e,*], Caroline Bender [a], Brunna Tuschen-Caffier [a], Anne Brodführer [a], Swantje Matthies [d], Christiane Hermann [b], Eva K. Geisse [b], Jennifer Svaldi [a], Eva-Lotta Brakemeier [a,c], Alexandra Philipsen [d], Gitta A. Jacob [a]

[a] Department of Clinical Psychology and Psychotherapy, University Freiburg, Germany
[b] Department of Clinical Psychology and Psychotherapy, University Giessen, Germany
[c] Psychologische Hochschule, Berlin, Germany
[d] Department of Psychiatry and Psychotherapy, University Medical Center Freiburg, Germany
[e] Department of Clinical Psychology and Psychotherapy Research, University Zurich, Switzerland

ARTICLE INFO

Article history:
Received 23 July 2013
Received in revised form
1 June 2014
Accepted 27 July 2014
Available online 1 August 2014

Keywords:
Borderline personality disorder
Social anxiety
SHAME
Self-conscious emotions
Existential shame
Major depression

ABSTRACT

Shame is related to several mental disorders. We assume that facets of shame, namely bodily, cognitive and existential shame, may occur in typical patterns in mental and personality disorders. An excessive level of shame may lead to psychopathological symptoms. However, a lack of shame may also lead to distress, for instance as it may facilitate violation of social norms and thus may promote interpersonal problems. In this study we investigated facets of shame in females suffering from various mental disorders and personality disorders presumably associated with specific aspects of shame. Women suffering from borderline personality disorder (BPD, $n=92$), attention deficit hyperactivity disorder (ADHD, $n=86$), major depressive disorder (MDD, $n=17$), social anxiety disorder (SAD, $n=33$), and a community sample (COM, $n=290$) completed the SHAME questionnaire, which is a newly developed instrument to assess adaptive and maladaptive aspects of shame. BPD patients reported the highest level of existential shame compared to all other groups. Compared to the controls, SAD patients displayed stronger bodily and cognitive shame, and ADHD showed lower bodily shame. As assumed, specific aspects of shame were found in different patient groups. It may be important to specifically address these specific aspects of shame in psychotherapy.

1. Introduction

Shame is a very powerful self-conscious emotion, related to intense feelings of worthlessness, inferiority, and a damaged self-image, which is typically experienced after moral transgressions or incompetence (overview in de Hooge et al. (2010)). Thus, shame serves the important social function of maintaining societal norms and protecting against group separation. Furthermore, the experience of shame can motivate individuals to engage in repairing behaviors in order to restore their damaged self or damaged relationships to others (de Hooge et al., 2010). Therefore shame seems to be adaptive in a number of situations – e.g. by leading to prosocial behavior – and accompanied with positive consequences for the individuals social life. However, strong feelings of shame are also associated with many psychopathological problems and may further exacerbate them (Tangney et al., 1996). Studies have found relationships between shame and various mental disorders, including borderline personality disorder (BPD), social anxiety disorder (SAD), and major depressive disorder (MDD; Dost and Yagmurlu, 2008). Shame connected to psychopathological symptoms of course is maladaptive which means it impairs one's well-being and functioning.

Shame-proneness (trait-shame) or state shame have typically been conceptualized as unidimensional construct. According to the relevance for mental disorders in our work we focus on shame as a personality trait, i.e. an individual's proneness or sensitivity to get ashamed in specific situations. However, in several theoretical models it has been assumed that shame is a multidimensional emotion. The findings showing both adaptive (Keltner and Harkner, 1998; Tangney et al., 2007) as well as maladaptive (Andrews, 1995; Tangney et al., 2007) functions of shame underpin this suggestion. Based on the literature and interviews we developed the questionnaire *Sh*ame *a*ssessment for *m*ultifarious *e*xpressions of shame (*SHAME*, Scheel et al., 2013a) to assess both adaptive and maladaptive aspects of shame, assuming that both

* Corresponding author at: Department of Clinical Psychology and Psychotherapy Research, University Zurich, Binzmühlestrasse 14/16, 8050 Zurich, Switzerland. Tel.: +41 44 635 7322; fax: +41 44 635 7329.
E-mail address: c.scheel@psychologie.uzh.ch (C.N. Scheel).

http://dx.doi.org/10.1016/j.psychres.2014.07.062
0165-1781/

lack of shame and increased shame might be dysfunctional. The *SHAME* was validated using a representative community sample ($n=506$, Cronbach's $\alpha=0.83$; factorial validity: χ^2/d.f.$=2.44$, confirmatory fit index (CFI)$=0.920$; for further information see Scheel et al. (2013a)). It consists of the three scales *bodily, cognitive,* and *existential* shame. While a moderate level of *bodily* and *cognitive* shame can be considered adaptive, *existential* shame is assumed to be dysfunctional. This assumption was supported by our findings in the community sample of mean values of $M=2.76$ (S.D.$=1.02$) for *bodily* and $M=4.25$ (S.D.$=1.09$) for *cognitive* shame representing the middle of the possible response scale from one to six which may be interpreted as moderate level. Contrary the mean value for *existential* shame ($M=1.71$, S.D.$=1.00$) was quite low which may hint to the idea that this aspect of shame was sparse in a non-clinical population. Bodily shame contains shame concerning the body ideal, intimacy and sexuality. The body ideal covers someone's figure, face, personal hygiene and clothing. Therefore *bodily* shame arises if the individual fails to meet her or his standards according to one's body ideal; if body parts which are defined as intimate for the individual suddenly get disclosed in inappropriate ways or situations and, according to sexuality, after inadequate denudation of sexually relevant regions of the body (e.g.: I buy myself underwear. While I decide what to buy I notice that two of my colleagues have been watching while I made a selection).

Cognitive shame includes shame connected to the person's moral standards, competence and social exclusion. It may arise after trespassing one's personal or moral values. *Cognitive* shame may also be evoked following the experience of being incompetent or being socially excluded (e.g.: I retell someone something private without considering the consequences).

Existential shame differs from bodily and cognitive shame describing an enduring feeling of shame comprising someone's person as a whole. It does not need to be evoked by specific situations and may be described by experiencing the own self as worthless, irrelevant or deficient (e.g. I get a card from a friend who is on holiday. On it he/she says they are really missing me). This facet may often be a chronic feeling of being ashamed of who you are (Scheel et al., 2013a). Possibly existential shame could be understood as an enduring shameful mood.

As already mentioned, shame is related to several mental disorders, one of these is BPD. Clinically, BPD patients report intense feelings of shame, related to low self-esteem and self-hatred. This is reflected by the DSM-5 diagnostic criteria (APA, 2013) of emotional instability and identity disturbance. Accordingly, several studies have demonstrated higher levels of shame in patients with BPD as compared to healthy and clinical groups (Chan et al., 2005; Rüsch et al., 2007; Brown et al., 2009), both on an explicit and an implicit level of processing (Rüsch et al., 2007). Furthermore, shame has been linked to severe BPD symptoms such as dysregulation of anger (Lutwak et al., 2001; Gratz et al., 2010; Scheel et al., 2013b), hostility, irritability, long-term interpersonal problems (Tangney et al., 1996), suicidality (Lester, 1998), and self-injury (Brown et al., 2009). These findings go in line with previous results of an overall heightened shame proneness in BPD, but an especially increased level of existential shame as compared to the community sample (Scheel et al., 2013a, 2013b).

Anyway the question arises whether increased shame levels are similar in different mental disorders or whether several clinical groups differ with regard to their shame proneness in the different facets of shame. Another upcoming question was, if *existential* shame may be specific to BPD patients compared to other clinical samples.

Therefore in this study we compared different clinical groups with regard to their characteristic aspects of shame, as measured with the *SHAME* questionnaire. Five groups were included: (1) Women with BPD, (2) women with attention-deficit-hyperactivity disorder (ADHD), (3) women with SAD, (4) women with MDD, and (5) the community sample.

A sample of women suffering from ADHD was included, according to some clinical features such as affective vulnerability including extreme mood swings, stress intolerance, impulsivity and reported states of “aversive inner tension” that have been reported from both BPD and ADHD patients. Therefore a relevant overlap of symptoms seems to be present in BPD and ADHD, whereas still there is a serious difference according to clinical appearance, severity of impairment and prognosis. Also high rates of comorbidity between BPD and ADHD are reported for childhood ADHD as well as for adult ADHD (Philipsen et al., 2008). As some of the overlapping symptoms such as impulsive reactions especially in interpersonal situations may be a source of shame, it seems to be of high interest if both groups are comparable due to their shame proneness or specific aspect of shame. In addition, issues coming from consequences of ADHD (e.g. interpersonal problems) leading to impairments of daily life-demoralization, learned helplessness and low self-esteem (Wehmeyer et al., 2010) may also be connected to shame proneness. These findings may hint to an elevated shame level in the ADHD patients. Nonetheless ADHD has been linked to conduct disorder and high comorbidity to antisocial personality disorder (ASPD) is reported (Cumyn, et al., 2009; Holmes, et al., 2001). These disorders include transgressions and violations of other person's rights and needs which may intend lowered level of shame. No studies have explored shame in ADHD, although ADHD in adulthood is a common and impairing condition (Kessler et al., 2006).

With regard to SAD, the fear of feeling ashamed in front of other people (e.g., failing in social interactions, being rejected) is a core DSM-5 diagnostic criteria (APA, 2013). Empirically, very high levels of external shame defined as cognitions of other people looking down on the self have been observed in patients with SAD as compared to healthy controls and patients with psychosis (Michail and Birchwood, 2013). Shame is related to negative assumptions about anticipated social interactions which is a core feature of SAD (Harder et al., 1992; Lutwak and Ferrari, 1997; Fergus et al., 2010; Tangney et al., 1992). Therefore investigating patients suffering from SAD with SHAME seems to be of interest to find out more about the characteristics of different facets of shame in SAD.

Shame might also be related to MDD, even though depression may not be linked to shame as strong as in BPD or SAD. Several studies have found in patients with MDD the level of shame to be associated with the level of depressive symptoms (Harder et al., 1992; Guimón et al., 2007; overview in Kim et al. (2011); Pinto-Gouveia et al. (2012)).

MDD is often reported to decrease self-esteem which may be attended by increased shame. Anyway it has to be mentioned that even concerning only diagnostic criteria (DSM-5; APA, 2013) guilt has also been mentioned in relation to depression. Differences of shame and guilt have been addressed in further research with mostly bringing up shame as the more dysfunctional in contrast to guilt as the more functional emotion. (Dost and Yagmurlu, 2008; Joireman, 2004). On the other hand a meta-analytic review did underpin the findings of a relationship between shame and depressive symptoms but did also find two subtypes of guilt as equally important (Kim, et al., 2011). However, a study by Scheel et al. (2013b) did not find increased shame levels in MDD as compared to healthy controls.

The goal of this study was to assess if patients suffering from different mental disorders show different typical aspects of shame. This means to be the combination of different facets of shame – here described throughout bodily, cognitive and existential shame – adding up to an individual shame proneness. Primarily this study