

References

Abrams, S. (1990). Orienting perspectives on shame and self-esteem. *Psychoanalytic Study of the Child*, 45, 411-6.

Adams K. M.; Robinson D. W. (2001). Shame Reduction, Affect Regulation, and Sexual Boundary Development: Essential Building Blocks of Sexual Addiction Treatment. *Sexual Addiction and Compulsivity*, 1 January 2001, vol. 8, no. 1, pp. 23-44(22). (Sexual addiction is an intimacy disorder that is rooted in impaired early attachment experiences. This impaired bonding causes the developing self to be shrouded in shame. Primary needs and desires become contemptuous to the individual. Affect regulation also is damaged because of negative bonding experiences. This further impairs the capacity to master feelings and successfully guide the process of need fulfillment. Sexual addiction is a compulsive cycle that attempts to compensate, soothe, and regulate the internal struggle. The cycle, in turn, creates more shame and dysregulation of affect. Strategies to reduce shame, regulate affect, and create sexual boundaries necessary for successful treatment of sexual addiction are outlined).

Adamson, J. (1997). *Melville, Shame and the Evil Eye: a psychoanalytic reading*. State University of New York Press.

Adamson, J. and Clark, H. (1998). *Scenes of Shame: psychoanalysis, shame and writing*. State University of New York Press.

Adler, G. (1994). Transference, countertransference, and abuse in psychotherapy. *Harv Rev Psychiatry*, 2(3), 151- 9. (The complex factors that can lead to either creative or destructive

experiences in psychotherapy for both patients and therapists are explored with reference to the treatment of patients with a history of abuse. Particular emphasis is placed upon the formation of an intermediate space, in which a safe therapeutic environment is established, allowing for the creative interplay of past and present. The concepts of the transitional object, transitional phenomena, and projective identification are defined and amplified in explaining how they help to determine whether a safe therapeutic space is achieved, or whether destructive, abusive experiences are re-created, for both patient and therapist. In addition, the importance of the therapist's capacity to tolerate the ambiguity and uncertainty of psychotherapy is elaborated. The relationship between these formulations and the therapist's countertransference is emphasized. Also described is the importance of supervision in helping therapists--during training and throughout professional life--to discuss shame-arousing experiences with their patients).

Alessandri, S.M and Lewis, M. (1996). Differences in pride and shame in maltreated and non maltreated pre-schoolers. *Child Development*, 67(4), 1857-69. (Maltreating mothers offered more negative feedback, particularly to their daughters, than non maltreating mothers. Maltreated girls showed more shame when they failed and less pride when they succeeded than nonmaltered girls. The relationship between different socialisation practices and the self-conscious emotions is explored as it relates to gender differences).

Alexander, B. et al. (1999). An investigation of shame and guilt in a depressed sample. *British Journal of Medical Psychology*, 72(3), 323-38. (Shame-proneness showed a unique association with a stable attributional style for negative outcomes, global

negative self-evaluation, submissive behaviour and internalised anger).

Alonso, A. and Rutan, J.S. (1988). The experience of shame and the restoration of self-respect in group therapy. *International Journal of Group Psychotherapy*, 38, 3-13.

Alonso, A.; Rutan, J. S. (1988). Rejoinder to the critiques of "The experience of shame ... in group psychotherapy". *Int J Group Psychother*, 38(3), 387-9.

Andresen, J. J. (1980). Why people talk to themselves. *J Am Psychoanal Assoc*, 28(3), 499-517. (Findings were presented from a study of a group of patients who were able, by talking to themselves, to create a pleasurable sense of another's presence. These patients talked to themselves when they would otherwise feel shame or loneliness. The "presence" created was in each case a member of the family of origin, a family members whose loss had never been mourned. Because they had failed to mourn, they had not acquired sufficient enriching identifications with their family members. In some instances, the self-directed talks also constituted a resistance in treatment. The patients gave up the behavior as they mourned their previously unaccepted losses and internalized as identifications certain important regulatory interactions with the mourned figures).

Andrews, B. (1997). Bodily shame in relation to abuse in childhood and bulimia: a preliminary investigation. *Br J Clinical Psychology*, 36(1), 41-49. (Bodily shame has been shown to play a mediating role in the relationship between experiences of childhood physical and sexual abuse and depression in mature women. The current study investigated the role of such shame in the relationship between childhood abuse and

bulimia. A significant association between bodily shame and childhood abuse was replicated in this younger sample. Bodily shame was also related to bulimia, and this relationship could not be explained by bodily dissatisfaction. Childhood abuse showed a significant association with bulimia, but this was no longer apparent once bodily shame had been taken into account. The results suggest bodily shame may act as a mediator between early abuse and bulimia).

Andrews, B. et al (2000). Predicting PTSD symptoms in victims of violent crime: the role of shame, anger, and childhood abuse. *J Abnormal Psychol.*, 109(1), 69-73. (To examine the role of cognitive-affective appraisals and childhood abuse as predictors of crime-related posttraumatic stress disorder (PTSD) symptoms, 157 victims of violent crime were interviewed within 1 month post-crime and 6 months later. Measures within 1 month post-crime included previous physical and sexual abuse in childhood and responses to the current crime, including shame and anger with self and others. When all variables were considered together, shame and anger with others were the only independent predictors of PTSD symptoms at 1 month, and shame was the only independent predictor of PTSD symptoms at 6 months when 1-month symptoms were controlled. The results suggest that both shame and anger play an important role in the phenomenology of crime-related PTSD and that shame makes a contribution to the subsequent course of symptoms. The findings are also consistent with previous evidence for the role of shame as a mediator between childhood abuse and adult psychopathology).

Barry, M. (1962). Depression, shame, loneliness and the psychiatrist's position. *American Journal of Psychotherapy*, 16, 580-590.

Bea, J. and Hernandez, V. (1984). *International Journal of Psychoanalysis*, 65(2), 141-53. (An attempt to examine the process occurring in the transformations which Alonso Quijano undergoes when becoming Don Quixote as an expression of his disturbance, and the evolution at work during his travels to dissipate his grandiose narcissism by means of a cure of humiliation which makes him humble and able to recognise dependence and internal conflicts, finally culminating in the working through of the depressive position and the resolution of the prior schizo-paranoid phase just before his death).

Belsky, J. et al. (1997). Temperament and parenting antecedents of individual differences in three-year-old boy's pride and shame reactions. *Child Development*, 68(3), 456-66.

Bentovim, A. (1976). Shame and other anxieties associated with breast-feeding: a systems theory and psychodynamic approach. *Ciba Found Symp*, 45, 159-78. (It is easy to be oversimplistic about breast-feeding--what determines the choice of the breast; what causes rejection of breast-feeding as a feeding method; what determines success and what its failure? In fact, a bewildering range of factors, physical, psychological and sociological play a part. How can these be related to each other and ordered in general and for the individual? A general systems theory approach, in which the elements are envisaged as interacting dynamically, seems to offer a possible satisfactory explanatory model. Moving from social systems to the individual's intrapsychic system helps to understand the complexity of emotions aroused about the breast and breast-feeding. Shame and anxieties are seen to arise from the confluence of life history and current events. Intervention is necessary at many levels--societal, family and individual--if breast-feeding is to be re-established as the feeding method of first choice).

Berke, J. (1986). Shame and Envy. *British Journal of Psychotherapy*, 2(4).

Bion, W.R. (1970). *Attention and Interpretation*. London: Tavistock.

Birtchnell, J. (1997). The Psychology of Shame: theory and treatment of shame-based syndromes. *Personality and Individual Differences*, 22(5): 781-?.

Blomstedt, J. (1998). *Shame and Guilt: Diderot's moral rhetoric*. University of Jyvaskyla Press.

Bouson, J. Brooks. (2000). *Quiet as it's kept : shame, trauma, and race in the novels of Toni Morrison*. SUNY series in psychoanalysis and culture. Albany: State University of New York Press.

Bradlow, P. A. (1973). Depersonalization, ego splitting, non-human fantasy and shame. *Int J Psychoanal*, 54(4), 487-92.

Bradshaw, J. (1988). *Healing the Shame That Binds You*. Florida: Health Communications, Inc.

Braithwaite, J. (1987). *Crime, Shame and Reintegration*. Cambridge University Press.

Bronheim, H.E. (1998). *Body and Soul: the role of object relations in faith, shame and healing*. Jason Aronson.

Broucek, J.F. (1982). Shame and its relation to early narcissistic developments. *International Journal of Psychoanalysis*. 63: 369-378.

Brown, G.W. (1995). Loss, humiliation and entrapment among women developing depression: a patient and non-patient comparison. *Psychological Medicine*, 25(1), 7-21. (The experience of humiliation and entrapment was important in provoking depression in both the patient and non-patient groups. It proved to be associated with a far greater risk of depression than the experience of loss or danger without humiliation or entrapment).

Buchele, B. J. (1994). Innovative uses of psychodynamic group psychotherapy. *Bull Menninger Clin.* 58, 215-23. (Psychodynamic group psychotherapy is gaining renewed attention as an effective form of treatment, due in part to increasing economic constraints that make other forms of treatment less accessible. The author highlights some innovative applications of both extended and time-limited groups. She also describes specific issues, including shame, that can be addressed effectively in homogeneous time-limited group therapy).

Burney, J. and Irwin, H.J. (2000). Shame and guilt in women with eating disorder symptomatology. *J Clinical Psychology*, 56(1), 51-61. (The relationship of shame and guilt to eating-disorder symptomatology was investigated in a sample of 97 Australian women. In terms of the objective of predicting the severity of eating disturbance, the study explored the predictive utility of proneness to shame and guilt in a global sense, shame and guilt associated specifically with eating contexts, and shame associated with the body. The study also sought to determine if shame is a more prominent emotion than guilt among women who have eating difficulties. Shame associated with eating behavior was the strongest predictor of the severity of eating-disorder symptomatology. Other effective

predictors were guilt associated with eating behavior and body shame. Eating disturbance was unrelated to proneness to shame and guilt in a global sense. Discussion of these findings focuses on the issue of determining whether self-conscious affects are best regarded as causes or as consequences of eating disturbance).

Buss, A.H. (1980). *Self consciousness and Social Anxiety*. W.H. Freeman.

Buss, A. H.; Iscoe, I.; Buss, E. H. (1979). The development of embarrassment. *J Psychol*, 103(2d Half), 227-30. (Parents of children in the age range 3 to 12 years were asked about their children's embarrassment and blushing during the previous six months. This survey revealed that roughly one in four preschool children showed embarrassment. Starting with age 5, a majority of children showed embarrassment. There were no systematic gender differences. Blushing was reported in slightly more than half the children who were embarrassed. On the assumption that embarrassment signals the presence of a social self, a social self develops at about 5 years of age for most children).

Bybee, J. (1998). *Guilt and Children*. London: Academic. Also about shame and emotions in children and adolescents.

Cairns, D.L. (1993). *Aidos: the psychology and ethics of honour and shame in ancient Greek literature*. Clarendon Press.

Campbell, B. (1998). *Honor, Shame and the Rhetoric of 1 Peter*. Scholars Press.

Campbell, F.A. (1984). The concept of shame. *Perspect psychiatr Care*, 22(2), 62-4.

Catherall, D.R. et al. (1996). Men's groups for post traumatic stress disorder and the role of shame. In Andronico, M.P. (ed). Men in Groups: insights, interventions and psycho educational work. American Psychological Association. (The authors stress the role of shame in these groups and suggest how it can be managed).

Clance, P.R. (1985). The Imposter Phenomenon. Atlanta, Georgia: Peachtree Publishers.

Coffey, P. et al. (1996). Mediators of the long-term impact of child sexual abuse: perceived stigma, betrayal, powerlessness, and self-blame. Child Abuse Negl., 20(5), 447-55. (The level of psychological distress currently experienced by adult women who had been sexually abused in childhood was mediated by feelings of stigma and self-blame. This result provides partial support for Finkelhor and Browne's traumagenic dynamics model of child sexual abuse).

Colby, K. M. (1976). Clinical implications of a simulation model of paranoid processes. Arch Gen Psychiatry, 33(7), 854-7. (A shame-humiliation theory of paranoid processes embodied in a successful computer simulation model has clinical implications for the understanding, treatment, management, and prevention of paranoid disorders. The multiplicity and variety of these implications indicate that the theoretical model is more than ad hoc, since it potentially contributes new empirical content to existing knowledge about paranoid disorders. Among rival theories, a more acceptable one is that with a large consequence class, members of which turn out to be true, and that which most effectively serves multiple purposes).

Courtois, C.A. (1988). *Healing the Incest Wound: Adult Survivors in Therapy*. New York: Norton.

Cramerus, M. (1990). Adolescent anger. *Bulletin of the Menninger Clinic*, 54(4), 512-23. (Adolescent hostility, resentment, blame, and reproach are dynamically determined and serve important defensive, alloplastic, and restitutional aims. The author examines how these negative affects, the accompanying victim role, and oppositional defiance enable angry adolescents to defend against depression and loss, to demand nurturance from others, to protect their precarious inner autonomy, and to undo their humiliation and shame by vengeance and reversal. The author suggests that adolescent anger arises from an underlying wish to coerce objects into providing all-giving restitution for losses and narcissistic injuries, not necessarily from a wish to sadistically or enviously destroy them).

Crozier, R. (1990). *Shyness and Embarrassment*. Cambridge University Press.

Dalziell, Rosamund. (1999). *Shameful autobiographies : shame in contemporary Australian autobiographies and culture*. Carlton South, Vic., Australia : Melbourne University Press, 302 p. ; 22 cm. ISBN: 0522848605.

Dann, O.T. (1977). A case study of embarrassment. *Journal of the American Psychoanalytic Association*, 25(2): 453-70. (The psychoanalytic references to embarrassment are reviewed. Embarrassment, in the literature, is seen largely as an affect involving exhibitionistic and scopophilic conflicts and defenses against these. A case in which embarrassment was prominent is discussed. Embarrassment in the patient was an ego response which implied an external object for its

manifestation. It involved exhibitionistic and scopophilic conflicts and projective defenses, but also operated in ego-gratifying and adaptive ways. Her embarrassment was understood through the analysis of an initial embarrassing dream of nakedness and other dreams and associated material as the defensive out-growth of repeated exposures to the primal scene. Embarrassment was a resistance to remembering in the analysis, and the primal-scene experiences were partially reconstructed. The analytic situation was, in many ways, a symbolic re-creation of the primal scene, including the patient's response of embarrassment. The development of embarrassment in the patient's childhood was furthered and confirmed by its being an identification with the attitudes of both parents. Finally, some reflections on embarrassment and shame in its various forms are set forth).

Demos, E.V. (1983). A perspective from infant research on affect and self-esteem. In J. Mack and S. Ablon (Eds.), *The development and sustaining of self-esteem in childhood* (pp. 45-78). New York: International Universities Press.

De Paola, H. (2001). Envy, jealousy and shame. *International Journal of Psychoanalysis*, vol. 82, no. 2, pp. 381-384.

Dubner, M.A. (1998). Envy in the group-therapy process. *International Journal of Group Psychotherapy*, 48(4), 519-31. (The origins and vicissitudes of envy are discussed from the viewpoints of Boris and the Kleinians. Their ideas, coupled with a relational perspective of the therapeutic process, enrich our understanding and inform our work concerning the emergence, processing, and working through of envy in the therapy group. A variable in the negative therapeutic reaction, envy can be destructive to the therapy process. It is proposed that envy, accompanied by shame and guilt, is likely to enter the group via enactments. They are fueled by projective identification,

which, if ignored, impede the continuation of the group process. Four clinical vignettes illustrate how envy enters the group and how the group functions as a container and transformational object as it processes the projective identifications and works through the enactments. It is proposed that envy, accompanied by shame and guilt, is likely to enter the group via enactments, fuelled by projective identification, which, if ignored, impede the continuation of the group process. Four clinical vignettes illustrate how envy enters the group and how the group functions as a container and transformational object as it processes the projective identifications and works through the enactments).

Dunnegan, S.W. (1997). Violence, trauma and substance abuse. *J. of Psychoactive Drugs*, 29(4), 345-351. (A review of the literature concerning PTSD, violence and domestic violence suggests that violent behaviour, trauma, and substance abuse have a substantial connection; it also suggests that shame is a powerful agent for rage. Shame permeates many levels of society: the individual, the family, institutions and the community. The policies of the criminal justice system are directed towards promoting more shame in a population that has been saturated with shame in many levels of the culture).

Dutton, D.G. et al. (1995). The role of shame and guilt in the intergenerational transmission of abusiveness. *Violence Vict*, 10(2), 121-31. (Shame-proneness has been found to be related to anger arousal and a tendency to externalise attributions for one's own behaviour, both common features of men who assault their wives. The present study examined a potential origin of a shame-prone style by analysing reports of shaming experiences by one's parents as reported by a population of assaultive males. Significant relationships were found for recollections of shaming actions by parents on adult anger,

abusiveness (as reported by wives), and a constellation of personality variables related to abusiveness in prior research. These shaming actions were largely comprised of recollections of parental punishment that were public, random, or global. The role of shame experiences in disturbances of self-identity and rage is discussed).

Edelmann, R.J. (1981). Embarrassment in social interaction. PhD Thesis, University of London.

Edelmann, R.J. (1987). The Psychology of Embarrassment. Wiley.

Efrati, Carol. (2002). The road to danger, guilt, and shame : the lonely way of A.E. Housman. Madison, NJ : Fairleigh Dickinson University Press ; London ; Cranbury, NJ : Associated University Presses. Projected Pub. Date: 0203 Description: p. cm. ISBN: 0838639062 (alk. paper).

Einstein, D. and Lanning, K. (1998). Shame, guilt, ego development, and the five-factor model of personality. *J Pers*, 66(4), 555-82. (Shame, guilt, and ego development are conceptually interrelated constructs, yet their empirical relations have not yet been examined. This study shows that the relationship between shame and ego level is curvilinear, with shame greatest for people at intermediate stages of ego development. Relations between ego level, proneness to shame and guilt, and the five factors of personality were modest, suggesting that these represent complementary approaches to the study of personality).

Eisenberg, N. (2000). Emotion, regulation, and moral development. *Annu Rev Psychol*, 51, 665-97. (Research on differences between embarrassment, guilt, and shame and

their relationship towards moral behaviour is reviewed, as is research on the association of these emotions with negative emotionality and regulation. Recent issues concerning the role of such empathy-related responses as sympathy and personal distress to prosocial and antisocial behaviour are discussed, as is the relationship between empathy-related responding to situational and dispositional emotionality and regulation. The development and socialisation of guilt, shame, and empathy are discussed briefly).

Ephron, D., with drawings by Edward Koren. (1982). *Teenage romance, or, How to die of embarrassment*. London: Gollancz.

Epstein, A.L. (1984). *The Experience of Shame in Melanesia: an essay in the anthropology of affect*. Royal Anthropological Institute.

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

Eurich-Rascoe, B.L. (1997). *Femininity and Shame: women, men, and giving voice to the feminine*. University Press of America.

Fairbairn, W.R.D. (1952). *Psychoanalytic Studies of the Personality*. New York: Basic Books.

Feiring, C. Taska, L. and Lewis, M. (1996). A process model for understanding adaptation to sexual abuse: the role of shame in defining stigmatisation. *Child Abuse and Neglect*, 20(8), 767-82. (The model presented proposes that sexual abuse leads to shame because of cognitive attributions about the abuse and shame, in turn, leads to poor adjustment. Developmental and clinical research supporting the model is reviewed).

Feiring, C. et al. (1998). The role of shame and attributional style in children's and adolescent's adaptation to sexual abuse. *Child Maltreatment*, 3(2), 129-42. (Study examined the role of shame and self-blame in influencing the degree of psychological distress in victims of sexual abuse. It found a significant association).

Ferguson, T.J. et al. (1999). Guilt, shame, and symptoms in children. *Dev Psychol*, 35(2), 347-57. (Shame and projective guilt were related to symptoms, and also associated with self-blame and attempts to minimise painful feelings).

Fernie, Ewan. (1999). Shame in Othello. *The Cambridge quarterly*, vol. 28, no. 1, pp. 19.

Fernie, Ewan. (2002). *Shame in Shakespeare*. London ; New York : Routledge, 2002. Projected Pub. Date. ISBN: 0415258278 (alk. paper) 0415258286 (pbk. : alk. paper). (One of the most intense and painful of our human passions, shame is typically seen in contemporary culture as a disability or a disease to be cured. Shakespeare's ultimately positive portrayal of the emotion challenges this view. Drawing on philosophers and theorists of shame, *Shame in Shakespeare* analyses the shame and humiliation suffered by the tragic hero, providing not only a new approach to Shakespeare but a committed and provocative argument for reclaiming shame. The volume provides: an account of previous traditions of shame and of the Renaissance context; a thematic map of the rich manifestations of both masculine and feminine shame in Shakespeare; detailed readings of Hamlet, Othello, and King Lear; an analysis of the limitations of Roman shame in Antony and Cleopatra and Coriolanus; a polemical discussion of the fortunes of shame in modern literature after Shakespeare).

Finnell, J.S. (1992). Sadomasochism and complementarity in the interaction of the narcissistic and borderline personality type. *Psychoanal Rev*, 79(3), 361-79. (The narcissist and borderline personality types complement one another's defensive style providing needed defensive externalisation of disavowed and split-off feelings. One is exploitative, grandiose, and dominant, forever seeking admiration and exhibiting an aggrandised self; the other experiences humiliation, neediness, helplessness, and terror of aloneness. They form a powerful complementary dyad wherein each identifies with disavowed emotional experiences displayed in the other. In the first case discussed a masoborderline patient was victimised and humiliated by her sadonarcissistic lover).

Fischer A. H.; Manstead A.S.R.; Mosquera P.M.R. (1999). The Role of Honour-related vs. Individualistic Values in Conceptualising Pride, Shame, and Anger: Spanish and Dutch Cultural Prototypes. *Cognition and Emotion*, 13(2), 149-79. (We investigated how differences in self-related values affect the way in which members from different cultures describe emotion episodes. Spain and the Netherlands were selected for comparison, on the assumption that these countries differ with respect to the importance of individualistic versus honour-related values. This assumption was tested in Study 1. The results showed that honour-related values are indeed more important in Spain, whereas values relating to individualism are more important in the Netherlands. In the second, main study, we investigated whether these differences in values would be reflected in cultural prototypes of pride, shame and anger. Dutch and Spanish respondents completed questionnaires in which they described typical examples of specified components of these emotions. Content analysis of responses revealed systematic differences in the cultural

prototypes of pride and shame; these differences can be seen as reflecting the influence of individualistic versus honour-based values on the way in which self-conscious emotions are conceptualised).

Fischer, B. (1988). The process of healing shame. *Alcoholism Treatment Quarterly*, 4, 25-38.

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

Foulkes, S.H. (1964). *Therapeutic Group Analysis*. London: George Allen and Unwin.

Foulkes, S.H. (1990). *Selected Papers: Psychoanalysis and Group Analysis*. London: Karnac.

Fox, P. (1994). *Class Fictions: shame and resistance in the British working-class novel, 1890-1945*. Duke University Press.

Frank, E.S. (1991). Shame and guilt in eating disorders. *American Journal of Orthopsychiatry*, 61(2), 303-6. (A study of 94 college students supported the hypothesis that women with eating disorders experience more shame and guilt in relation to eating than do either normal or depressed women, and that such shame and guilt differentiate the eating disorders from other psychopathology. Findings revealed an apparent difference in the nature of the depression experienced by eating disordered women and that of depressed women without such disorders. Developmental and clinical implications are discussed).

Freud, S. (1914). On Narcissism: An Introduction. S.E. 14.

Gabbard, G. O. (1979). Stage fright. *Int J Psychoanal*, 1979, 60(Pt 3), 383-92. (Stage fright is a universal human experience that occurs with varying intensity in everyone who stands before an audience. The anxiety generated in this situation stems from the re-emergence of certain key developmental experiences. The dynamics involved are related both to genital and to pre-genital conflicts. Shame arises from conflicts around exhibitionism, from concerns over genital inadequacy, and from the fear of loss of control. Guilt is produced from the aggression inherent in self-display and from the fear of the destruction of one's rivals, along with the dread of retaliation. A major portion of the stage fright reaction is the reactivation of the crisis of separation-individuation, which generates separation anxiety connected to the fear that asserting oneself as a separate individual will result in withdrawal of love and admiration by maternal figures, i.e. the audience. The various developmental experiences are differentially weighted in each individual's stage fright reaction depending on the vicissitudes of his early childhood experience. Perhaps it is fortunate that few performers ever completely master stage fright, for an intangible sense of communion between the performer and his audience might well be lost as a by-product of the mastery).

Gans, J.S. (2000). The detection of shame in group psychotherapy: uncovering the hidden emotion. *International Journal of Group Psychotherapy*, 50(3), 381-96. (Shame, recently so extensively investigated in the individual and family therapy literature, has remained curiously underexplored in the group literature since Alonso and Rutan's article in 1988. Shame is frequently bypassed because, as a result of its hidden nature, its presence is often not detected. We catalogue and discuss six defences that may suggest the workings of shame: 1) focusing on themes that stress similarities between members 2) generating feelings of scorn

and disdain 3) avoiding here-and-now material 4) inducing guilt 5) transference reactions 6) preserving the illusion of the leader's infallibility. Detection of shame is important because shame plays some role in many of our patient's complaints).

Gerard, A.S. (1993). *The Phaedra Syndrome: of guilt and shame in drama*. Amsterdam; Atlanta, GA: Rodolpi.

Gilbert, C. M. (1988). Sexual abuse and group therapy. *J Psychosoc Nurs Ment Health Serv*, 26(5), 19-23. (This article described the formation of a structured, open-ended, time-limited, repeatable group for sexually abused girls. The sexually abused pre-adolescent and young adolescent must address developmental tasks while attempting to cope with tremendous guilt, shame, and loss of self-esteem. The value of group therapy as a support to sexually abused children was explored and a format was devised to help them deal with their issues. Discussion questions and topics designated for each session helped meet their specific needs. The group members evaluated the group as being helpful overall. In conclusion, the expansion of psychotherapeutic services to sexually abused children through a structured group format has been proposed. If others are encouraged to engage in such work, then the purpose of this article has been achieved)

Gilbert, P. et al. (1994). The phenomenology of shame and guilt: an empirical investigation. *British Journal of Medical Psychology*, 67(1), 23-36. (This paper explores the various literatures concerned with shame and guilt. Lewis' model of shame is outlined. The phenomena she suggested to be part of shame (feelings of helplessness, anger at others, anger at self, self-consciousness and feelings of inferiority) were investigated as to their relationship with shame. Strong support for these phenomena being related to shame, but not

guilt, was found. Although located in separate literatures, shame and fear of negative evaluation have considerable overlap and this study set out to explore this relationship. The study further considered the role of submissive behaviour in shame and depression. Evidence was found to support the view that submissive behaviour is involved in both shame and depression).

Gilbert, P. (1997). The evolution of social attractiveness and its role in shame, humiliation, guilt and therapy. *British Journal of Medical Psychology*, 70, 113-147. (This paper suggests that humans have innate needs to be seen as attractive to others. These needs form the basis for shame and mediate evaluations of social standing, social acceptance and social bonds. Shame and humiliation are associated with attacks on, and losses of, social attractiveness. The paper goes on to look at the defensive aspects of shame in therapy).

Gilbert, P. (1998). *Shame: interpersonal behaviour, psychopathology, and culture*. Oxford University Press.

Gilbert, P. and Gerlsma, C. (1999). Recall of shame and favouritism in relation to psychopathology. *British Journal of Clinical Psychology*, 38(4), 357-73. (There is good evidence that early rearing experiences affect vulnerability to subsequent psychopathology. Recent research on memories of rearing style have been influenced by attachment theory and have focused primarily on domains of emotional warmth and control. However, early experiences of being shamed, criticized and made to feel inferior, together with believing one's sibling is favoured over oneself, are also likely to play a role in vulnerability. This study therefore explored recall of being shamed and sibling favouritism. METHOD: A large community sample (N = 638) and a varied non-psychotic patient sample (N

= 213) completed two recall of parent rearing scales (the PBI and EMBU). These gave measures of recall of emotional warmth, overprotection/control, being shamed and shown up, and self or sibling favouring. Participants also completed the SCL-90-R scale. RESULTS: Patients recalled less warmth, more control, more shame and more favouring of siblings than the community sample. The difference was greatest for shame, and following MANOVA analysis shame remained significantly different between the two groups even after controlling for emotional warmth and control. Similarly, recalling being less favoured than a sibling and shamed had robust associations with indicators of psychopathology and these were only marginally reduced when emotional warmth was controlled for. Moreover, hostility (as measured by the SCL-90-R) was specifically related to recall of being shamed but not emotional warmth. CONCLUSION: This study suggests that over and above issues of emotional warmth and control, recall of direct experiences of being shamed, feeling inferior and less favoured in a family, may be particularly pathogenic. They operate independently of warmth and may be especially important in proneness to hostile feelings. Given this, therapists may wish to specifically explore shame issues with patients).

Gill, H. S. (1991). Psychotherapy of a fatherless young woman. *Br J Med Psychol*, 64(Pt 3), 225-32. (Psychotherapy of some fatherless adult patients suggests that they may replace the shameful experience of their childhood by an illusory picture of their past, and that they may exalt their absent fathers to an ideal perfection in order not to face the possibility that their fathers might have been irresponsible deserters. The two conflicting versions of the absent father, one conscious and one unconscious, are reflected in their image of themselves. They do not talk of their shame, because they hide it from themselves and from others, but it emerges in their dreams.

They are driven to enact shame repeatedly, not by experiencing it themselves, but by subjecting their partners and lovers to shame. Their anger against the deserting father remains unexpressed, and is revealed, instead, in relation to the therapist, and in other relationships, and should be interpreted as an unconscious device to conceal their shame at the hands of their fathers. Such interpretations take time to be effective, because knowing the true source of anger (the absent father) would bring the patients too close to the unbearable experience of shame).

Gillman, R.D. (1990). The oedipal organization of shame: the analysis of a phobia. *Psychoanalytic Study of the Child*, 45, 357-75.

Glasser, M. (1992). Problems in the psychoanalysis of certain narcissistic disorders. *International Journal of Psychoanalysis*, 73(3), 493-503. (This paper considers the psychopathology and treatment of a particular group of narcissistic disorders which can be characterised by their use of "simulation" in their attempt to resolve the conflicts of the Core Complex. The invasive, narcissistic mother's demand for success is responded to with an evident compliance but with a covert rebellion manifested in failure, accompanied by intense feelings of shame and low self-esteem. This is seen in the analysis in the patient's apparently positive response being followed by a Negative Therapeutic Reaction. The structure is seen to be as much concerned with protecting the mother from the infant's destructiveness as it is with protecting the infant from the colonising mother (cf. Winnicott's "False Self"). What is regarded as the hallmark of narcissistic disorders, namely shame, is found to be part of a defensive structure concerned with the exclusion of extreme violence and intolerable guilt.

The significance of the father is discussed. Difficulties that arise in the analysis of such patients is considered).

Glickauf-Hughes, C. (1997). Teaching students about primitive defenses in supervision. *The Clinical Supervisor*, 15(2), 105-113. "Treating clients who employ primitive defense mechanisms often leads therapists to experience intense emotional reactions such as shame, rage and despair that are difficult for them to understand".

Goldberg, C. (1988). The role of shame in therapeutic misalliance. *Group Analysis*, 21, 339-344.

Goldberg, C. (1989). The shame of Hamlet and Oedipus. *Psychoanalytic Review*, 76(4), 581-603.

Goldberg, C. (1991). *Understanding Shame*. Northvale, N.J.: Jason Aronson.

Goldberg, Carl. (1999). The Role of Shame in Constructive Behaviour. *Journal of contemporary psychotherapy*, vol. 29, no. 3, pp. 253.

Gomberg, E.S.L.(1987). Shame and guilt issues in women alcoholics. *Alcoholism Treatment Quarterly*, 4(2), 139-155.

Gorsuch, S. (1990). Shame and acting out in psychotherapy. *Psychotherapy*, 27, 585-590.

Green, A. (1982). Moral Narcissism. *Psychoanalytic Psychotherapy*, 7, 243-269.

Greist, J.H. (1995). The diagnosis of social phobia. *J Clin Psychiatry*, 56 Suppl. 5:5-12. (The core feature of social phobia

is marked and persistent fear of embarrassment or humiliation in social situations where the individual worries that others may judge his or her performance as too much or too little ["being found wanting". T. Birchmore]).

Grosch, W.N. (1994). Narcissism: shame, rage and addiction. *Psychiatric Quarterly*, 65(1), 49-63. (This paper employs perspectives from Self Psychology to illuminate our understanding of narcissism. Striving for complete independence and autonomy, a goal of classical psychoanalysis, encourages the disavowal of narcissism. Instead, narcissism is viewed as necessary for the survival of a sense of self and not on the same continuum with object love. The concepts of self-object and self-object functions are defined. Shame and rage are explained as byproducts of self-object failure. It is postulated that shame emerges out of self-depletion and that narcissistic rage emerges out of self-fragmentation. Countertransference and treatment implications are discussed. Following Lichtenberg, addictions are viewed as deriving from the quest for self-object experience, regardless of the long-term detriment).

Gross, C.A. & Hansen, N.E. (2000). Clarifying the experience of shame: the role of attachment style, gender, and investment in relatedness. *Personality and Individual Differences*, 28(5), 897-907.

Hahn, W.K. (1994). Resolving shame in group psychotherapy. *International Journal of Group Psychotherapy*, 44(4), 449-61. (This article addresses shame and the defences against shame in group psychotherapy. The experience of shame involves the activation of devalued and devaluing introjects, either of which can be externalised through projection or projective identification resulting in the manifestation of contempt and

envy. This article will examine ways to identify, understand, and manage these defences in order to help resolve shame. The resolution of shame involves experiencing and verbalising the profound sense of inadequacy associated with shame without resorting to splitting or receiving the anticipated rejection and condemnation from self and others).

Hahn, William K. (2000). Shame: Countertransference Identifications in Individual Psychotherapy. *Psychotherapy*, vol. 37, no. 1, pp. 10.

Harder, D.W. et al. (1992). Assessment of shame and guilt and their relationships to psychopathology. *Journal of Personality Assessment*, 59(3), 584-604.

Harper, J.M. (1990). *Uncovering Shame: An Approach Integrating Individuals and their Family Systems*. New York: W.W. Norton.

Harvey, O.J. et al. (1997). Relationship of shame and guilt to gender and parenting practices. *Personality and Individual Differences*, 23(1): 135-146.

Harvey, O.J. et al. (1998). Relationship of belief systems to shame and guilt. *Personality and Individual Differences*, 25(4): 769-783.

Hawkins, C.A. (1996). Pathogenic and protective relations in alcoholic families(2): ritual invasion, shame, ACOA traits, and problem drinking in adult offspring. *Journal of Family Social Work*, 1(4), 51-62. "This paper explores the relationship between the perception of ritual disruption by parental alcohol abuse in the family of origin and shame based characteristics in adult offspring".

Haynes, J. (1993). 'In a dark time, the eye begins to see'. *J Anal Psychol.* 38(2), 137-54. (In this paper I discuss a patient whose shadow became his rival, or as Jung put it, 'The shadow is lived'. I describe the beginning of a process of the assimilation of shadow contents, whereby the rupture between ego and shadow can no longer be maintained. I also discuss how it is primarily through the mutual experience and analysis of archetypal images that the unconscious contents become more integrated. In my clinical illustrations I also explore the relationship between my patient's fight with his shadow and his experiences of childhood shame. I consider how fear expressed through a panic attack may open a royal door to the unconscious, and the way in which its mediation through empathy and analysis can lead to unconscious infantile contents becoming more accessible. In addition, I show how, once some of the fear had subsided, it became possible for play to enter into the analysis).

Heimannsberg, B. and Schmidt, C.J. (eds.) (1993). *The Collective Silence: German Identity and the Legacy of Shame.* San Francisco, CA: Jossey-Bass Publishers.

Heller, A. (1985). *The Power of Shame: a rational perspective.* Routledge and Kegan Paul.

Heller, E. (1974). Man guilty and man ashamed: 1. Man guilty. *Reflections on The Trial, by Franz Kafka. Psychiatry,* 37(1): 10-21.

Heller, E. (1974). Man guilty and man ashamed: 2. Man ashamed. *Psychiatry,* 37(2): 99-108.

Her, Emily Huei-ling. (1990). *A phenomenological explication of shame in a shame culture: a cross-cultural perspective.* PhD

Thesis Southern Illinois University at Carbondale. Also held at Durham University Library, UK.

Herrmann, F.; De Paola, H. (2001). Envy, jealousy and shame. *Int J Psychoanal.* 82(2).

Hoglund, C.L. and Nicholas, K.B. (1995). Shame, guilt, and anger in college students exposed to abusive family environments. *Journal of Family Violence*, 10(2), 141-57. (The relationship between an abusive environment within the family and proneness to shame, guilt, anger, and hostility in college students revealed that greater exposure to emotional abusiveness was significantly related to higher shame, overt and covert hostility, and expressed and unexpressed anger. Greater exposure to physical abusiveness was significantly related to overt hostility and a tendency to experience anger without a specific provoking situation. Women reported higher shame and guilt, whereas men reported higher levels of overt hostility and expressed anger. Shame proneness was related to covert hostility and unexpressed anger for both men and women. However, guilt proneness was not related to exposure to family abusiveness, or, with one exception, to anger and hostility variables. Implications for therapy with adult survivors of childhood abuse are discussed).

Holly, C. (1995). *Intensely Family: The Inheritance of Family Shame and the Autobiographies of Henry James*. University of Wisconsin Press.

Horner, A.J. (1979). *Object relations and the developing ego in therapy*. New York: Jason Aronson.

Hultberg, P. (1988). Shame - a hidden emotion. *J Anal Psychol*, 33(2), 109-26.

Imber-Black, E. (1993). *Secrets in Families and Family Therapy*. New York: Norton.

Irwin, H.J. (1998). Affective predictors of dissociation. 2: Shame and guilt. *Journal of Clinical Psychology*, 54(2), 237-45. (As a contribution to an understanding of the psychodynamics of dissociative disorders this study investigated proneness to shame and to guilt as predictors of dissociative tendencies. One hundred and three Australian university students completed self-report measures of dissociative tendencies, proneness to shame and to guilt, gender, and age. Proneness to shame, proneness to guilt, and age were found to contribute significantly to the prediction of dissociative tendencies. The data provide further support for the view that common affective consequences of childhood trauma may mediate between such trauma and the development of a dissociative coping style. This study investigated the proneness to shame and guilt as predictors of dissociative tendencies. This association was confirmed).

Jacoby, M. (1993). Is the analytic situation shame-producing? *Journal of Analytical Psychology*, 38(4), 419-36. (The question whether the analytic situation is shame-producing has to be answered in an affirmative way. But it is often difficult to discern to what extent this is a quite natural reaction to the "artificial inequality" of the analytic situation itself, of which patients so often complain. Indeed, it is also in most cases due to the patient's excessive susceptibility to shame and his/her transference feelings. Yet, on the whole, shame has an important place in the economy of the psyche. It can have a blocking, counterproductive influence on the analysis, but this is not necessarily so. Shame can be defined as a "guardian of human dignity" in at least two senses. We react with shame if

we are afraid of losing dignity "in the eyes of others". But shame is also aroused - at best - if we betray our inner integrity and truth. Although analysts should be sensitive to their patients' vulnerability to shame, avoiding unnecessary and counterproductive shaming, they still need to face issues of shame for the sake of the individuation process. This may result in greater self-acceptance, including one's shadow, and a shift may take place; we may become less fearful of what others think of us and more concerned to adhere to our own truth).

James, S.R. (1992). Treatment of the shame involved in the experience of incest. In J. Scott Rutan (ed.), *Psychotherapy for the 1990's* (pp. 273-285). New York: Guilford Press.

Jewkes, R. et al. (1998). Why do nurses abuse patients? Reflections from South African obstetric services. *Soc Sci Med*, 47(11), 1781-95. (Although nursing discourse usually emphasises "caring", nursing practice is often quite different and may be more strongly characterised by humiliation of patients and physical abuse. Many of the patients in this study report clinical neglect, verbal and physical abuse from nursing staff that was at times reactive, and at other times, ritualised in nature. Although they explained nurses' treatment of them in terms of a few "rotten apples in the barrel", analysis of the data revealed a complex interplay of concerns including organisational issues, professional insecurities, perceived need to assert "control" over the environment and sanctioning of the use of coercive and punitive measures to do so, and an underpinning ideology of patient inferiority. The findings suggest that the nurses were engaged in a continuous struggle to assert their professional and middle class identity and in the process deployed violence against patients as a means of creating social distance and maintaining fantasies of identity

and power [So the shame became the shame of someone else through a process involving projective identification - T. Birchmore]).

Johnson, C.L. (1995). Shame, trauma, and empathy: impasse to connection; self-in-relation and the therapeutic relationship: a case study. Doctoral Dissertation, Chicago School of Professional Psychology. (Chronic trauma affects one's view of the world and of one's self. In daily life, transient shame directs us to reconnection with others. However, with the complicated reactivation of trauma, prolonged shame sits at centre stage. Shame affects one's personal standards, the meaning one finds or creates of the world; it affects how and to whom various behaviours and beliefs are attributed; it alters one's sense of self. There is a case study that reflects this author's work with a client over an extensive time period. Major foci involved the impact of recurring trauma on the client's sense of self, or her capacity to initiate self-enhancing, goal-directed activity, and on the quality of her interpersonal relationships. Additionally, the impact of prolonged shame - which contributed to her intense relational disconnection and inhibited her creative ability to create a new meaning for her life - is addressed. The literature review for this work includes an examination of the theoretical underpinnings of therapy and the therapeutic process itself, as well as clinical practice lore concerning what clinicians actually do in a session with a client. This paper will address several areas relevant to the client's history: a). attachment literature with regard to early life attachments/transitions/losses. b). trauma literature, particularly sexual abuse and its long-term sequelae, including a definition of PTSD and borderline personality disorder; and c). the construct of shame as it is used to describe affect and experience. The case study addresses the following questions: How does a mutually empathic relationship affect one's sense

of self? How does shame impede self development? What is the role of shame in trauma? How does a mutually empathic relationship facilitate healing from trauma?).

Kafka, E. (1971). On the development of the experience of mental self, the bodily self, and self consciousness. *Psychoanalytic Study of the Child*, 26: 217-40.

Kassebaum, D.G. and Cutler, E.R. (1998). On the culture of student abuse in medical school. *Acad Med*, 73(11), 1149-58. (The abuse of students is ingrained in medical education. The authors describe the profiles of student abuse, and focus on the more common forms of reported mistreatment - public belittlement and humiliation - that appear to be misguided attempts to reinforce learning. This is likely to produce a "transgenerational legacy" that leads to future mistreatment of others).

Katz, P. (1995). The psychotherapeutic treatment of suicidal adolescents. *Adolesc Psychiatry*, 20, 325-41. (The therapeutic work with a suicidal adolescent begins with the therapist's recognition that there are a multitude of causes for suicidal behavior and that the risk of a serious suicide attempt lies in the patient's feeling of desperation about his situation, the feeling that he faces intolerable pain due to shame or embarrassment, degradation, guilt or loss. The patient can not assess whether his view of his situation is realistic or not, and he is unable to conceive of alternative solutions. The therapist must throw the patient a lifeline to give him hope of escaping from his belief that he is trapped in a world of unending pain. That lifeline may be an active intervention in the life of a patient, reality testing of the patient's perceptions that he is trapped, or both. The choice of interventions is based on an exploration of the psychodynamic and psychopathological

constellations that have caused the patient to feel so trapped. Patients, in their anguish, will resort to extremes of coercion and manipulation; the therapist must be able to tolerate and work with these behaviors. The therapist must maintain his belief that he can find ways to help the patient, while accepting the possibility that some day he might fail. He can succeed only if he is prepared to fail. Meeks (1984) summed up his article on suicidal adolescents in the following way: Success in the therapy of these youngsters does not depend on brilliant insights as much as on persistence, patience, and a sustained hope for the future. The treatment process may become a demonstrated proof that the therapist can stand to feel the patient's feelings and live the patient's painful existence, without giving up on life or the patient).

Kaufman, G. (1992). *Shame: The Power of Caring*. Cambridge, MA: Schenkman Publishing Company.

Kaufman, G. (1989). *The Psychology of Shame: Theory and Treatment of Shame-based Syndromes*. New York, NY: Springer Publishing Company.

Keltner, D. and Buswell, B.N. (1997). Embarrassment: its distinct form and appeasement functions. *Psychol Bull*, 122(3): 250-70.

Kessler, B.L. and Bieschke, K.J. (1999). A retrospective analysis of shame, dissociation, and adult victimization in survivors of childhood sexual abuse. *Journal of Counselling Psychology*, 46(3), 335-341. (Study found an association between childhood sexual abuse and victimization as an adult. Shame was found to be a significant predictor of victimization as an adult whereas dissociation did not predict adult victimization).

Kilborne, B. (1995). Of Creatures Large and Small: size anxiety, psychic size, shame, and the analytic situation. *Psychoanalytic Quarterly*, 64(4), 672-90.

Kilborne, B. (1999). When trauma strikes the soul: shame, splitting, and psychic pain. *American Journal of Psychoanalysis*, 59(4), 385-402.

Kinston, W. (1983). A theoretical Context for shame. *International Journal of psychoanalysis*, 64, 213-226.

Klaassen, J. A. (2001). The Taint of Shame: Failure, Self-Distress, and Moral Growth. *Journal of Social Philosophy*, vol. 32, no. 2, pp. 174-196.

Kleeman, J. A. (1973). The peek-a-boo game. A evolution and associated behavior, especially bye-bye and shame expression, during the second year. *J Am Acad Child Psychiatry*, 12(1), 1-23.

Kohut, H. (1971). *The Analysis of the Self*. New York: International Universities Press.

Kris, A.O. (1990). Helping patients by analyzing self-criticism. *J Am Psychoanal Assoc*, 38(3), 605-36. (This paper is addressed to patients' need for help with punitive self-critical attitudes. Such help has not always been sufficiently provided by psychoanalysts, owing to an unrecognised failure of neutrality. Historically, a gradual overemphasis on the concept of an unconscious sense of guilt has acted as a barrier to the appreciation of shame. An alternative concept, punitive unconscious self-criticism, which stands in contrast to constructive self-criticism and is common to the painful affects of guilt, shame, humiliation, and depression, can facilitate

helpful analytic treatment. Kohut's contributions are examined).

Lansky, M.R. (1994). Shame: contemporary psychoanalytic perspectives. *Journal Am Acad Psychoanal*, 22(3), 433-41.

Lansky, M.R. (1996). Shame and suicide in Sophocles' Ajax. *Psychoanalytic Quarterly*, 65(4), 761-86.

Lansky, M.R. (1997). Posttraumatic nightmares: a psychoanalytic reconsideration. *Psychoanalysis and Contemporary Thought*, 20(4), 501-521. (This paper reports on a 7-year study of posttraumatic nightmares in an inpatient psychiatric population. In every case, the patient's account of the nightmare scenario differed significantly from that person's account of the trauma, but the discrepancy was kept from consciousness by secondary revision. These posttraumatic nightmares were instigated by shame and fragmentation in the day preceding the dream. Psychoanalytically informed treatment of trauma patients should consider shame conflicts related to the disorganised posttraumatic state as well as the conflicts in the manifest content of the nightmare).

Lansky, M.R. and Morrison, A.P. (1997). *New Perspectives on Shame*. Analytic Press.

Lansky, M. R. (2000). Shame dynamics in the psychotherapy of the patient with PTSD: a viewpoint. *J Am Acad Psychoanal*. 28(1), 133-46.

Laor, N. (1987). Psychoanalysis without shame. *Isr J Psychiatry Relat Sci*, 24(4), 257-64.

Lax, R. F. (1992). A variation on Freud's theme in "A child is being beaten"--mother's role: some implications for superego development in women. *J Am Psychoanal Assoc*, 40(2), 455-73. (Clinical material is presented leading to a discussion of beating fantasies which varies from Freud's model. Analysis shows that the fantasied role girls assign to mother as the punisher in the oedipal drama is equivalent to the fantasied role boys ascribe to father as castrator. For both sexes, castration anxiety spurs the internalization of parental prohibitions, the repression of oedipal wishes, and the subsequent structuralization of the superego. Mother establishes the "oedipal law" for the girl analogously to father's doing the same for the boy. The role that such fantasies play in the formation of the female superego is examined).

Lazare, A. (1987). Shame and humiliation in the medical encounter. *Arch Intern Med*, 147(9), 1653-8. (Patients are at high risk for experiencing shame and humiliation in any medical encounter. This is because we commonly perceive diseases as defects, inadequacies, or shortcomings; while the visit to the hospital and doctor requires psychological and physical exposure. Patients respond to the suffering of shame and humiliation by avoiding the doctor, withholding information, complaining, and suing. Doctors may also experience shame and humiliation in medical encounters resulting in their counterhumiliation of patients and dissatisfaction with medical practice. A heightened awareness of these issues can help medical practitioners diminish the shame experience in their patients and in themselves. Twelve clinical strategies for the management of shame and humiliation in patients are discussed).

Lear, T.E. (1987). Silver linings of shame clouds. *Group Analysis*, 20, 49-63.

Lear, T.E. (1990). Shameful encounters, alienation, and healing restitution in the group. *Group Analysis*, 23, 155-161.

Lee, R. and Wheeler, G. (1996). *The Voice of Shame: Silence and Connection in Psychotherapy*. Jossey Bass.

Leith, Karen P. and Baumeister, Roy F. (1998). "Empathy, Shame, Guilt, and Narratives of Interpersonal Conflicts: Guilt-Prone People Are Better at Perspective Taking", *Journal of Personality* 66: 1--37.

Lesse, S. (1970). Mortality, shame, and scientific organizations. *Am J Psychother*, 24, 1- 3.

Lester, D. (1998). The association of shame and guilt with suicidality. *J Soc Psychol*, 138(4), 535-6.

Levin, S. (1967). Some metaphysical considerations on the differentiations between shame and guilt. *International Journal of Psychoanalysis*, 48, 267-276.

Levin, S. (1971). The psychoanalysis of shame. *International Journal of Psychoanalysis*, 52, 335-362.

Lewis, H.B. (1987). *The role of shame in symptom formation*. Hillsdale, N.J., L. Erlbaum Associates.

Lewis, H.B. (1971). *Shame and Guilt in Neurosis*. New York: International University Press.

Lewis, H.B. (1990). Shame, Repression, Field Dependence, and Psychopathology. In J.L. Singer. *Repression and Dissociation: implications for personality theory, psychopathology, and health*. University of Chicago Press.

Lewis, M. (1992). *Shame: The Exposed Self*. New York: The Free Press.

Lowenfeld, H. (1976). Notes on shamelessness. *Psychoanal Q*, 45(1), 62-72. (The effect of the decline of the sense of shame on the individual and on society is discussed. It is postulated that when the element of shame is changed in relation to instinctual drives, the later power of shame in preserving social cohesion is weakened, and a regression in some important functions of the ego results).

Lowry, E.R. (1991). *Thersites: a study in comic shame*. Garland.

Lutwak, N. and Ferrari, J.R. (1996). Moral affect and cognitive processes: differentiating shame from guilt among men and women. *Personality and Individual Differences*, 21(6): 891-896.

Lutwak, N. and Ferrari, J.R. (1997). Understanding shame in adults: retrospective perceptions of parental bonding during childhood. *Journal of Nervous and Mental Disease*, 185(10), 595-8. (The association between perceptions of parental-bonding style during childhood and moral affect of shame at young adulthood were examined with 264 women and 140 men (mean age [\pm SD] = 20.4 \pm 1.6 years old). Shame affect was significantly positively related to fear of negative evaluation by others and social avoidance, and negatively related to recalled parental care in one's childhood. Multiple regression analyses indicated that maternal protectiveness, paternal care, fear of negative social evaluation, and social avoidance were

significant predictors of shame, explaining 41% of the variance. Results support object relations theory, which states that shame is a moral affect associated with social evaluation apprehension and may have developmental implications for one's parental relations).

Lutwak, N. et al. (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(6): 1027-1036.

Lutwak, N. (1998). Shame, Women, and Group Psychotherapy. *Group*, 22(3), 129-144

Lynd, H. (1958). *Shame and the Search for Identity*. New York: Science Edition.

Lynd, H.M. (1971). The nature of shame. In H. Morriss. *Guilt and Shame*. Wadsworth Publishing.

Lynd, H. (1985). *On Shame and the Search for Identity*. New York: Harcourt, Brace and World.

McDonagh, C. (1997). *Shame and body image*. M.Ed. Dissertation, University of Nottingham.

McDougal, J. (1980). *Plea for a Measure of Abnormality*. New York: International University Press.

Macdonald, J.; Morley, I. (2001). Shame and non-disclosure: a study of the emotional isolation of people referred for psychotherapy. *Br J Med Psychol*. 74(1), 1-21. (Thirty-four people referred to an NHS psychotherapy department were given a modified form of Oatley and Duncan's (1992) emotion

diary which included questions about whether each recorded emotion had been subsequently disclosed to anyone (for example a partner, friend or professional). One week later the diaries were collected and participants interviewed. Interviews focused, among other things, on reasons for nondisclosure of recorded emotional experiences and the relationship between shame and non-disclosure. The results indicated that a majority of the emotional incidents recorded in the diaries were not disclosed (68%). This result contrasts with studies on non-clinical samples in which only approximately 10% of everyday emotions are kept secret. Qualitative analysis of the interview data revealed that participants appeared to be habitual non-disclosers of emotional and personal experiences and that non-disclosure was related to the anticipation of negative interpersonal responses to disclosure (in particular labelling and judging responses) in addition to more self-critical factors including shame. It is suggested that these results add to the existing literature on shame by illustrating the interpersonal effects of shame in a clinical sample).

McDowell, N.A. (1975). Kinship and the concept of shame in a New Guinea village. PhD Thesis, Cornell University. Also held by Durham University, UK.

McFarland, B. (1990). Shame and Body Image: culture and the compulsive eater. Deerfield Beach, Fla.: Health Communications.

Martin, Daniel D. (2000). Organizational Approaches to Shame: Avowal, Management, and Contestation. *Sociological Quarterly*, vol. 41, no. 1, pp. 125.

Martin, J. T. (1993). Shame and the origin of physician-patient conflict. *J Am Osteopath Assoc*, 93(4), 486. (Shame is a

powerful negative emotion that motivates much intrapersonal and interpersonal conflict. The relationship between patient and physician can turn to conflict if the medical environment elicits shame in the patient; conflict arises when the patient externalizes the cause and blames the physician for negative feelings. Patients who suffer from hyperactive and reactive shame responses may require particularly sensitive care. Including the assessment of shame reactivity in the medical history can help identify such persons. Measures that reduce shame should improve compliance and reduce the incidence of malpractice suits).

Masheb, R.M. (1999). Shame and its psychopathologic correlates in two women's health problems: binge eating disorder and vulvodynia. *Eat. Weight Disord.*, 4(4), 187-93.

Middleton-Moz, J. (1990). *Shame and Guilt: the masters of disguise*. Deerfield Beach, Fla.: Health Communications.

Miller, R.S. (1996). *Embarrassment: poise and peril in everyday life*. Guilford Press.

Miller, S. (1985). *The Shame Experience*. Hillsdale, NJ: Analytic Press.

Miller, S.B. (1988). Humiliation and shame. Comparing two affect states as indicators of narcissistic stress. *Bulletin of the Menninger Clinic*, 52(1), 40-51.

Miller, S.B. (1989). Shame as an impetus to the creation of conscience. *International Journal of Psychoanalysis*, 70.
(Shame 'absorbed by' guilt is an issue that was flagged for consideration by Erikson. The most compelling reason for using guilt to obscure shame is that guilt is associated with a sense

of the self as strong, though burdened and culpable, whereas shame brings with it a painful sense of vulnerability. Erikson described the way in which compulsive ordering-about of the self allows a child to feel less helpless and less vulnerable to the shame affect. In instituting this type of self-directive behaviour, the child is developing conscience. The irony of this type of self-manipulation is that ultimately the child, or adult, finds himself again burdened by impotence, though it is the impotence of guilt rather than that of shame. The topic of shame yielding to guilt is of interest in part because it demonstrates the highly interactive relationship between narcissistic concerns and superego responses to impulse-expression, and the role of such interactions in the formation of psychological structures).

Miller, S.B. (1996). *Shame in Context*. Analytic Press.

Miller, W.I. (1993). *Humiliation: and other essays on honor, social discomfort and violence*. Cornell University Press.

Mindell, C. (1994). Shame and contempt in the everyday life of the psychotherapist. *Psychiatric Quarterly*, 65(1), 31-47. (Psychotherapy is seen as moving between the poles of shame and hope. Shame-anxiety alerts us to the imminent danger of being shamed; shame is described as the experience of finding our individuality unacceptable and contempt is seen as a means of coping with shame where the other is made to feel one's shame. Examples of each are provided as well as comments about psychotherapy issues with patients who exhibit shame-anxiety, shame and contempt. Shame-anxiety, shame, contempt and tyranny are seen as points along a spectrum of humiliation experiences).

Mittwoch, A. (1987). Aspects of guilt and shame in psychotherapy. *Group Analysis*, 20(1), 33-42.

Modell, J. (1999). The wall of shame: Ruth Benedict's accomplishment in the *Chrysanthemum and the Sword*. *Dialectical Anthropology*, 24(2), 193-215.

Mollon, P. (1984). Shame in relation to narcissistic disturbance. *British Journal of Medical Psychology*, 57, 207-214.

Mollon, P. (1986). Narcissistic vulnerability and the fragile self: a failure of mirroring. *Br J Med Psychol*, 59 (Pt 4), 317-24. (The phenomenon of narcissistic vulnerability is described and the history of the concept is outlined. With clinical illustrations from individual and group psychotherapy it is described how some people are prone to show strong reactions to the narcissistic injuries of feeling slighted or ignored. These are associated with a proneness to shame. Drawing on Broucek's suggestion that the basis of the sense of self is the sense of efficacy, it is proposed that the fundamental injury is an incapacity to evoke a meaningful emotional response in the caretaker. This notion is compared with the related views of Winnicott and Kohut. It is apparent that a superficial mirroring response is not sufficient; what the child (and patient) needs is a deeper empathic response. In therapy, patients attempt to master the original injury by seeking again a response that mirrors in depth).

Morris, H. (1971). *Guilt and Shame*. Basic Problems in Philosophy Series. Wadsworth Publications.

Morris, P. A. (1994). Superkids: short-term group therapy for children with abusive backgrounds. *J Child Adolesc Psychiatr*

Nurs. 7(1), 25-31. (Many children who are hospitalized have a history of physical or sexual abuse. A short-term therapy group for children with abusive backgrounds, called Superkids, was led by nurse therapists using a combination of active role playing, masks, picture drawing, and discussion. The group was structured and covered five topics over a 2 1/2 week period: shame, anger, fear, trust and love. Clinical observations suggest that the Superkids group structure helps children talk about their feelings and the abuse they have suffered. Through a brief intervention group, members learn they are not alone and that they are accepted by their peers).

Morrison, A.P. (1983). Shame, ideal self and narcissism. *Contemporary Psychoanalysis*, 19, 295-318.

Morrison, A.P. (1984). Working with shame in psychoanalytic treatment. *Journal of the American Psychoanalytic Association*, 32(3), 479-505.

Morrison, A.P. (1989). *Shame: The Underside of Narcissism*. Hillsdale, NJ: The Analytic Press.

Morrison, D.M. (1997). The relations between social rank and status, shame and provoked anger in special hospital psychopaths: an exploration of the utility of evolutionary concepts in a sample of "psychopathic disorder" males. *Clinical Psychology Diploma Thesis, University of Leeds*.

Moses-Hrushovski, R. (1994). Deployment: hiding behind power struggles as a character defense. Jason Aronson. *About shame, humiliation and narcissistic injuries*.

Murphy, N.B. (1997). Experience of shame in early parenthood. *Clinical Psychology Diploma Thesis, University of Leeds*.

Murray, et al. (2000). Family dysfunction and bulimic psychopathology: the mediating role of shame. *International Journal of Eating Disorders*, 28(1), 84-89. (Although disturbed family function has some association with bulimic psychopathology, the psychological mechanisms that account for that link are not clear. This study explores the hypothesis that shame acts as a mediator in that relationship, whereas shame-proneness is a moderator variable. **METHOD:** The participants were 139 nonclinical women. Each completed measures of perceived family function, shame-proneness, internalized shame, and bulimic psychopathology. Regression analyses were used to test for the mediating and moderating effects of shame. **RESULTS:** The findings were compatible with a model where shame-proneness acts as a moderator and internalized shame is a perfect mediator in the link between paternal overprotection and bulimic attitudes. **CONCLUSIONS:** The experience of shame appears to be a critical element in understanding the relationship between perceived family dysfunction and bulimic psychopathology. Where individuals perceive their families as problematic, it may be clinically valuable to focus on shame as a psychological consequence of that experience).

Nathanson, D. (1987). A timetable for shame. In D. Nathanson (ed.), *The Many Faces of Shame* (pp. 1-63). New York: Guilford Press.

Nathanson, D.L. (1989). Understanding what is hidden. Shame in sexual abuse. *Psychiatric Clinics of North America*, 12(2), 381-8.

Nathanson, D.L. (1992). *Shame and Pride: Affect, Sex, and the Birth of the Self*. New York: W.W. Norton.

Nathanson, D.L. (1994). Shame, compassion, and the "borderline" personality. *Psychiatric Clinics of North America*, 17(4), 785-810. (This article focuses on the emotionality of the individual diagnosed as "borderline". There may be no clinical condition characterised by so wide a range of affective expression. The author points out that both Kernberg and Kohut view this cohort from the standpoint of drive theory, in which all emotion is traced to drive forces gone awry. Viewed from the perspective of affect theory, it becomes possible to explain this otherwise puzzling cluster of symptoms as the expression of and defences against the painful emotion of shame. The very concept of a "borderline" illness may prove to be a construction made necessary by previous misunderstanding of shame psychology, and the symptoms themselves perhaps an artifact of a wider, societal misunderstanding of shame).

Neyrey, J.H. (1998). *Honor and Shame in the Gospel of Matthew*. Westminster John Knox Press.

Nicholas, M.W. (1993). How to deal with moral issues in group therapy without being judgmental. *International Journal of Group Psychotherapy*, 43(2), 205-21. (The author discusses the pervasive difficulty psychotherapists seem to have in discussing patient morality, relating it to the fear of imposing (and feeling) shame and guilt. A way of nonjudgmentally discussing moral values with patients is presented, which places emphasis not on moral abrogations, but rather on the "virtues" of altruism, responsibility, justice, egalitarianism, and honesty. Ways are suggested by which the therapist can help the patient deal with thorny moral issues and confront the morally confused patient without causing shame).

Nichols, M.P. (1991). *No Place to Hide: Facing Shame so we can find Self-respect*. New York: Simon and Schuster.

Nitsun, M. (1996). *The Anti-Group: Destructive Forces in the Group and their Creative Potential*. London: Routledge.

Noble, L.L. (1975). *Naked and Not Ashamed: an anthropological, Biblical and psychological study of shame*. Jackson, Mitch: Lowell Noble.

O'Connor, Lynn E.; Berry, Jack W.; Weiss, Joseph. (1999). Interpersonal Guilt, Shame, and Psychological Problems. *Journal of social and clinical psychology*, vol. 18, no. 2, pp. 181.

Orr, S. W. (2001). The Economics of Shame in Work Groups: How Mutual Monitoring Can Decrease Cooperation in Teams. *Kyklos*, vol. 54, no. 1, pp. 49-66.

Parkin, A. (1985). Narcissism: its structures, systems and affects. *International Journal of Psychoanalysis*, 66(2), 143-56. (The growth of object relationships may be studied along either the developmental line of the discharge-object or that of the reflexive-object. The former is the well-known line of development from the need-satisfying object to the constant object and is the study of id-ego relationships. The developmental line of the reflexive-object, on the other hand, follows the history of the introjects and is a study of either ego-superego or ego-ego ideal relationships. It is the latter that constitutes the study of narcissism. The development of narcissism, the ego and ego ideal are outlined. Various narcissistic states and affects such as shame, humiliation, depression, grandiosity, pomposity, arrogance, adoration, and enthrallment are the result of either hypercathexis of the

introjects of the ego ideal and the resulting conflict with the ego, or hypercathexis of the introjects and resulting dormancy of the system ego ideal).

Paster, G.K. (1993). *The Body Embarrassed: Drama and the Disciplines of Shame in Early Modern England*. Cornell University Press.

Pattison S. (2000). *Shame: Theory, Therapy, and Theology*. Cambridge University Press.

Paulson, J.S. (1983). Covert and overt forms of maltreatment in the preschools. *Child Abuse and Neglect*, 7(1), 45-54. (This paper examines the preschool environment, finding within it forms and patterns of maltreatment. Covert forms of maltreatment lie predominantly in staff (directore, teachers, assistants) attitudes toward young children. These include: insistence that children learn to be independent while reinforcing dependent behaviour; overemphasis on the acquisition of academic skills, irrespective of age; excessive reliance on packaged "educational" materials; non-use of materials that have intrinsic interest for children; lack of enthusiasm for working woth young children; rigid adherence to routine for convenience; dislike of particular children. Overt forms of maltreatment to gain compliance or obedience from young children range from direct verbal attack (insult, sarcasm, ridicule, threats, name calling, humiliation) through emotional abuse (withholding of affection or compassion) to clear physical coercion (pulling, pushing, shoving, yanking, expulsion from class, isolation in class). Their significance suggests that caring for and educating young children in group settings amy not be the panacea society wants it to be).

Piers, G. and Singer, M.(1953). Shame and Guilt: a psychoanalytic and cultural study. Springfield, IL: Thomas.

Pines, M. (1987). Shame: what psychoanalysis does and does not say. *Group Analysis*, 20: 16-31.

Pittman, F. (2001). Screening Room Meet the Parents, The Contender and Billy Elliot Three wildly divergent films demonstrate how the furious and intensely private force of shame patrols our dreams of glory and keeps us in our place. *Family Therapy Networker*, vol. 25, no. 1, pp. 75-87.

Potter-Efron, P.S. (1987). *The Treatment of Shame and Guilt in Alcoholism Counselling*. New York: Haworth Press.

Potter-Efron, R.T. (1989). *Shame, Guilt and Alcoholism: Treatment Issues in Clinical Practice*. New York: Haworth Press.

Pulakos, J. (1996). Family environment and shame: is there a relationship? *Journal of Clinical Psychology*, 52(6), 617-23. (The shame young adults feel is associated with their perceived family environment as a child, particularly with test items associated with family cohesion and expressiveness and higher conflict scores).

Rabkin, L. Y. (1976). Survivor themes in the supervision of psychotherapy. *Am J Psychother*, 30(4), 593-600. (Some themes of survivorhood are discussed in relation to their effects on the supervisory process. The focus of this paper is on the intrusive themes of survivor shame, survivor rage, and survivor panic. Three illustrative case examples are presented).

Raphael, Lev. (1991). *Edith Wharton's prisoners of shame : a new perspective on her neglected fiction*. New York: St. Martin's Press.

Rashid, S.F. and Michaud, s. (2000). Female adolescents and their sexuality; notions of honour, shame, purity and pollution during the floods. *Disasters*, 24(1), 54-70. (Explores the experiences of female adolescents during the 1998 floods in Bangladesh, focusing on socio-cultural norms related to notions of honour, shame, purity and pollution).

Reed, G. S. (2001). Shame/contempt interchanges: a frequent component of the analyst-patient interaction. Panel report. *J Am Psychoanal Assoc.* 49(1). pp 269.

Reimer, M.S. (1996). "Sinking into the Ground": The development and consequences of shame in adolescence. *Dev Rev*, 16(4), 321-63. (This article reviews the literature on shame and on adolescence and suggests that attention to the role of shame in adolescent development is warranted for several reasons. Social-cognitive, physical, and interpersonal changes associated with adolescence may each be associated with normative increases in shame during adolescence. In addition, several lines of evidence converge to suggest that shame may be implicated in some of the important gender-related shifts in self-esteem and developmental psychopathology that occur over the adolescent years).

Richard-Jodoin, R. M. (1989). The "holding function" of the therapist in the treatment of borderline patients. *J Am Acad Psychoanal*, 17(2), 305-12. (In this paper, I have attempted to show that during crises in the therapy of borderlines it is crucial not to respond, needless to say in reality, but neither by confrontation nor with interpretation to the apparently

impulse-ridden transference. To interpret to the patient, during such periods, the vicissitudes of the object hunger in the transference often intensifies the turmoil, confuses the issue, and precipitates further regression. It is of primal importance to recognize that during these crises the patient needs a holding environment to restore and enhance the observing, anxiety-containing, and integrative capacity of the ego. This holding environment rests not only on the stability of the therapeutic setting, including the reliability and acceptance of the therapist, but on helping the patient acknowledge and process the precipitants of the emotional crises).

Ribkoff, F. (2000). Shame, Guilt, Empathy, and the Search for Identity in Arthur Miller's *Death of a Salesman*. *Modern Drama*, vol. 43, no. 1, pp. 48-55.

Ridley, P. J. (1993). Kaufman's theory of shame and identity in treating childhood sexual abuse in adults. *J Psychosoc Nurs Ment Health Serv.* 31(6), 13-17. (The competent nurse/therapist treats shame of the adult survivor of childhood sexual abuse. Shame must be identified, validated, and treated. Kaufman's Developmental Theory of Shame and Identity is easily applied to post-sexual-abuse phenomenon. Treatment principles can be incorporated in both individual and group therapy. Nurse/therapists are encouraged to further explore the role of shame in the psychopathology of the adult survivor of childhood sexual abuse).

Rizzuto, A.M. (1991). Shame in psychoanalysis: the function of unconscious fantasies. *International Journal of Psychoanalysis*, 72(2), 297-312. (The conceptualization of shame as an emergent affect in the clinical situation gains clarity by linking it to unconscious fantasies. The author suggests that shame appears when an individual fails in his efforts to obtain from

another person, in reality or in imagined scenes, an expected similar affect or a complementary message, or both. A self-evaluation emerges of being undeserving of the desired response. In this respect shame is related to the narcissistic component of any experience or fantasy, be it pre-oedipal, oedipal, or post-oedipal. In cases where there is a pathological predisposition to shame, the predisposition is linked to unconscious fantasies portraying the individual as the desiring and frustrated subject of an unresponded to affective message. After its formation the unconscious fantasy itself, and all its unrepressed derivatives, become a source of shame. A clinical example illustrates these points).

Roseby, V. and Johnston, J.R. (1998). Children of Armageddon. Common developmental threats in high-conflict divorcing families. *Psychiatric Clinics of North America*, 7(2), 295-309. (This article traces how parental vulnerability to feelings of humiliation and loss (inherent in highly conflicted divorce and custody litigation) distorts parenting capacities and parent-child relationships in distinctive ways, putting children at risk of specific kinds of developmental difficulties. Pre-oedipal children often fail to achieve a complete separation from their primary caretakers. Oedipal children, already struggling with separation issues, manifest sexualised anxiety and discomfort with gender identity. By latency, these children present as fragmented within themselves and in relationships with others.)

Roth, B.E. (1989). Critique of A. Alonso and J.S. Rutan "The experience of shame and the restoration of self-respect in group psychotherapy" (Jan, 1988) and their rejoinder (July, 1988). *International Journal of Group Psychotherapy*, 39(4), 543-5.

Rothstein, A. (1984). Fear of Humiliation. *J Am Psychoanal Assoc*, 32(1), 99-116. (This paper explores the ontogeny of fear of humiliation, conceived as an important organising affect-laden fantasy in certain narcissistic personality disorders. The influence of the pleasure of the parental object in sadistically humiliating is emphasised in the overdetermined genesis of this fear. While "seduction of the humiliator" is a fundamental defensive process observed in masochistic characters, identification with the humiliator is a sadonarcissistic defense observed in work with certain narcissistic personality disorders. The countertransference potential to enjoy humiliating such analysands, as well as the defensive functions of fear to humiliation, are noted).

Rothstein, A.M. (1994). Shame and the Superego. *Clinical and theoretical considerations. Psychoanalytic Study of the Child*, 49, 263-77. (The conception of the superego as a set of compromise formations characterised by the calamity of parental disapproval and the striving of winning or regaining parental love and approval facilitates the awareness that shame and guilt are affects with similar fantasied contents. This paper explores the clinical value of this emphasis on similar fantasied contents of shame and guilt for analytic work with adults).

Rutan, J.S. (2000). Growth through shame and humiliation. *International Journal of Group Psychotherapy*, 50(4), 511-6.

Rycroft, C. (1968). *A Critical Dictionary of Psychoanalysis*. London: Nelson.

Sack, J.L. (1994). The dynamics of shame in Japanese chronically absent students: a study of the theological-psychological meaning and pastoral implications of shame in

caring for chronically absent students. Ann Arbor: University Microfilms.

Sas, S.A. (1992). Ambiguity as the route to shame. *International Journal of Psychoanalysis*, 73(2), 329-41. (In patients who have been exposed to extreme conditions, shame is connected with a dilemma of identity: it is indicative of the patient's conflict over his alienation, his adaptation to and familiarisation with the conditions offered by an unacceptable frame. Bleger's (1967) model, with the concepts of the symbolic link, ambiguity, and the ambiguous position (which precedes the classical Kleinian positions), dynamically combines the problem of the frame or context with that of the capacity of discrimination between the ego and its objects. Ambiguity is characterised by the adaptability, malleability, permeability, and non-conflictuality which it confers on the personality. Shame appears as an alarm signal concerning ambiguity, connected with the ego's need to maintain its internal conflictuality, its capacity for integration and its sense of continuity. Experiences of dependance and passivity, or ones which touch upon the dilemma between true and false, private and public, ethics and aesthetics, etc., give rise to shame. In this paper it is suggested that a common denominator for the many different factors of shame may be found in the dynamics of ambiguity).

Saul, L.J. (1966). Embarrassment dreams of nakedness. *International Journal of Psychoanalysis*, 47(4): 552-8.

Saunders, E.A. and Edelson, J.A. (1999). Attachment style, traumatic bonding, and developing relational capacities in a long-term trauma group for women. *Int J Group Psychotherapy*, 49(4), 465-85. (Adults with histories of severe childhood abuse often experience considerable difficulties with interpersonal

trust. At the same time, they may strongly desire to be less alone with the painful aftereffects of their traumatic pasts. Psychotherapy groups have often been recommended as important components of treatment for reducing survivors' feelings of isolation and shame. We propose that an understanding of attachment styles and of traumatic bonding helps to clarify the specific manifestations of interpersonal distrust as they may emerge in a survivors' group. In addition, we suggest guidelines for determining what kind of group may be appropriate for a given individual at a particular point in treatment).

Scheff, T.J. and Retzinger, S.M. (1991). *Emotions and Violence: Shame and Rage in Destructive Conflicts*. Levington, Mass.: Lexington Books.

Schneider, C. (1977). *Shame, Exposure and Privacy*. Boston: Beacon.

Seidler, G.H. (1997). From object-relations theory to the theory of alterity: shame as an intermediary between the interpersonal world and the inner world of psychic structure. *American Journal of Psychotherapy*, 51(3), 345-56. (This paper takes its theoretical bearings from object relations theory and the theory of psychic structure. In terms of development, three types of internalization are described - narcissus, Tiresias, and Oedipus, dependant on the capacity to be related to the self and to others).

Seidler, Günter H. (2000). *In others' eyes : an analysis of shame*. Translated from the German by Andrew Jenkins. Madison, Conn.: International Universities Press.

Seu, I.B. (1996). A psychoanalytic feminist enquiry into shame. PhD Thesis, University of London.

Severino, S.K., et. al. (1987). Shame and the development of autonomy. *Journal of the American Academy of Psychoanalysis*, 15(1), 93-106. (The authors hypothesize that the development of a capacity to experience the affect of shame, like the development of a capacity for anxiety and depression, is crucial for growth towards autonomy. They delineate the sources of shame, discuss gender-related differences in the experience of and management of shame, and describe the impact of a capacity, or lack of capacity, for shame on the development of autonomy in both men and women. They illustrate their discussions with case examples and describe some therapeutic implications of their observations).

Shane, P. (1980). Shame and learning. *Am J Orthopsychiatry*, 50(2), 348-55. (This paper argues that an examination of cognitive shame provides opportunities for educators and students to cope more adequately with issues of trust, loneliness, and separation in classroom settings. It is further maintained that overcoming cognitive shame can lead to learning, mastery, and competence. Implications for mental health work in other settings are offered).

Shapiro, Emanuel, (1999). Trauma, Shame, and Group Psychotherapy: A Self Psychology Perspective. *Group*, vol. 23, no. 2, pp. 51.

Shields, W. (2000). Hope and the inclination to be troublesome: Winnicott and the treatment of character disorder in group therapy. *Int J Group Psychotherapy*, 50(1), 87-103. (While some group participants communicate about their problems by patterns of troublesome behaviour, others may

accommodate superficially to the needs of the group but feel an inner sense of futility and quite desperation. Through the use of Winnicott's paradoxical emphasis on the hope that is expressed within the "antisocial inclination" in all character disorders, the group may negotiate an adequate alliance for the discovery, containment, and exploration of the inclination to be troublesome in all group participants. It may also provide supportive holding during the experience of affects that formerly were overwhelming, such as shame and unresolved guilty anxiety).

Sidoli, M. (1988). Shame and the shadow. *J Anal Psychol*, 33(2), 127-42.

Sperber, M. (1999). Variations on a theme of shame: Chekhov, Glenn Gould, and the "cased-in-man" syndrome. *Psychoanalytic Review*, 86(2), 175-89.

Spero, M.H. (1984). Shame. An object-relational formulation. *Psychoanalytic Study of the Child*, 39, 259-82.

Spiegel, D.; Alpert, J. L. (2000). The Relationship Between Shame and Rage: Conceptualizing the Violence at Columbine High School. *Journal for the Psychoanalysis of Culture and Society*, vol. 5, no. 2, pp. 237-245

Spiegel, L.A. (1966). Affects in relation to self and object. A model for the derivation of desire, longing, pain, anxiety, humiliation, and shame. *Psychoanalytic Study of the Child*, 21, 69-92.

Stiebert, J. (1998). The construction of shame in the Hebrew bible: the prophetic contribution. PhD Thesis, University of Glasgow.

Stierlin, H. (1974). Shame and guilt in family relations. Theoretical and clinical aspects. *Arch Gen Psychiatry*, 30(3), 381-9.

Stierlin, H. (1977). *Psychoanalysis and Family Therapy*. Jason Aronson.

Stone, A.M. (1992). The role of shame in post-traumatic stress disorder. *American Journal of Orthopsychiatry*, 62(1), 131-6. (Shame is an important part of human experience but, by its very nature, is often neglected as an issue in treatment. Various recent conceptions of shame and its place in personality development, interpersonal relationships, and psychotherapy are presented. The contributions of affect theory are explored in their applications to the understanding of post-traumatic stress disorder, and implications for treatment are discussed).

Suslow, T. et al. (2000). 20-Item Toronto Alexithymia Scale: do difficulties describing feelings assess proneness to shame instead of difficulties symbolizing emotions? *Scand J Psychol.*, 41(4), 329-34. (A hallmark of alexithymia is the difficulty putting emotional states into words which has to be differentiated from problems to communicate emotions to others. Shame proneness is a personality trait that is to be expected to be closely related to a reduced emotional self-disclosure in social interactions. This study shows that Difficulties Describing Feelings scores are associated with shame assessing scales but not with guilt assessing scales. In our view one should therefore be cautious in interpreting scores from this scale as indices of difficulty to symbolize emotions. Instead, the TAS-20 scale seems to evaluate aspects of social shame).

Talbot, N.L. (1995). Unearthing shame in the supervisory experience. *American Journal of Psychotherapy*, 49(3), 338-49. (The premise of this article is that the supervisee typically experiences shame in psychotherapy supervision. The purpose is to demonstrate that the discovery and exploration of shame by the supervisor and the supervisee enhance both the therapy and the supervision. The focus is on the supervisor's attitudes and behaviours towards the supervisee's shame. Using a case example, three important sources of shame are discussed: 1). Shame that evolves from the relationship between therapist and patient. 2). Shame that arises from the therapist's fears of, or actual experience of, not being approved of or admired by an idealised supervisor. 3). Shame inherent in revealing personal material in a supervisory relationship. Six recommendations for exploring shame are offered to supervisors: 1). be alert to the therapist's disguised shame. 2). encourage the supervisee to explore how the therapy and supervision are experienced 3). demonstrate the qualities of a psychotherapist by assisting the therapist in uncovering personal material that affects the psychotherapy, and 4). create an environment of safety where shame-related phenomena can be discussed with candour and curiosity. Supervisors should also 5). ease insecurities by modeling the activities they seek to encourage, and 6). avoid attempts to dissuade the supervisee of an idealising transference towards them. Limitations of the recommendations are discussed).

Talbot, N.L. (1996). Women sexually abused as children: the centrality of shame issues and treatment implications. *Psychotherapy*, 33(1), 11-18. (This article focuses on the important role of shame in psychotherapy with women who have reported histories of childhood sexual abuse. The dynamics of shame in the self-development of sexually abused children are

discussed. A case summary illustrates the treatment recommendations for identifying and treating this powerful and frequently disguised emotion).

Tangney, J.P. et al. (1992). Proneness to shame, proneness to guilt, and psychopathology. *Journal of Abnormal Psychology*, 101(3), 469-78. (Shame-proneness was found to be strongly related to psychological maladjustment in general. Shame accounted for substantial variance in depression, above and beyond attributional style).

Tangney, J.P. et al. (1992). Shamed into anger? The relation of shame and guilt to anger and self-reported aggression. *Journal Pers Soc Psychol*, 62(4), 669-75. (Shame-proneness was consistently correlated with anger arousal, suspiciousness, resentment, irritability, a tendency to blame others for negative events, and indirect (but not direct) expressions of hostility).

Tangney, J.P. and Fischer, K.W. (1995). *Self-conscious Emotions: The Psychology of Shame, Guilt, Embarrassment and Pride*. New York: Guilford Press.

Tangney, J.P. (1996). Conceptual and methodological issues in the assessment of shame and guilt. *Behaviour Research and Therapy*, 34(9): 741-754.

Tangney, J.P. et al. (1996). Are shame, guilt, and embarrassment distinct emotions? *J Pers Soc Psychol*, 70(6): 1256-69.

Tangney, J.P. et al. (1996). Relation of shame and guilt to constructive versus destructive responses to anger across the lifespan. *J Pers Soc Psychol*, 70(4): 797-809.

Tantum, D. (1990). Shame and Groups. *Group Analysis*, 23, 31-43.

Taylor, G. (1987). *Pride, Shame and Guilt: Emotions of Self-assessment*. Clarendon Press.

Thelle, R. I. (2000). Shame and Honor in the Book of Esther. By Timothy S. Laniak. *Hebrew Studies*, vol. 41, pp. 303-305.

Thomas, H.E. (1995). Experiencing a shame response as a precursor to violence. *Bulletin of the American Academy of Psychiatry Law*, 23(4), 587-93. (The shame response is a primitive physiological response to a rejection of oneself by another. When emotional pain is sufficient it causes anger that may be directed outward against another or inward against oneself. The intensity of the shame response, hence the intensity of the pain and anger, is related to the significance of the other, the significance of witnesses to the rejection, one's vulnerability, whether or not the rejection is of oneself or an aspect of oneself, and if the rejection comes as a surprise. Understanding that a shame response can lead to violence and anger allows for the prevention of violence).

Thrane, G. (1979). Shame and the construction of the self. *Annual of Psychoanalysis*, 7, 321-341.

Troop, N.A. et al (2000). Disgust sensitivity in eating disorders: a preliminary investigation. *Int J Eat Disord.*, 27(4), 446-51.

Wallace, B. and Nosko, A. (1993). Working with shame in the group treatment of male batterers. *International Journal of Group Psychotherapy*, 43(1), 45-61. (The authors argue that shame is a core issue for many men who assault their partners.

Shame must therefore be addressed in treatment groups. This article outlines how one intervention, "the confession", elicits shame and how that shame is negotiated through the various stages of group development).

Wanzo, R. (2000). Quiet As It's Kept: Shame, Trauma, and Race in the Novels of Toni Morrison by J. Brooks Bouson. *American Literature*, vol. 72, no. 4, pp. 887. DUKE UNIVERSITY PRESS.

Ward, H. P. (1972). Shame--a necessity for growth in therapy. *Am J Psychother*, 26(2), 232-43.

Ward, H. P. (1972). Aspects of shame in analysis. *Am J Psychoanal*, 32(1), 62-73.

Watson, P.J. et al. (1996). Self-reported narcissism and shame: testing the defensive self-esteem and continuum hypotheses. *Personality and Individual Differences*, 21(2): 253-259.

Weille, K. (1997). The dynamics of sexual victimisation/victimising in the members of a child sexual abuse group: exploring the theoretical role of shame. *Smith College Studies in Social Work*, 67(2), 225-239. (A weekly inpatient group for preadolescent children who have been sexually abused and/or sexually abusive provides insights into the convergences of victimisation and victimising. It was hypothesised that shame forms a crucial affective bridge by which the transition from victim to victimiser occurs. The group fosters exploration of this transition, viewing it as an attempt to master, or annihilate, the initial pain of exploitation. Examination of feeling states that underlie early traumatic experience illustrates the defensive transformations that translate the painful affects of victimisation into victimising

behaviours. The group provides a suitably shame-reducing clinical context for this process).

Welch, J.D. et al. (1999). Stigmata: part 1. Shame, guilt, and anger. *Plast Reconst Surgery*, 104(1), 65-71. (Discusses the symbolic meaning of self-inflicted wounds on the forearm).

Wells, M. and Jones, R. (2000). Childhood parentification and shame-proneness: A preliminary study. *Am. J. Family Therapy*, 28(1).

Wharton, B. (1990). The hidden face of shame: the shadow, shame and separation. *Journal Anal Psychol*, 35(3), 279-99.

Wilson, S. (1991). *Rising Above Shame: healing family wounds to self-esteem*. Launch press.

Winnicott, D.W. (1951). Transitional objects and transitional phenomena. In (1958). *Collected Papers: Through Paediatrics to Psycho-analysis*. London: Tavistock.

Winnicott, D.W. (1965). *The Maturation Processes and the Facilitating Environment*. London: Hogarth.

Winnicott, D.W. (1974). Fear of breakdown. *International Review of Psychoanalysis*.

Wittig, V.R. and Wittig, J.H. (1993). Severe compulsive overeating: how to obtain a more accurate history through non-shaming, non-blaming interview techniques. *Obes Surg*, 3(1), 79-84. (The ability to obtain accurate histories for a comparative study of compulsive overeating and alcoholism was severely compromised by the high degree of denial, shame and self-blame present in these two overlapping disease

entities. Areas of overlap included similar progression of the disease, familial tendencies, and the presence of protein enzymatic markers for alcoholism within the bariatric population. Since both shame-based diseases tend to run in the same families, four techniques were developed to reduce the amount of shame that obese patients experienced when talking about family histories and their own compulsive, obsessive disease as it progresses through five identifiable stages. These techniques include: the use of specific non-shaming words and gestures; normalization of patients' history and experiences; education about similar biological, genetic, progressive, stress-related diseases to solidify the disease concept of obesity; and a loosely structured interview format which proceeds from the general to the specific and the past to the present, in an orderly, non-shaming fashion).

Woods, S. M. (1976). Some dynamics of male chauvinism. *Arch Gen Psychiatry*, 33(1), 63-5. (Male chauvinism was studied in the psychoanalytic therapy of 11 men. It refers to the maintenance of fixed beliefs and attitudes of male superiority, associated with overt or covert depreciation of women. Challenging chauvinist attitudes often results in anxiety or other symptoms. It is frequently not investigated in psychotherapy because it is ego-syntonic, parallels cultural attitudes, and because therapists often share similar bias or neurotic conflict. Chauvinism was found to represent an attempt to ward off anxiety and shame arising from one or more of four prime sources: unresolved infantile strivings and regressive wishes, hostile envy of women, oedipal anxiety, and power and dependency conflicts related to masculine self-esteem. Mothers were more important than fathers in the development of chauvinism, and resolution was sometimes associated with decompensation in wives).

Woodward, K. (2000). Traumatic Shame: Toni Morrison, Televisual Culture, and the Cultural Politics of the Emotions. *Cultural Critique*, no. 46, pp. 210-240.

Wurmser, L. (1987). Shame: the veiled companion of narcissism. In D. Nathanson (ed.), *The Many Faces of Shame*. New York: Guilford Press.

Wurmser, L. (1981). *Mask of Shame*. Baltimore: Johns Hopkins Universities Press.

Yeazell, R. B. (2001). Sexuality, Shame, and Privacy in the English Novel. *Social Research*, vol. 68, no. 1, pp. 119-144.

Yorke, C. et al. (1990). The development and functioning of the sense of shame. *Psychoanalytic Study of the Child*, 45, 377-409.

Zak, W.F. (1984). *Sovereign Shame: a study of King Lear*. Bucknell University Press.

Zander, A.; Fuller, R.; Armstrong, W. (1972). Attributed pride or shame in group and self. *J Pers Soc Psychol*, 23(3), 346-52.

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