A STUDY OF THE DIFFERENCES IN TRAIT SHAME ACROSS AXIS-I DIAGNOSES IN AN INTENSIVE OUTPATIENT CLINICAL SETTING

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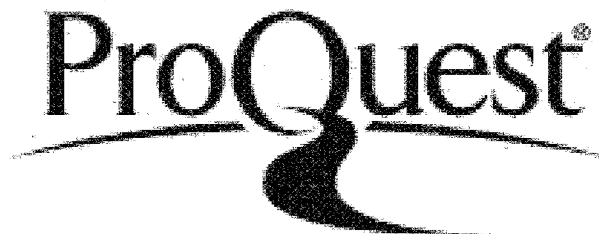

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APPROVAL SHEET

A STUDY OF THE DIFFERENCES IN TRAIT SHAME ACROSS AXIS-I DIAGNOSES I IN AN INTENSIVE OUTPATIENT CLINICAL SETTING

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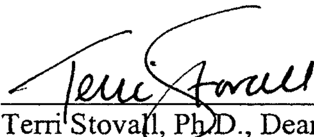

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Date 03/28/2013

To my wife

Mary

Who, in her tireless support,

has taught me more about

the Holy Spirit,

the faithfulness of Christ,

and the Love of God

than I ever deserved to know.

ABSTRACT

NAME OF AUTHOR: Luis (Luigi) Victor Leos

DATE OF DEGREE GRANTED: May 2013

NAME OF DEGREE: Doctor of Philosophy

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NAME AND TITLE OF ADVISOR: W. M. McGuire, Ph.D., Retired Associate Professor of Psychology and Counseling

TITLE: A Study of the Differences in Trait Shame Across Axis-I Diagnoses in an Intensive Outpatient Clinical Setting

PROBLEM: This study examined Internalized Shame Scale (ISS) score differences between Axis-I diagnoses groups at two intensive outpatient (IOP) clinics.

PROCEDURES: Psychiatric Axis-I diagnosis, psychological testing (MMPI-2), and therapist impressions were used to establish four diagnostic groups. Six months of data was collected on 104 patients at clinics in Richardson, Texas, and Wheaton, Illinois.

FINDINGS: No significant differences in ISS scores were found between Axis-I diagnostic groups: $F(3, 100) = 2.297$, $p = .082$. Post-analysis investigation revealed a small statistically significant correlation between ISS scores and number of co-morbid Axis-I diagnoses: $r = .28$, $n = 102$, $p = .005$. Comparisons to MMPI-2 scales associated with guilt (Pd_5) indicated statistically significant variances with the addictive behaviors Group: $F(3, 100) = 3.16$, $p = .028$. Three factors identified within the ISS instrument

revealed significantly higher scores for women (N = 72, M = 61, SD = 17.9) than men (N = 32, M = 47.7, SD = 18.7): t (104) = -3.4, and p = .001, 2-tailed.

CONCLUSIONS: Differences observed in general clinical populations were not observed in the clinical population seeking Christian faith-based treatment. Internalized shame may either be expressed or experienced differently in populations seeking Christian faith-based treatment of clinical Axis-I disorders. Correlation with co-morbid symptom clusters suggested a foundational role for shame in human behavior, that when internalized, may result in a cross-sectional influence on Axis-I dysfunction. Guilt operated in a way different from internalized shame, suggesting a distinction in the two expressions and the focus of the two instruments: ISS and MMPI-2 scales. Additional research is necessary to characterize the cause-or-effect nature of the relationship between internalized shame and mental health pathology, and the finer resolution of shame and guilt-measurement instruments.

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PREFACE

I am grateful to God and the gift of His Holy Spirit, by whose power I was able to keep moving forward, albeit not always quickly, but consistently. Additionally, I am grateful for the gift of His revelation of Himself and the joy of the search: It is the glory of God to conceal a matter, but the glory of kings to search out a matter (Prov 25:2).

I want to express my love to my wife for the countless hours she encouraged, and the countless pages she read.

I am indebted to Drs. Ian Jones, Scott Floyd, Mike McGuire, Dana Wicker, and Elias Moitinho, and Margaret Lawson for their openness to God's vision and the excellence and courage they brought to the program to make it a reality on earth, even for a time. I have been honored to be part of a group of peers who mutually challenged each other to an excellence beyond what I was ever capable of before entering their ranks. I am indebted to my advisors, Dr. Mike McGuire and Dr. Dana Wicker, for their wisdom and guidance in this project, and also the integrity of completing a commitment to finishing this effort with me, long after their obligation. Their actions speak to their great integrity and fidelity to God's calling in their lives. I have been privileged to stand on the shoulders of great men and women of God, theologians, physicians, philosophers, who have dared to look into the creation to see the handiwork, the wisdom, and the beauty of the Creator.

My prayer, before this great cloud of witnesses, is not to bring shame upon those whose work I now stand, but to run with endurance: "Fixing our eyes on Jesus, the author and perfecter of faith, who for the joy set before Him endured the cross, despising the shame, and has sat down at the right had of the throne of God" (Heb 12:2).

Luis (Luigi) Victor Leos
Carrollton, Texas
May 2013

CHAPTER 1

INTRODUCTION

Introductory Statement

Theologically, shame is not identified at creation (Gen 2:25),[1] and scientifically, shame is not considered present at birth, yet the emotion is a powerful experience and key motivator in post-Eden existence.[2] The experience of shame, feeling unwanted or unworthy, is so painful to some people that they attempt to avoid it at all costs. This pain characteristic makes the abuse of shame in order to control others a temptation for those in positions of authority, an abuse warned against in Scripture with predictions of damaging consequences (Proverbs 15, Eph 6:4). Associated verses suggest that when shame is misused, the recipient's spirit is damaged, resulting in fearful, angry, and/or rebellious behavior responses that work against spiritual, psychological,

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[1]Unless otherwise noted, all biblical references will be taken from the New American Standard Version (NASV).

[2]Louis Cozolino, *The Neuroscience of Human Relationships* (New York: W. W. Norton & Co., 2006), 86; Nicolay Gausel and Colin Wayne Leach, "Concern for Self-Image and Social Image in the Management of Moral Failure: Rethinking Shame," *European Journal of Social Psychology* 41 (2011): 468-78; John P. J. Pinel, *Biopsychology*, 8th ed., ed. Jessica Mosher (Boston: Pearson Education, 2011), 450; Daniel J. Siegel, "Emotion as Integration: A Possible Answer to the Question, What Is Emotion?," in *The Healing Power of Emotion: Affective Neuroscience, Development & Clinical Practice*, ed. Diana Fosha, Daniel J. Siegel and Marion F. Solomon (New York: W. W. Norton & Co., 2009), 166; and Curt Thompson, *Anatomy of the Soul: Surprising Connections Between Neuroscience and Spirtual Practices that Can Transform Your Life and Relationships* (Carol Stream, IL: Tyndale House Publishers, 2010), 134.

and physical healing.[3] Researchers have observed manifestations of these warnings in resultant self-talk and defensive behaviors when shame messages are internalized.[4]

From a theological perspective, Johnson suggests, "believers who have been spiritually abused or raised in an environment that focuses on sin without the gospel of grace may have difficulty reading the Bible without it activating perfectionism or excessive shame and guilt."[5] Consequential self-perceptions of being a broken person result in defensive behaviors of avoidance/fear and rebellion/anger, rather than acceptance, repentance, and contrition.[6]

Affect theories, the study of the biological portion of emotion, have included propositions that as a person receives chronic messages of personal worthlessness, the messages are internalized.[7] The point at which the person begins repeating the messages

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[3]Jessica L. Tracy and Richard W. Robins, "The Self in Self-Conscious Emotions: A Cognitive Appraisal Approach," in *The Self-Conscious Emotions: Theory and Research*, ed. Jessica L. Tracy, Richard W. Robins, and June Price Tangney (New York: Guilford Press, 2007), 3; Helen Joy Policar, "Shadow of the American Dream: The Clash of Class Ascension and Shame," *Revision* 31, no. 1 (Winter 2010): 20; and Gausel and Leach, "Concern for Self-Image and Social Image," 468.

[4]Cozolino, *Neuroscience*, 86; Gausel and Leach, "Concern for Self-Image and Social Image," 468-78; Jose Pinto-Gouveia and Marcela Matos, "Can Shame Memories Become a Key to Identity? The Centrality of Shame Memories Predicts Psychopathology," *Applied Cognitive Psychology* 25 (April 2011): 282; Pinel, *Biopsychology*, 450; Siegel, "Emotion as Integration," 166; Thompson, *Anatomy of the Soul*, 134; Tracy and Robins, "Self in Self-Conscious Emotions," 3; Policar, "Shadow of the American Dream," 20; and Arne Vikan, Anne Marit Hassel, Arild Rugset, Hedda Eline Johansen, and Tomas Moen, "A Test of Shame in Outpatients with Emotional Disorder," *Nord Journal of Psychiatry* 64 (2010): 196-202.

[5]James R. Beck and Bruce Demarest, *The Human Person in Theology and Psychology; A Biblical Anthropology fo the Twenty-First Century* (Grand Rapids: Kregel Publications, 2005), 250; and Eric Johnson, *Foundations for Soul Care: A Christian Psychology Proposal* (Downers Grove, IL: IVP Academic, 2007), 14, 311.

[6]Mark 9:42; Luke 11:46, 17:1-2; Acts 15:10; 2 Pet 2:1; and Johnson, *Foundations for Soul Care*, 310.

[7]Donald L. Nathanson, *Shame and Pride: Affect, Sex, and the Birth of the Self* (New York: W. W. Norton & Co., 1992), 48; and Silvan S. Tomkins, *Affect, Imagery, Consciousness: The Complete Edition*, vol. 1, 4 vols. (New York: Springer Publishing Co., 2008; first published 1962), 5.

to him or herself is called internalized shame.[8] Nathanson proposed a relationship between levels of internalized shame messages, types of defensive behavior manifest, with types of mental health disorder that would likely result.[9] He theorized that a subject would rather express defensive emotions of fear or anger than to experience or show shame, assumedly to protect against anticipated shaming messages from others.[10] Which defensive emotion the person might express would depend on the level of internalized shame messages the person was experiencing.

In research based on affect theories, a high frequency of internalized shame messages, represented by high internalized shame scores, has been positively correlated with defensive and avoidant behaviors even in the presence of neutral or encouraging input.[11] Cook applied Nathanson's theory in his development of the Internalized Shame Scale (ISS) designed to measure levels at which subjects were experiencing internalized shame messages.[12] Pinto-Gouveia and Matos found significant results when they used the ISS to study if repeated internalized shame messages received during childhood were

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[8]Ibrahim Cankaya, "Anger as a Mediator of the Effects of Anxiety on Aggressiveness in Teacher Trainees," *Social Behavior and Personality* 39, no. 7 (2011): 936; Gausel and Leach, "Concern for Self-Image and Social Image," 473; Pinto-Gouveia and Matos, "Shame Memories," 282; J. W. Kalat and M. N. Shiota, *Emotion*, 2nd ed. (Belmont, CA: Wadsworth, 2007), 226; Pinel, *Biopsychology*; Thompson, *Anatomy of the Soul*; Colwyn Trevarthen, "The Functions of Emotion in Infancy: The Regulation and Communication of Rhythm, Sympathy, and Meaning in Human Development," in *The Healing Power of Emotion: Affective Neuroscience Development & Clinical Practice*, ed. Diana Fosha, Daniel J. Siegel, and Marion Solomon (New York: W. W. Norton & Co., 2009), 61; and Tracy and Robins, "Self in Self-Conscious Emotions," 11.

[9]Donald L. Nathanson and James M. Pfrommer, "Affect Theory and Psychopharmacology," *Psychiatric Annals* 23, no. 10 (October 1993): 584.

[10]David R. Cook, *Internalized Shame Scale: User's and Technical Manual* (North Tonawanda, NY: Multi-Health Systems, 2001), 28.

[11]Gausel and Leach, "Concern for Self-Image and Social Image," 473; and Cankaya, "Anger as a Mediator," 936.

[12]Cook, *Internalized Shame Scale,* 1; and Donald L. Nathanson, "About Emotion," *Psychiatric Annals* 10 (1993): 544.

related to pathology later in adulthood.[13] Other research results have also suggested a significant relationship between internalized shame messages levels, defensive behaviors, and mental health diagnostic groupings.[14] These authors have called for additional research with non-university student populations such as the clinical population observed in this current study.

In summary, internalized shame is defined as the tendency to repeat devaluing messages to oneself as a result of trauma or repeated environmental messages. The defensive/fear or rebellion/anger behaviors that result become challenges to therapy and evangelism. Subjects reject healing freedom messages in anticipation of ridicule, abandonment, or punishment in each relationship without cause. As a result, subjects defend themselves, mistaking conviction messages for condemnation.[15] Additional research is needed to explore this process in a clinical venue.

Thesis Statement

The thesis of this study is that a relationship exists between internalized shame and mental health pathology.[16]

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[13]Pinto-Gouveia and Matos, "Shame Memories," 282.

[14]Vikan, *et al.*, "Test of Shame," 196-202. ISS scores were observed to have a greater correlation with general depression than anxiety.

[15]Pinto-Gouveia and Matos, "Shame Memories," 281; and Jerry W. Rudy, *The Neurobiology of Learning and Memory* (Sunderland, MA: Sinauer Associates, 2008), 43.

[16]American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Text Revision*, 4th ed. (Arlington, VA: American Psychiatric Association, 2000). Only Axis I diagnosis not related to another medical condition will be used in this study.

Statement of the Problem

The problem of this study was to examine differences in internalized shame scale (ISS) scores between clinical mental health diagnostic groups and established personality test score patterns. The dependent variable in both cases was scores on an ISS.[17] The selected grouping variable for ISS score differences between Axis-I diagnoses was five Diagnostic Groups: mood, anxiety, substance dependence, psychosis, and dissociation. In cases of co-morbid diagnoses, the primary Axis-I diagnoses made by a psychiatrist was associated with the appropriate group as they appeared in the Diagnostic and Statistical Manual of Mental Disorders, Text Revision, Fourth Edition (DSM-IV-TR).[18] The grouping variable for ISS test score differences regarding defensiveness was the presence or absence of established MMPI-2 validity scale score configurations associated with defensiveness.

Purpose of the Study

The purposes of this study were:

1. To measure internalized shame scores for patients receiving intensive outpatient (IOP) treatment in a Christian clinical mental health setting in two clinics in Richardson, Texas, and in Wheaton, Illinois.

2. To collect the primary Axis-I diagnosis for patients receiving IOP treatment in a Christian clinical mental health setting at two clinics in Richardson, Texas, and Wheaton, Illinois.

3. To collect clinical and supplementary scale scores from MMPI-2 personality tests administered to the same patients receiving IOP treatment in a Christian clinical mental health setting at two clinics in Richardson, Texas, and Wheaton, Illinois.

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[17]Cook, *Internalized Shame Scale*, 30.

[18]American Psychiatric Association, *DSM-IV-TR*, 231.

4. To determine the differences in ISS scores across the following DSM-IV-TR diagnostic category groups: mood, anxiety and substance dependence disorders, psychosis, and dissociation, as indicated by the primary diagnosis of a psychiatric medical doctor.

5. To determine the differences in ISS scores between patients whose MMPI-2 score patterns indicate test-response-defensiveness and those that do not.

6. To add to the literature in the fields of clinical mental health care and biblically based Christian psychology.

Significance of the Study

This study is significant in that it:

1. Explored the possibility of a distinguishable very-low avoidance measure hypothesized by Vikan, *et al.*, and Elison and Partridge to be separate from normal low scores.[19]

2. Provided analysis of variations in the structure of internalized shame between mental health diagnosis and treatment in clearly delineated clinical diagnostic groups as called for by Vikan, *et al.*, and Pinto-Gouveia and Matos.[20]

3. Provided analysis of variance of internalized shame across diagnostic groups with greater diligence than previous studies via inclusion of physician's formal diagnosis as called for by Vikan, *et al.*, and use of the ISS instrument as called for by Pinto-Gouveia and Matos.[21]

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[19]Cook, *Internalized Shame Scale*, 30; Jeff Elison and Julie A. Partridge, "Relationships Between Shame-Coping, Fear of Failure, and Perfectionism in College Athletes," *Journal of Sport Behavior* 35, no. 1 (2011): 24-26; and Vikan, *et al.*, "Test of Shame," 196. Elison and Partridge suggested Shame-Compass pole behaviors would be present in differing order, high to low, for given mood experiences (i.e., non-diagnosed depressed mood or anxiety). Vikan, *et al.*, suggested uncategorized score ranges in ISS result meta-analysis.

[20]Pinto-Gouveia and Matos, "Shame Memories," 282; and Vikan, *et al.*, "Test of Shame," 202. Vikan recommended further analysis of variations in the structure of shame or variations in the index of shame in clearly delineated clinical groups as in the design of this study. Factor Analysis of ISS indicated three factors: inadequacy, emptiness, and vulnerability; researchers recommended repetition of the analysis. Higher ISS scores have been associated with depression rather than anxiety; it is possible that anxiety includes another unidentified variable (possibly fear/anger).

[21]Vikan, *et al.*, "Test of Shame," 202, recommended a repetition of the ISS test in a clinical environment for correlations to depression and/or anxiety with greater diagnostic diligence by applying the physicians' diagnosis and analysis of variance of score in clinical delineated diagnosis groups as in the design of this study. Matos and Pinto-Gouveia suggested a need for additional research regarding the relationship between internalized shame and pathology, especially within a clinical population. Pinto-Gouveia and Matos had reservations using their ESS instrument in measurement of internalized shame and recommend use of the ISS instead.

4. Provided analysis of emotions in a Christian psychological framework as called for by Johnson.[22]

5. Added to empirical evidence in support of future treatment protocol development, adaptation, or improvement as called for by Cook.[23]

6. Provided quantitative data regarding the influence of internalized shame on psychopathology as called for by Pinto-Gouveia and Matos.[24]

7. Added to the current scientific body of knowledge as called for by researchers and scholars in the field.[25]

8. Illuminated areas to dislodge footholds interfering with individual freewill with regard to a clear understanding and choice regarding acceptance of the Gospel (Luke 4:18, Rom 1:25).[26]

Statement of the Hypotheses

1. The first hypothesis of this study was that a significant difference in ISS scores would occur between the diagnostic groups of mood, anxiety, substance dependence, psychosis, and dissociation.

2. The second hypothesis of this study was that ISS scores for the substance dependence group would be significantly lower than the mood, anxiety, psychosis, and dissociation diagnostic groups.

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[22]Johnson, *Foundations for Soul Care*, 99.

[23]Cook, *Internalized Shame Scale*, 30. Currently, Cook proposed that Attack-Other would be present when shame and anger were combined with anger greater than shame, Avoidance would be present if shame were greater than anger, withdrawal would be present if fear were greater than shame, and Attack-Self would be present if shame were greater than fear. High-effect interventions for shame have been suggested as integrity and acknowledgement (Carnes), courage and exposure for fear (CBT), and interrupt and distraction for anger.

[24]Pinto-Gouveia and Matos, "Shame Memories," 288. Pinto and Matos's comment that "the recently growing body of research into the role of shame in the etiology and course of psychopathology present a novel perspective on the nature of shame, empirically supporting the proposal that shame memories can become central to personal identity and life story influencing shame in adulthood and vulnerability to psychopathology."

[25]Joseph J. Campos, "Forward," in *The Self-Conscious Emotions: Theory and Research*, ed. Jessica L. Tracy, Richard W. Robins, and June Price Tangney (New York: Guilford Press, 2007), ix. Campos describes a zeitgeist regarding emotions, citing Karen Barrett's functionalist theory and Fischer and Mascolo's cognitive sequential explanation of emotional development suggesting new observational self-report and narrative assessments of emotions more complex than the basic six supposedly developed by Tangney, Barrett, and Fridja.

[26]Johnson, *Foundations for Soul Care*, 14.

3. The third hypothesis of this study was that a significant difference would occur in the presence of defensiveness as indicated by MMPI scale patterns across ISS score categories (very low, high, very high, and extremely high).[27]

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[27]R. Michael Bagby, Margarita B. Marshall, Alison S. Bury, Jason R. Bacchiochi, and Lesley S. Miller, "Assessing Underreporting and Overreporting Response Styles on the MMPI-2," in *MMPI-2: A Practitioner's Guide*, ed. James N. Butcher (Washington, D.C.: American Psychological Association, 2006), 45; and John R. Graham, *MMPI-2: Assessing Personality and Psychopathology*, 4th ed. (New York: Oxford University Press, 2006), 54.

CHAPTER 2

REVIEW OF RELATED LITERATURE

Biblical Foundations for the Internalized Shame Concept

While the term itself is not found in Scripture, the concept of internalized shame, as a corruption of the natural shame and guilt processes, is present in the Bible beginning in Genesis. Scriptural references include descriptions, causes, and consequences associated with the internalization of shame. Structure and context for the natural shame process is illustrated in the Old Testament (OT) dominion/dynasty theological concept, and connections from this concept to New Testament (NT) doctrines of salvation and sanctification. It is within the temporal concept of sanctification as occurring in the past, present, and future concurrently, that a natural purpose for the experience of shame and guilt is manifest for both pre- and post-salvation individuals. Additionally, it is within this temporal process that risk is present either for the corruption or abuse of that natural purpose, which creates a stumbling block to spiritual healing. This corruption represents the essence of internalized shame.

Scriptural References: Shame Representations in Hebrew and Greek

Greek and Hebrew terms alike convey a similar meaning of both shame and internalized shame. While the majority of these terms are descriptive of objective shame and guilt, the subjective experiences described in Scripture parallel the experiences

observed in internalized shame.[1] The terms are used in scriptural descriptions of guilt, shame, warnings against actions that manifest in internalized-shame-like behaviors in others, and prescriptions for resolution of unworthiness and guilt before God. In descriptions, the shame experience is represented as complex, with many characteristics, sources, and expressions or outcomes. The emotion is depicted as inflicting a social and physical burden (Num 12:14; Ezra 9:7; Ps 6, 32), and/or internal cognitive symptoms of confusion (Ps 35:26; Ps 40:14; Jas 1:6; Jude 1:13).[2] The emotion is affectively associated with fear and anger (Gen 3:8; 4:7), or behaviorally as inciting avoidance, internalization, and withdrawal (Gen 3:10; Phil 3:17-19). Additionally, shame is described as having a social component that includes consequences of rejection (Ps 14:6; 53:5) and separation (Ezek 44:13).

The emotion is depicted as being triggered by social, environmental, or internal events (Phil 1:20; 3:19; 1 Cor 1:27; Job 4:14, Ps 6:2). Shame is associated with the valuation or devaluation of an effort (Gen 4:7; 2 Sam 19:5), and usefulness in correction

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[1]Gen 3:10, 4:6, and 4:8; Cankaya, "Anger as a Mediator," 936; Gausel and Leach, "Concern for Self-Image and Social Image," 473; Pinto-Gouveia and Matos, "Shame Memories," 282; Kalat and Shiota, *Emotion*, 226; Pinel, *Biopsychology*, 126; Thompson, *Anatomy of the Soul*, 37; and Trevarthen, "Functions of Emotion in Infancy,"11. Cankaya has identified the following as defensive behaviors to toxic or internalized shame: propensity to hide (Gen 3:10), look at the ground (4:6), and display rage toward others (4:8). He defines anger as the emotion normally present in response to one's perception that he or she is being suppressed, attacked, threatened, deprived, or limited.

[2]BibleMaster.com, *Greek Lexicon* [on-line]; accessed May 2011; available at www.Bible master.com/bible/interlinear.asp; Internet; Bill Thayer and William Smith, "*Entrepo*," *Greek Lexicon Entry for Arche* (October 2011) [on-line]; accessed October 4, 2011; available at www.studylight. org/lex/grk/view.cgi?number-1788; Internet; Ilona E. de Hooge, Marcel Zeelenberg, and Seger M. Breugelmans, "Restore and Protect Motivations Following Shame," *Cognition and Emotion* 24, no. 1 (2010): 111; Franz Delitzsch, *A System of Biblical Psychology*, 2nd ed., trans. Robert Ernest Wallis (London: Edinburgh, 1867), 15-19; and Charles M. Stuart, "Shame," in *International Standard Bible Encyclopedia* [on-line]; accessed May 10, 2011; available at www.biblemaster.com/bible/ency/isb/view. asp?number=7901; Internet. The verse simply indicates the use of the term "shame"; however, the lexicon defines the term as "the confusion of one who is ashamed" such that "their glory is in their shame." One's manifestation of this confusion could be a person taking pride in their sin or in their ability to conceal it.

across individual, social, and spiritual spectrums (2 Tim 3:16; Titus 2:8). As an indicator, the threshold for experiencing shame is described as adjustable (2 Tim 3:16; 1 Cor 4:14) and corruptible by false teachers (Gal 1:6-9), or social/cultural influences over what is acceptable (Rom 1:24-25;1 Cor 11:22). Inferential references to internalized shame come from admonitions against the abuse of shame by those in authority (Eph 6:4) or failures to express the emotion (Gen 4:7).[3]

One of the most common Hebrew terms for shame in the OT is transliterated "*bowsh*."[4] This term is first represented in Gen 2:25 as "the man and his wife were naked as without shame."[5] Later representations associate this term with the "clothed-with-shame" image (Gen 9:22-27; Ezra 9:7; and Job 8:13-22). Other terms used to convey the "clothed-with-shame" concept of internalized shame include *ashem*, sometimes translated as guilt (Gen 42:21; 2 Sam 14:13; Ezra 10:19), and *keilimmah* (Ps 69:7), translated as disgrace, reproach, shame, or confusion (Ps 35:26; Isa 45:16; Ezek 32:30).[6] The term "*avon*," is used in the prophetical texts as associated with corruption, perversity, guilt, or depravity as in Zechariah 3:4: "'remove the filthy garments from him.' Again he said to him, 'See, I have taken your iniquity [*avon*] from you and will clothe you with festal robes'."

The concept of being "clothed in shame" (Ps 40:15) represented the worst curse that could be inflicted on another in ancient Hebrew culture (Ps 40:15) such that the

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[3]Ibid.

[4]Ibid. The adjective version of the word "*bosheth*" is used in these verses.

[5]Ibid. Additionally, the term is used in Joab's reprimand of David's lament (2 Sam 19:5), or the concept of putting the counsel of enemies to shame in Ps 14:6; 31:17; and 44:7 as "put to shame."

[6]Ibid.

wearer of the shame anticipated humiliation as a natural course of their existence and independent of the events that would have occurred in the moment. The wearing of the shame on their persons as visible to others would guarantee their isolation from community.[7] Internalized shame represents this state of being clothed in shame without just cause or reason, except that the person has been abused by someone in authority to the point they begin to believe and self-inflict the abuse.

The concept of shame is described by several Greek terms. Examples include *aischron* (also *aischune* and *aischuno*), which represent the act of devaluing, rejecting (Luke 16:3), or disgrace as in Luke 14:9 when a man was asked to move to last place at a banquet. *Oneidos* is a term representing reproach, and is sometimes translated as such (Luke 1:25). *Atimazo* is the word for an act of treating another with dishonor or insult (Mark 12:4; Rom 1:24).[8] The use of this term in Rom 1:24, "therefore God gave them over to the lusts of their hearts to impurity, so that their bodies would be dishonored (*atimazo*) among them," may suggest that how one experiences shame is adjustable by social or cognitive forces, and not always in a healing direction.[9]

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[7]Johanna Stiebert, *The Construction of Shame in the Hebrew Bible: The Prophetic Contribution* (New York: Sheffield Academic Press, 2002), 50.

[8]BibleMaster.com, "Acts 5:41"; "Rom 1:24"; and "2 Cor 11:21," *Greek Lexicon*; Internet. Forms of the word include *atimazo* (v), and *atimia* (n). The public justice use of shame is a concept similar to Barrett's theory that emotions can only be deciphered within the context of socialization, except that Barrett's focus on the social dynamic does not fully address the internal or spiritual aspects of the emotion experience. Additionally, *atima* is used in Rom 1:24 to convey the idea of shame as adjustable or subjectable to being seared.

[9]BibleMaster.com, *Greek Lexicon*, Internet; Thayer and Smith, "*Entrepo*," Internet; de Hooge, Zeelenberg, and Breugelmans, "Restore and Protect Motivations," 111; Delitzsch, *Biblical Psychology*, 15-19; and Stuart, "Shame," Internet. Stuart suggests, "In the first biblical reference to this emotion, 'shame' appears as 'the correlative of sin and guilt.'" Delitzsch described shamelessness as a characteristic of abandoned wickedness, citing Phil 3:19 and Jude 1:13 (margin "Greek: 'shames'"). Manifestly, then, shame is a concomitant of the divine judgment upon sin; the very worst that a Hebrew could wish for an enemy was that he might be clothed with shame (Ps 109:29), that the judgment of God might rest upon him visibly."

Two terms describe the act of shaming a person as motivation for a positive behavioral change. The first is *entrepo*, as in "I do not write these things to shame (*entrepo*) you, but to warn you, as my dear children . . . for in Christ I became your father through the gospel. Therefore I urge you to imitate me" (1 Cor 4:14-16; 2 Thess 3:14). The second term "*elegcho*" is often translated as conviction or reprimand (Luke 3:19; John 16:8; 1 Tim 5:20). The facial configuration of shame, "downcast countenance," is described by the word "*katepheia*," also translated "gloom" (Jas 4:9). The social justice form of shame is represented by the Greek word "*paradeigmatizo*," meaning "to put to open shame" (Heb 6:6).[10]

The Greek terms most closely aligned with natural shame as identified in this writing are the words "*entrepo*," and "*elegcho*." The most aligned with the internalized shame concept, as a corruption of the natural shame process, are the transliterations *aischuno* and *parorgizo*. *Aischuno* represents an unjust attempt to shame in a disfiguring or dishonoring way as in "I will not be put to shame in anything" (Phil 1:20; 2 Cor 10:18). *Parorgizo*, also translated provoked in Ephesians 6:4, "fathers do not provoke (*parorgizo*) your children to wrath" represents an extreme or harsh shaming that produces a retaliatory response.[11]

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[10]BibleMaster.com, *Greek Lexicon*, Internet; and Bill Thayer and William Smith, "*Parorgizo*," *Greek Lexicon Entry for Arche* (May 2012) [on-line]; accessed August 20, 2012; available at www.study light.org/lex/grk/view.cgi?number-3949; Internet. *Parorgizo* is a form of the word "*paradeigmatizo*."

[11]BibleMaster.com, *Greek Lexicon*, Internet; and Karen C. Barrett, "The Development of Nonverbal Communication of Emotion: A Functionalist Perspective," *Journal of Nonverbal Behavior* 17, no. 3 (Fall 1993): 145-69. *Paradeigmatizo* (v, Strong's 3856, from *paradeigmaitioz* [Strong's 3844 and 1165]) to set forth as a public example; make an example of in a bad sense; to hold up to infamy; and to expose to public disgrace. In the KJV, the word is translated as "make a public example, put to open shame" as used in Heb 6:6.

Theological Context: Shame in the Old Testament

The Genesis account provides several characteristics regarding shame. In Genesis 3:9, shame is associated with fear: "I was afraid because I was naked," and attributed with the natural desire to hide oneself or one's impurity, "so I hid myself." Additionally, the Scripture narrative describes attempts to hide as ultimately futile (Gen 3:9-10).[12]

Shame behavior is characterized as generational in that it is repeated by Adam and Eve's son Cain as a natural reaction to God's rejection of his sacrifice (Gen 4:5). God directly addresses Cain's physiological expression of anger and shame as a downcast countenance, with an admonition to "master" both (Gen 4:6). In the narrative, God does not punish Cain for either emotion expression, but warns him of the serious nature of not addressing them, "sin is crouching at the door; and its desire is for you" (Gen 4:7).[13] Cain expressed his inability to process the emotions in a healthy manner externally and socially when he killed his brother Abel (Gen 4:8-12).

In both the Adam and Cain illustrations, shame is not identified as sin, but rather an indicator signal warning of an at-risk position that could result in sin,

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[12]Gen 3:10; Beck and Demarest, *Human Person*, 323; Johnson, *Foundations for Soul Care*, 14; and Allen P. Ross, *Genesis*, Bible Knowledge Commentary; Old Testament, ed. John F. Walvoord and Roy B. Zuck (Colorado Springs: Cook Communication Ministries, 2004), 31. Adam's attempts to hide his guilt include defensiveness and blameshifting (Gen 3:12ff). Shame, in that Gen 2:25 states "they were not ashamed," a state no longer present in Gen 3:10. Fear in that they immediately hid themselves physically and sexuality in that what they hid was their nakedness.

[13]Gen 3:10; Beck and Demarest, *Human Person*, 323; Johnson, *Foundations for Soul Care*, 14; and Ross, *Genesis*, 31. God asks Cain why he is angry, then directs Cain to deal with both the anger and the downcast countenance (shame).

corruption, or the occurrence of an unresolved act of sin.[14] Once sin was present in creation, the shame emotion became apparent, suggesting a possible function to the emotion as indicator for the presence of sin or corruption.[15]

Theological Context: Dominion and Dynasty

Allender suggested that the consequences of Original Sin in the Garden of Eden impacted the man and woman in different ways.[16] He asserted the impact for woman had to do with pain in peer and generational relationships, while for the man the impact was identified as an atrophy of his ability to subdue his environment.[17] Dempster identifies this distinction between relationship and ability as a pattern of two axial themes that flow throughout the OT: dominion and dynasty.[18]

> The engine that drives these themes forward is that of the relationship between the Creator and his human creatures on the earth. He creates them like himself for a relationship with them, and their main task is to exercise lordship over the earth; that is, to represent God's rule over the world. The relationship fails at the beginning, and, instead of subduing the world, they are subdued by it.

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[14]Johnson, *Foundations for Soul Care*, 310. At this point, the distinction between guilt and shame has not been established. A discussion of the distinctions between these two emotions will be explored later in this writing, so for the time being, the two will be considered the same.

[15]L. Berkhof, *Systematic Theology* (Grand Rapids: William B. Eerdmans Publishing Co., 1941), 226; Charles Hodge, *Systematic Theology* (Grand Rapids: William B. Eerdmans Publishing Co., 1982), 123; and Wayne Grudem, *Systematic Theology* (Grand Rapids: Zondervan Publishing House, 1994), 494.

[16]Gen 3:16-19; Dan Allender, interview by Dennis Rainey and Bob Lepine, "Sexual Problems in Marriage," *FamilyLife Today* (Little Rock: FamilyLife, August 16, 2010), m9.35, 10.00; Raymond C Ortlund Jr., "Male-Female Equality and Male Headship: Genesis 1-3," in *Recovering Biblical Manhood & Womanhood: A Response to Evangelical Feminism*, ed. John Piper and Wayne Grudem (Wheaton, IL: Crossway Books, 2006), 109; and Ross, *Genesis*, 32. For the man, "futility" because in anything he does (will it last, will it work, no, not for long, definitely not forever) "death will be its end." For women, Allender suggests "'Your desire will be for your husband' means that a woman's loneliness leads her to want to consume her husband to find fullness for her heart."

[17]Dan Allender, *Feeding Your Enemy*, NavPress (2012) [on-line]; accessed February 6, 2012; available at http://bible.org/article/feeding-your-enemy; Internet.

[18]Stephen G. Dempster, *Dominion and Dynasty: A Theology of the Hebrew Bible*, ed. D. A. Carson (Downers Grove, IL: InterVarsity Press, 2005), 49.

> The rest of the story recounts the restoration of the relationship through the twin themes of dominion and dynasty.[19]

According to Dempster, curse consequences of sin occurring in each axis were distinct: curse consequences in the dynasty axis were represented by a break in human relationships with self, each other, and God (Gen 2:25; 3:10), and dominion axis consequences were represented by futility and hardship in human capabilities to subdue their geography.[20] Berkhof's distinction between shame and guilt seemed to align with this dichotomy, a separation similar to the one applied later by both Hodge and Grudem.[21] In the dichotomy, shame was thought to signal an awareness of pollutedness, or corruption of motivational purity resulting in a desire to cover oneself, while guilt signaled an awareness of trespass resulting in an accusing conscience and the fear of God.[22] From this functional-indicator perspective, the out-of-bounds emotion experienced in the dominion axis would be labeled guilt, functioning to signal the occurrence of, or vulnerability to, a trespass of judicial law (Mark 12:28-31). In the dynasty axis, the same emotional experience would be labeled shame and would function as indicator for violation of motivation purity. In this instance, purity would be defined by the boundaries

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[19]Ibid.

[20]Dempster, *Dominion and Dynasty*, 49; and Jerome H. Neyrey, *Honor and Shame in the Gospel of Matthew* (Louisville: Westminster/John Knox Press, 1998), 3; and Stiebert, *Construction of Shame*, 50.

[21]Berkhof, *Systematic Theology*, 226; Hodge, *Systematic Theology*, 129; and Grudem, *Systematic Theology*, 492.

[22]Jas 1:8; Berkhof, *Systematic Theology*, 226; Hodge, *Systematic Theology*, 129; Grudem, *Systematic Theology*, 492; Johnson, *Foundations for Soul Care*, 24; and Stiebert, *Construction of Shame*, 49. This motivational purity represents both spiritual purity and identity as described in the NT term "double-minded" (Jas 1:8). Johnson describes a distinction in Scripture between guilt as associated with a person's actions (Rom 5:18-19), and shame as associated with a person's position, purity, essence, and value (Luke 9:26), as does Stiebert.

of one's vertical position/relationship of self before God, and one's horizontal position/relationship of self before others (Gal 6:2-8; Eph 4:25ff).

Not all theologians agree with distinctions between guilt and shame that would identify guilt as the result of actions taken versus shame as an indication of perceived corruption or defect in one's essence or being. Stiebert suggests that because OT texts represent a collection of texts written with regional diversity, the distinction between guilt and shame in them may not be precise and both terms may represent the same shame experience.[23] Thompson suggests that a distinction may not be present and that shame may simply be a form of guilt.[24] In this writing, shame and guilt are considered the same emotion occurring in two distinct axes: dynasty and dominion. The emotion is experienced as shame when associated with dynasty issues of relationship, inheritance, or essence. The emotion is experienced as guilt when associated with dominion issues of behavior, accomplishment, or the ability to subdue or rule one's environment. Hereafter, the term "shame" will refer to both shame and guilt unless a distinction is necessary. If these two experiences do represent the same emotion expressed differently in a dynasty axis versus a dominion axis, it would be important to consider whether God addresses them uniquely and, therefore, should ministry within the church address them differently?

Ross further distinguishes between the relational and behavioral axes corrupted by the consequences of the introduction of sin in Genesis.[25] He describes the relationship

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[23]Stiebert, *Construction of Shame*, 50.

[24]Rich Thomson, *The Heart of Man and the Mental Disorders: How the Word of God is Sufficient* (Alief, TX: Biblical Counseling Ministries, 2004), 21-22.

[25]Ross, *Genesis*, 31.

corruption as a shift in mankind's positional relationship to God, others, and himself into one of enmity, anger, and wrath. Thus, the purity of relationship is corrupted into a relationship of fear of a new vulnerability to the malicious and homicidal actions of others.[26] Schaeffer characterized the corruption of man's relationship with himself as an inability to perceive oneself realistically (1 Cor 13:12).[27] He suggested that, as a result of this inability, man has struggled to develop an identity before God as both "the creature" and above the rest of creation as an "image bearer of the Creator."[28]

Schaeffer suggests that without God the resulting identity struggle is futile because in sin, humans have no understanding of their position relative to their creator, a state that results in a consistent exposure to shame in a dynasty context.[29] He proposed the result would be a dichotomy to escape the pain of shame by either trying to behave as gods unto themselves with expectations beyond their created design (superhuman), or self-identify as nothing more than animal and less than they were created to be (subhuman).[30] From this perspective, a healthy process might be illustrated by the

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[26]Eph 2:1ff, Grudem, *Systematic Theology*, 658ff; I. F. Jones, *The Counsel of Heaven on Earth* (Nashville: Broadman & Holman Publishers, 2006), 33; Ross, *Genesis*, 31; and F. A. Schaeffer, *True Spirituality* (Wheaton, IL: Tyndale House, 1971), 94.

[27]Schaeffer, *True Spirituality*, 20.

[28]Ibid.

[29]John Bradshaw, *Healing the Shame that Binds You*, rev. ed. (Deerfield Beach, FL: Health Communications, 2005), 26; Jonathan Dodson, "Accountability Group," *Journal of Biblical Counseling* 24, no. 2 (2006): 48-52; Mark R. McMinn, *Sin and Grace in Christian Counseling: An Integrative Paradigm* (Downers Grove, IL: InterVarsity Press, 2008), 122; Schaeffer, *True Spirituality*, 44, and 88; and Dan Scott, *Naked and Not Ashamed: How God Redeems Our Sexuality* (Eugene, OR: Harvest House Publishers, 2008), 50. McMinn and Dodson warn that a focus on grace without regard to sin cheapens the immense gift that God's grace is to humanity.

[30]Dan 4:28ff; Judg 4:8ff; 6:11ff; Bradshaw, *Healing the Shame*, 26; and Schaeffer, *True Spirituality*, 44. Nebuchadnezzar, Debora and Barak, and Gideon represent examples of the superhuman/subhuman dichotomy. An inaccurate understanding of one's value as too high denies the need for God (Matt 19:24), and the inaccurate understanding of one's position as too low or too bad for God to redeem is inaccurate (John 5:5 and Mark 5:4ff); thus, they believe their "badness" as beyond God's ability to save.

manifestation of a physiological shame response resulting from operating outside design limits in either relational or behavioral axes, in an attempt to achieve sub- or superhuman expectations. The emotional stimulus would then be resolved through development of an accurate positional and behavioral identity/relationship of self, in society, before God.[31]

Theological Context: Shame in the New Testament

At the end of his book, Dempster proposes that both dynasty and dominion themes connect to, and are resolved by, two NT themes that result from the work of Jesus Christ: justification and sanctification, respectively.[32] Shame functions as symptom or indicator of the presence of sin, as in one's position before the law as guilt, and one's position in relationship to God and others as shame, not as sin itself. Johnson reiterates the OT distinction in NT Scripture, associating guilt with a person's actions (Rom 5:18-19), and shame with a person's essence or in other words purity, value, and relational position (Luke 9:26).[33]

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[31]Gen 3:10; Beck and Demarest, *Human Person*, 227; T. W. Hunt and C. V. King, *The Mind of Christ* (Nashville: LifeWay Press, 1994), 66; David K. Lowery, *1 Corinthians*, Bible Knowledge Commentary: An Exposition of the Scriptures by Dallas Seminary Faculty, New Testament Edition, ed. Dallas Seminary Faculty, J. F. Walvoord, and R. B. Zuck (Colorado Springs: Cook Communications Ministries, 2004), 509; Ross, *Genesis*, 31; and Stiebert, *Construction of Shame*, 48. Beck and Demarest propose that shame represents a signal provided by the Creator, to help the individual perceive the boundaries of his or her position and essence before God, and level of purity within those boundaries (e.g. identity, essence, relational position, or role).

[32]Dempster, *Dominion and Dynasty*, 234.

[33]Cook, *Internalized Shame Scale*, 20; James Leo Garrett Jr., *Systematic Theology: Biblical, Historical and Evangelical*, 2nd ed., vol. 1, 2 vols. (North Richland Hills, TX: Bibal Press, 1990), 539; Grudem, *Systematic Theology*, 494-95; Johnson, *Foundations for Soul Care*, 24, and 320; Schaeffer, *True Spirituality*, 25; and Johnathan R. Wilson, *God So Loved the World: A Christology for Disciples* (Grand Rapids: Baker Academic, 2001), 21. Cook, *Internalized Shame Scale*, 21, suggested "shame is experienced as guilt when positive affect is attenuated by virtue of moral normative sanctions experienced as conflicting with what is exciting or enjoyable."

Allender describes shame as the "gift of exposure," and a "severe mercy" that allows humanity to look deep inside to see what rules their hearts.[34] The implication is that the desire to hide could be a signal to move toward contrition, repentance, and restoration of boundaries for the created being before the Creator.[35] In this move, through relationship with Christ, dominion is resolved as one is empowered to subdue their existence and be justified of past crimes (John 15:5; Phil 4:13; Rom 3:24-28, 6:6-10), and their dynasty position is restored before God as essentially pure and familiarly related (John 1:12-13; Rom 8:12-17).[36]

Webster describes the sanctification process as an ongoing removal of the things, within the new boundaries, that are alien to one's position as a saint before God in Christ (Rom 6:11-13; Eph 4:22; Col 3:9; Jas 4:8).[37] Ferguson expands on the purity/sanctification concept to say that the saved person is not a purified version of his or her old self. Rather, they are a totally new creation with a new moral compass no longer valuing the treasures of sin as his or her ultimate prize or celebrating sin achievements.[38] Ferguson suggests the first of these two dynamics is outlined in Romans 5:12-21 in Paul's conceptualization of the boundaries appropriate with a believer's

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[34]Allender, *Feeding Your Enemy*, 20; Hunt and King, *Mind of Christ*, 66; Schaeffer, *True Spirituality*, 33; and Stiebert, *Construction of Shame*, 35.

[35]Ibid.

[36]Grudem, *Systematic Theology*, 326.

[37]John Webster, *Holy Scripture: A Dogmatic Sketch* (Cambridge: Cambridge University Press, 2004), 86.

[38]Sinclair B. Ferguson, *The Holy Spirit: Contours of Christian Theology* (Downers Grove, IL: InterVarsity Press, 1996), 111.

ascribed identity and position in Christ as a result of salvation (Rom 6:11-13; Eph 4:22; Col 3:9).[39]

The second dynamic is expressed in new identity warnings or shame triggers of polluted consequences from repetition of "old-self" identity behaviors.[40] This concept is parallel to James 1:13-15 regarding sin conception and germination of death, and Schaeffer's conceptualization of Christians as the bride of Christ giving birth to either heavenly outcomes by yielding oneself to Christ, or evil outcomes by yielding oneself to evil.[41] Under these conceptualizations, the maintenance of purity would maintain honor and value, while falling out of purity into pollution would increase dishonor and activate shame.[42] Similarly, the maintenance of integrity would maintain alignment with the power of the Holy Spirit, and actions out of integrity with one's stated beliefs would result in transgression and the activation of guilt.[43] A distinction could thus be drawn between what is lawful as indicated by guilt, and what is profitable in relational and positional alignment (purity) as indicated by shame (1 Cor 6:12, 1 Tim 4:8).

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[39]Ibid.; 1 Pet 2:4-10; and Barth L. Campbell, *Honor, Shame, and the Rhetoric of 1 Peter* (Atlanta, GA: Scholars Press, 1998), 230. Campbell suggests that Peter makes this same construct in 1 Pet 2:4-10 of their new identity in Christ they, as a result, become "the honored people of God."

[40]Gen 3:10, and Ross, *Genesis*, 31. Shame in this case represents an indicator of boundary integrity when boundaries are established in accordance with Gal 6:2 and 5ff. From this perspective, boundaries represent a line by which one can discern whether to say "yes" or "no" to requests on their God-given resources (e.g. time, money, talent, commitment, and obligation).

[41]Jas 1:15; Campbell, *Honor, Shame, and the Rhetoric*, 12; David A. deSilva, *New Testament Themes* (St. Louis: Chalice Press, 2001), 92; Ferguson, *Holy Spirit*, 149; and Schaeffer, *True Spirituality*, 15.

[42]Gen 3:10; Beck and Demarest, *Human Person*, 227; Hunt and King, *Mind of Christ*, 66; Lowery, *1 Corinthians*, 509; Ross, *Genesis*, 31; and Stiebert, *Construction of Shame*, 48.

[43]Ibid.

Synthesis of Scriptural and Theological Substrates Regarding Natural Shame

Up to this point in the writing, the focus has been on a Scriptural description of the natural process for shame as it could occur in the two dimensions of dynasty and dominion. This emotion within the dominion axis has been described as guilt, and is associated with the approval or disapproval of an effort compared to a legal system and fear of consequential punishment (Gen 4:7, 2 Sam 19:5). This emotion within the dynasty axis has been described as shame and is associated with the purity or corruption of one's identity or spirit as compared to one's relationship primarily with God, but also with self and community.[44]

The fear in this case is loss of power to influence or value to be considered by the community or God. In both axial expressions, the emotion has been depicted as physiologically powerful (Num 12:14; Ezra 9:7; 2 Chr 32:21).[45] Shame expressions have been associated with fear and anger as secondary expressions (Gen 3:10; Gen 4:9), or behavioral expressions of avoidance, internalization, and withdrawal (Gen 3:10).

Theological Conceptualization: Internalized Shame as Corruption of Natural Shame

Scriptural references go beyond descriptions of the experience of shame to include guidelines for its use and warnings against misuse. The emotion has been described in Scripture as useful in confrontation and correction across individual, social,

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[44]Gen 3:10; Beck and Demarest, *Human Person*, 227; Hunt and King, *Mind of Christ*, 66; Lowery, *1 Corinthians*, 509; Ross, *Genesis*, 31; and Stiebert, *Construction of Shame*, 48.

[45]BibleMaster.com, *Greek Lexicon*, Internet; and Thayer and Smith, "*Entrepo*," Internet; de Hooge, Zeelenberg, and Breugelmans, "Restore and Protect Motivations," 111; Delitzsch, *Biblical Psychology*, 15-19; and Stuart, "Shame," Internet.

and spiritual spectrums (Titus 2:8; Phil 4:8). At least three warnings against misuse of shame are given: prohibitions against abuse or overly severe use by those in authority (Gal 1:6-9; Eph 6:4), warnings against its repression and internalization by those who experience it (Gen 4:7); and warnings that it can be corrupted by social expectations (Rom 1:22-32) or false teachers (Rom 1:18; Gal 1:6-9).

Theological discussions that explore boundaries between use and abuse of shame and guilt tend to center on distinctions between justice and grace-based responses to human behavior. The difficulty in establishing the boundary lies in how to distinguish and apply confrontation effectively (Titus 2:8; Phil 4:8) without condemnation (Gal 1:6-9; Eph 6:4). Dodson and McMinn make a powerful point when they suggest, "if one's focus is grace without sin, the subject does not have a chance to confront narcissism and the grace is inadvertently cheapened."[46] Johnson illustrates the importance of the confrontation-without-condemnation distinction by describing the internalized shame consequences of indistinct application of shame. He warns, "believers who have been spiritually abused or raised in an environment that focuses on sin without the gospel of grace may have difficulty reading the Bible without it activating perfectionism or excessive shame and guilt."[47]

Hunt and King illustrated the difficulty of maintaining the confrontation-without-condemnation boundary in their description of the effort to practice Christ-like virtues as likened to maintaining balance over a fulcrum point between two polar

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[46]Dodson, "Accountability Group," 48-52; and McMinn, *Sin and Grace*, 122. In their use of the word "cheapened," the perspective of this writing is that Dodson and McMinn are suggesting God's grace is disrespected, and is not an allusion to cost paid by the redeemed person.

[47]Beck and Demarest, *Human Person*, 250; and Johnson, *Foundations for Soul Care*, 14, 311.

temptations, corruption and rebellion. Rebellion was defined as the temptation to move away from the virtue toward its opposite. Corruption, or "perverting" the virtue, was defined as the temptation to add extraneous requirements, demands, or definitions to it.[48] For example, the virtue of purity would hold a central position between the opposite of lustfulness and the perversion of puritanical legalism. Based on previous discussions regarding connections between guilt and the virtue of justice, or shame with the virtue of purity, either corruption of purity would be expected to trigger shame. King and Hunt suggested the greatest vulnerability to falling into one of the corruptions would come from an ignorance of the actual contents of God's Word in Scripture.[49]

While the grace-versus-justice debate is important, it is only a part of the process that results in internalization of abusive shame messages. Internalized shame is not thought to occur as the result of a single event, but rather a consistent barrage of negative messages over years, and sometimes over a lifetime.[50] The process is illustrated in the following example. Internalized shame becomes manifest as a corruption of natural shame when scriptural guidelines are ignored and victims receive messages that they are worthless and unlovable. However, because of their trust in the condemning parent, pastor, community leader, or other authority figure, recipients believe just cause applies for their mistreatment.

When messages are repeated often enough, the person begins to believe the lie and begins to repeat the messages, self-inflicting the abuse. Such persons work to hide the presence of their self-sabotaging shame thoughts, and are defensive to new shame

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[48]Hunt and King, *Mind of Christ*, 66; and Stiebert, *Construction of Shame*, 35.

[49]Hunt and King, *Mind of Christ*, 63.

experiences for fear of abandonment and rejection similar to that experienced by shame-based communities and false teachers in their past. Further, the situation can become worse if abusers used Scripture references to bind subjects into false condemnation, such that presentation of biblical truths describing freedom for the prisoner are received through shame filters that tighten the bonds rather than remove them.

Johnson emphasizes that, in an effort to "root out sin," many children, spouses, and parishioners have been mistreated, resulting in the spread of sin rather than its diminution.[51] Johnson describes these occurrences as illustrative of Luke 17:1-2, suggesting that pathological training can become a stumbling block just as easily as accurate exegetical training can provide healing. One example of how Johnson's warning could apply to use of Scripture as harmful rather than healing is illustrated in Satan's use of Scripture in his efforts to tempt Jesus (Luke 4:10; 2 Cor 11:14). Several passages warn helpers to make sure interventions heal rather than harm (Matt 7:3ff; Gal 1:2) and to tread lightly when dealing with others trapped in sin, to take care that the helper does not become a perpetrator or victim (Heb 12:12-17).[52] Other passages present examples of treatment that is excessively harsh, resulting in fear/despair and anger/rebellion rather

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[50]Johnson, *Foundations for Soul Care*, 14, 311.

[51]Ibid., 310. "Christians must concede that the Christian doctrine of sin has been tragically misused by Christians and sometimes done untold damage. Children have been abused, spouses have been mistreated, and parishioners have been browbeaten by Christians, supposedly to root out sin. It is hard to fathom the horror of hatefully terrorizing a child through continual shaming and beating in order to rid that child of sin—the parent's sin craftily masking itself through projections in the fight against the child's sin. As we realize now, such treatment hurts and damages people and spreads, rather than diminishes, sin (something Jesus may have been alluding to in his reference to those who place stumbling blocks before children, Luke 17:1-2)."

[52]Gal 6:1, "restore him in a spirit of gentleness . . . so that you will not be tempted"; Matt 7:3ff; 2 Cor 2:5-9; and Heb 12:12-17.

than reconciliation and repentance (Prov 15:1; Matt 18:6; Eph 6:4).[53] Johnson's description suggests that desirable confession behaviors could be blocked by avoidance behaviors of internalized shame.

Several passages stand as a stark warning against those who would burden, misguide, or mistreat believers, especially children (Mark 9:42; Luke 11:46; Acts 15:10; 2 Pet 2:1). Other passages warn that false teachers would not only exist, but would also be present within the church itself (Matt 24:11; 2 Cor 11:13, Gal 2:4, 2 Pet 2:1; 3:16; 1 John 4:1). Additionally, Hunt warned teachers and authority figures to be especially vigilant that they do not present doubts and self-condemnation as truths lest the concepts become false beliefs for those under their care. Not only have false teachers attempted to implement perversions as truth, they have violated warnings of Christ (Mark 9:42) and Paul (Rom 7:5) by placing weights on children that are too heavy to bear, such that "the believer is tempted to despair" (Rom 7:5).[54]

Boa suggests that, because the dignity of man occurs in relation to God within the boundaries of Christian faith as does the resolution to human depravity, no place exists for pride, despair, or self-condemnation in one's new love-relationship position with God.[55] However, the Apostle Paul addresses the issue in his letters to both the

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[53]Christopher M. Faiver, Eugene M. O'Brien, and Elliott Ingersoll, "Religion, Guilt, and Mental Health," *Journal of Counseling & Development* 78 (Spring 2000): 156-58; and Rebecca Thomas and Stephen Parker, "Toward a Theological Understanding of Shame," *Journal of Psychology and Christianity* 23, no. 2 (2004): 176-80. According to Faiver, O'Brien, and Ingersoll, "Guilt is appropriate and virtuous from a Christian perspective when it leads one to a place of brokenness and repentance."

[54]Hunt and King, *Mind of Christ*, 66.

[55]Kenneth Boa, *Augustine to Freud: What Theologians & Psychologists Tell Us About Human Nature (and Why it Matters)* (Nashville: B & H Publishing Group, 2004), 187; and John A. Witmer, *Romans*, Bible Knowledge Commentary, New Testament Edition, ed. John F. Walvoord and Roy B. Zuck (Colorado Springs: Cook Communications Mininstries, 2004), 469.

Romans and Galatians when, after describing to readers their new positions in Christ as being without condemnation (Rom 8:1; Gal 4:1), he then wrote about how continually to take hold of and live out this new position before God (Rom 8:12-16; Gal 5:1ff), while remaining vigilant of the peril of false teachers (Gal 2:4).

Theological Conceptualization: Internalized Shame and Concept of Freedom from Bondage

Beck and Demarest propose that healing from internalized shame comes from the belief that the believer is valued, loved, and accepted in God's grace through Christ in one's relational position as an adopted family member (Rom 8:15; 1 John 3:1).[56] Rather than escalating the internalization of shame, Johnson recommends alignment with Gal 1:2 and John 8:10 in an approach of gentleness and humility that is healing and upbuilding."[57] He suggests that the imagery of Zechariah 3:4-7 and Revelation 3:18-21 illustrates God's response to shame as grace in the process of Christ's purchase of the right for the church to stand shameless before God.[58] Johnson relates this struggle with shame to "soul disorders" and points to Christ's work as a source for resolution and healing (Isa 53:5).[59] Johnson concludes: "To know one's shame and guilt are taken away

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[56]Beck and Demarest, *Human Person*, 250.

[57]Kenneth Boa, *Humility*, bible.org (2011) [on-line]; accessed March 10, 2011; available at bible.org/seriespage/humility; Internet; Johnson, *Foundations for Soul Care*, 311; and W. L. Walker, "Humility," *International Standard Bible* Encyclopedia [on-line]; accessed March 10, 2011; available at www.biblemaster.com/bible/ency/isb/view.asp? number=4475; Internet.

[58]Johnson, *Foundations for Soul Care*, 25; and Rev 3:18. Buy "white garments so that you may clothe yourself, and that the shame of your nakedness may not be revealed."

[59]Isa 53:5; and Johnson, *Foundations for Soul Care*, 26.

and replaced with God's goodness in Christ is the divinely ordained way to a new life of recovery."[60]

Theological Synthesis and Summary

The implication of these theological discussions is that unassessed, overly severe conviction messages likely engender or entrench internalized shame behaviors, placing an unnecessary stumbling block in their ability and willingness to hear the Gospel of Christ or to make a freewill choice (Gal 1:7). Internalization is a natural response of avoidance when a perpetrator uses shame for control, and the recipient begins to believe him or herself to be unworthy of consideration from others, themselves, or God.[61] The wearer is thus blinded to the truth and hope of Christ as "freedom for the prisoner" (Luke 4:18, NIV) in his or her relationship with reality, themselves, others, and most importantly, with God. One implication of internalized shame for believers is that they suffer unnecessarily in bondage, expecting to be punished in every relationship without cause. In essence, they are prisoners of their own walls against discipline, believing they are defending against messages of condemnation.[62]

Qualitative research results suggest that thoughts develop as the person integrates repeated character-defect accusations received during development or abuse.[63]

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[60]Johnson, *Foundations for Soul Care*, 140; Webster, *Holy Scripture*, 86; and Witmer, *Romans*, 437.

[61]Schaeffer, *True Spirituality*, 44; and Scott, *Naked and Not Ashamed*, 50.

[62]Pinto-Gouveia and Matos, "Shame Memories," 281.

[63]Natasha Petty Levert, "A Comparison of Christian and Non-Christian Males, Authoritarianism, and Their Relationship to Internet Pornography Addiction/Compulsion," *Sexual Addiction & Compulsivity* 14 (2007): 150; Rory C. Reid, "Assessing Readiness to Change Among Clients Seeking Help for Hypersexual Behavior," *Sexual Addiction & Compulsivity* 14, no. 3 (2007): 168; and Scott T. Wolf, Taya R. Cohen, A. T. Panter, and Chester A. Insko, "Shame Proneness and Guilt Proneness: Toward the Further Understanding of Reactions to Public and Private Transgressions," *Self and Identity* 9

When applied, internalized shame results in one's self-perception and experience of being a broken person rather than having a broken and contrite heart, and results in defensive behaviors which engender escalation of fear, anger, sin, and harm, instead of contrition and repentance.[64] Because of unjust and pathological messages from other people, authority figures, and sometimes parents, and not the righteous judgments of God, Christian believers possessing internalized shame live out curses like "clothed in shame," rather than embracing their positional freedom in Christ.

In Scripture, Jesus declares "freedom for the prisoner" to be a priority in his life on earth (Luke 4:18, NIV)," and he described severe penalties for those who would place barriers to salvation (Matt 18:7) or mislead those in their charge (Matt 18:6). Further, Paul warned sternly against teachings that polluted the purity of the Gospel of Christ (Gal 1:6-9), calling churches to return to their position before God as new creations in Christ (Rom 8:1). Exploration as to how these behaviors are established and whether these corrupted messages develop into generational defense mechanisms in an attempt to avoid parental, familial, or even congregational internalized shame is thus an important research topic.[65]

Transition from Theological to Psychological

The belief that emotions are the result of millions of years of natural selection or the intentional design of a transcendent Creator depends greatly upon the

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(2010): 360.

[64]Mark 9:42; Luke 11:46; 17:1-2; Acts 15:10; 2 Pet 2:1; Johnson, *Foundations for Soul Care*, 310; and John Patton, "Forgiveness in Pastoral Care and Counseling," in *Forgiveness: Theory, Research, and Practice*, ed. Michael E. McCullough, Kenneth I. Pargament, and Carl E. Thoresen, 281-95 (New York: Guilford Press, 2000), 288.

[65]Johnson, *Foundations for Soul Care*, 310.

epistemological perspective espoused and the associated eschatological model applied, what some have referred to as "metaphysical horizon."[66] Many current psychological research outcomes have been attributed to evolutionary epistemological rationalizations.[67]

Evolutionary or creationist epistemology distinctions are likely to result in differing conclusions drawn from similar research results, correspondent observations made in research studies suggest some surprising commonalities. Boa suggests humility as a healthy respect for one's own strengths and weakness capabilities, and shame as the result of living outside those design limits. Additionally, Exline research observations suggest a similar negative correlational relationship between operating within humility and one's experience of shame.[68]

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[66]Robert C. Fuller, "American Psychology and the Religious Imagination," *Journal of the History of the Behavioral Sciences* 42, no. 3 (Summer 2006): 227; and B. Michael Thorne and Tracey B. Henley, *Connections in the History and Systems of Psychology*, 3rd ed., ed. Kerry T. Baruth (NewYork: Houghton Mifflin Co., 2005), 51. St. Augustine called this final location one's "ultimate spiritual destiny."

[67]Boa, *Humility*, Internet; Philip Cushman, "Empathy—What One Hand Giveth, the Other Taketh Away: Commentary on Paper by Lye Layton," *Psychoanalytic Dialogues* 19 (2009): 128; Elison and Partridge, "College Athletes," 20; Fuller, "American Psychology," 225; Savatore R. Maddi, *Personality Theories; A Comparative Analysis*, rev. ed., ed. Howard F. Hunt (Homewood, IL: Dorsey Press, 1972), 66; and Pinel, *Biopsychology*, 20. One example of differing conclusions based on similar research observations is presented in evolutionary versus creationist and intelligent design explanations for the existence of the shame emotion. Elison and Partridge describe shame as the result of evolutionary survival needed for social inclusion as a signal of impending social exclusion. Boa describes shame as an indicator intentionally provided by a loving Creator to help identify boundaries between healthy operation within design limits versus at-risk behaviors outside design limits. The argument becomes whether the emotion is the result of survival need or the provisioning of an intelligent designer in order to equip his creation to meet survival needs and beyond into growth and fulfillment behaviors. Another example of equivalent research observation as a source for differing conclusions based on ontology is illustrated by therapy that explores emotions from the perspective of how they exist in language and interactions with others as opposed to how they "feel" within the client. The overall inductive perspective has taken several forms: G. W. Hall read Hegel as proposing that evolution is how pantheistic deity gains consciousness through humanity. Fuller proposes that "all psychology is political," and that the subliminal mind is linked with spiritual levels, a "psychological religiousness." Angyal and Baldwin view the individual as intrinsic part of the environmental biosphere.

[68]Boa, *Humility*, Internet; and Julie J. Exline, "Humility and the Ability to Receive from Others," *Journal of Psychology and Christianity* 31, no. 1 (2012): 42.

The two themes of dominion and dynasty, identified as prevalent through the OT, invite research into whether these two themes also exist as ontological plains. One secular theorist, Nathanson, has proposed a similar two-axis model from a materialistic psychological worldview to account for how shame is manifest in humans.[69] The Genesis account associates shame with fear, anger perception, and expression; Nathanson's Shame Compass uses anxiety and anger expression as its horizontal and vertical axes.[70] Theologians have argued the clarity of distinction between shame and guilt identified in Scriptures, a topic controversial in the scientific community as well.[71]

In a more practical vein, Scripture prohibits severe treatment by leaders, parents, and teachers of subjects under their authority and warns of personal, social, and eschatological consequences.[72] Internalized shame is a likely candidate to be a familial and internal type of consequence to severe treatment. Additionally, historical theorists and current researchers suggest the experience of shame as either adaptive or maladaptive, depending on how it is processed or approached. Exline has suggested that humility, defined as an acceptance of one's own true strenths and weaknesses, could serve as a "shock absorber" against ego threats posed by toxic applications of shame.[73] Elison and Partridge have proposed exploration of adaptive shame-processing tools to

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[69]Gen 3:10ff; 4:7ff; Allender, *Feeding Your Enemy*, Internet; Cook, *Internalized Shame Scale*, 29; and Dempster, *Dominion and Dynasty*, 49. Nathanson's Shame Compass has anger expression for a horizontal axis and fear/anxiety as its vertical axis.

[70]Gen 3:10; and 4:7ff, Cook, *Internalized Shame Scale*; and Elison and Partridge, "College Athletes," 19.

[71]Gen 3:10; Beck and Demarest, *Human Person*, 227; Hunt and King, *Mind of Christ*, 66; Lowery, *1 Corinthians*, 509; Ross, *Genesis*, 31; and Stiebert, *Construction of Shame*, 50; and Thomson, *Heart of Man*, 21-22.

[72]Gen 4:7ff; Matt 18:6-7; Gal 1:6-9; and Eph 6:4.

[73]Exline, "Humility and the Ability to Receive from Others," 48.

allow subjects to increase their capacity to experience shame without resorting to self-destructive behaviors.[74]

Carnes's research built upon the conceptual connection between shame and self-destructuve behaviors to indicate that internal, family, or social focus on accusatory shame has shown to inter self-destructive addiction behaviors (substance dependence) even deeper.[75] Janoff-Bulman and Sheikh concluded that punitive discipline is positively correllated with severity of shame levels and negatively correlated to internalization of moral values and behavior regulation, a dynamic illustrative of the warning given in Ephesians 6:4.[76] Additionally, Price illustrates the threat of the opposing end of this dynamic in his description of the toxic way shame is applied in the home environment, a process he refers to as "escape conditioning."[77]

Escape conditioning promotes the use of coercive means (secrecy, threats, and intimidation) as sanctioned or modeled methods to terminate conflict. The dynamic is thought to be a form of parental modeling that infers solutions for problems that stem from blaming or punishing others, thereby escaping the need to find assistance in, or

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[74]Elison and Partridge, "College Athletes," 22.

[75]Mark H. Butler and Ryan B. Seedall, "The Attachment Relationship in Recovery from Addiction, Part 1: Relationship Mediation," *Sexual Addiction & Compulsivity* 13 (2006): 295; Patrick Carnes, *Facing the Shadow*, 2nd ed. (Carefree, AZ: Gentle Path Press, 2005), 157-58; E. H. Erikson, *Insight and Freedom* (Cape Town, South Africa: Standard Press, 1968), 9; Levert, "Comparison of Christian and Non-Christian Males," 149; David M. Price, "Re-Building Shattered Families: Disclosure, Clarification and Reunification of Sexual Abusers, Victims, and Their Families," *Sexual Addiction & Compulsivity* 11 (2004): 199; and Reid, "Assessing Readiness," 168. Similar social behaviors (discussed later in this writing) were predicted by Erickson.

[76]R. Janoff-Bulman and S. Sheikh, "Unintended Consequences of Moral Over-Regulation," *Journal of Psychology & Theology* 3 (2011): 325.

[77]Butler and Seedall, "Attachment Relationship," 295; Carnes, *Facing the Shadow*, 157-58; Erikson, *Insight and Freedom*, 9; Levert, "Comparison of Christian and Non-Christian Males," 149; Rudy, *Neurobiology*, 199; and Reid, "Assessing Readiness," 168.

resolution of the issue. Escape conditioning is a recognized contributor in atrophied problem-solving skills and the development of addictive, aggressive, and antisocial behavior in children. Study results suggest a propensity in these children for addictive and co-addictive behaviors, even without additional exposure to addiction modeling.[78] Similar findings were reported in the research of shame used in a forensic modality, with effectiveness parallel to expectations consummate with the concepts described by the terms "*entrepo*" and "*elegcho,*" introduced in Scripture.

While observations present common data between research founded on these distinct ontological perspectives, implementation recommendations and conclusions will differ as they have distinct eschatological ends (metaphysical horizons).[79] For example, observations using an instrument based on a psychological theory of fight/flight and approach/avoidance homeostatic neural assessment, as is Nathanson's Shame Compass, can be accurate, especially if the instrument is adjusted based on research application results. However, implementation and theoretical conceptualization may be limited because they stop at anger and anxiety. Conceptualization within a comprehensive ontology, such as a creationist one, may yield greater depth of results and efficacy of implementation.

Psychological Foundations for the Internalized Shame Concept

Behaviorally, shame is observed by a flushing of the face and a tendency to look down or down and to the side. Several theories characterize shame as primarily a

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[78]Ibid.

[79]Fuller, "American Psychology," 227; and Thorne and Henley, *Connections*, 51. St.

social emotion based on the sense that one has failed to meet a predetermined set of expectations coupled with a fear of rejection from external negative evaluation, resulting in a desire to escape or hide oneself.[80] Results of shame have been observed in expressions of anger, especially in males, and expressions of pleasing behavior, especially in females; and in isolating behaviors that include seeking secluded work careers or leisure activities, intentional independence in social relationships, and working longer than non-shamed subjects on unsolvable tasks before requesting help.[81]

In order to make this comparison, theorists have suggested that a sense of self as separate from others is required.[82] Additionally, shame is described as a complex emotion as compared to other more personally concrete emotions of sadness and personal anger.[83] Beyond these basic characterizations, a great deal of disagreement and controversy exists regarding the definition of shame. Some distinguish between shame and guilt, suggesting guilt as a socially positive motivator, while shame is described as a

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Augustine called this final location one's "ultimate spiritual destiny."

[80]Jens Agerstrom, Fredrik Bjorklund, and Rickard Carlsson, "Emotions in Time: Moral Emotions Appear More Intense with Temporal Diostance," *Social Cognition* 30, no. 2 (2012): 182; Linda Carter, Jean Knox, Joe McFadden, and Marcus West, "Panel: The Alchemy of Attachment, Trauma, Fragmentation and Transformation in the Analytic Relationship," *Journal of Analytical Psychology* 56 (2011): 338; Ying-Hsien Chao, Ying-Yao Cheng and Wen-Bin Chiou, "The Psychological Consequence of Experiencing Shame: Self-Sufficiency and Mood Repair," *Motivation & Emotion* 35 (2011): 202; and Christopher R. D. Roberts and Steven K. Huprich, "Categorical and Dimensional Models of Pathological Narcissism: The Case of Mr. Jameson," *Journal of Clinical Psychology* 68, no. 8 (2012): 906. Chao, Cheng, and Chiou describe shame as a "global negative evaluation of self, often accompanied by a sense of devaluing exposure before a real or imagined audience."

[81]Chao, Cheng, and Chiou, "Psychological Consequence," 202; and Elison and Partridge, "College Athletes," 35.

[82]Agerstrom, Bjorklund, and Carlsson, "Emotions in Time," 184; and Erik H. Erikson, "Identity and the Life Cycle," *Psychological Issues* 1, no. 1 (1959): 66.

[83]Ibid., and Elison and Partridge, "College Athletes," 23.

pathological one.[84] Other writers suggest that shame, guilt, and embarrassment are variants of the same emotions and are all subject to either adaptive or maladaptive results.[85]

Social Cognition articles have presented research by Agerstrom and others to suggest that shame occurs as a result of a moral failure, while developmental theorists like Erikson have suggested that establishment of shame structures occurs many years before moral conceptualization is available to subjects.[86] Other counseling practitioners like Tracy and Robbins have argued that shame is a "self-conscious" emotion and requires the combination of both self-concept and comparison of that self-state with the environment or others.[87] Tracy suggests that the emotion is triggered when one's observed behaviors fall short of expectations or ideals.[88]

Triggers for the emotion are thought to be adjustable, a characteristic that acts as both hope for healing and vulnerability to pathology. Carnes has suggested statistically significant improvement using interventions of integrity and acknowledgement. When the subject is trained to process the shame and guilt as triggers toward integrity behaviors

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[84]Martha Sweezy, "The Teenager's Confession: Regulating Shame in Internal Family Systems Therapy," *American Journal of Psychotherapy* 65, no. 2 (2011): 179.

[85]Chao, Cheng, and Chiou, "Psychological Consequence," 203; and Elison and Partridge, "College Athletes," 20.

[86]Agerstrom, Bjorklund, and Carlsson, "Emotions in Time," 189.

[87]Tracy and Robins, "Self in Self-Conscious Emotions," 9.

[88]Ibid. Tracy suggests that shame requires a sense of self from three perspectives: observatory self-appraisal, ideal/desire self-appraisal (individual expectations, I want), and obligatory (social/duty expectation, should) self-appraisal. Observatory self-appraisal defined as who one believes themselves to be, ideal/desire self-appraisal or who one wants to become, and obligatory self-appraisal as who one should be. This proposal begs the question if this "self" or "I" assumes an other, or "you" object, implicating this model as a social process model between objects, therefore not only a sense of self, but also a sense of others, expectations (obligatory goals) of both, and the ability to make comparisons. This appears to parallel child development and current concepts regarding individuation that occur at approximately two years of age.

rather than self-punishment or self-disgust behaviors, a potential for health and growth is realized. This adjustability of one's sense of shame further points to vulnerability for pathology, one's belief that they exist as a source of death and destruction, and because it is part of their very essence, who they are is unforgivable and to change or be anything else might be outside their power.[89]

Internalized shame theories thus suggest that the defense mechanisms in place to hide this perceived global fault are an effort to protect one's intrinsic value as a human being, essentially their emotional and social life or death, and that these defenses prevent movement toward connection with self and others.[90] Chao and Cheng suggest that the self-perceptions of shame render a person as powerless and of low status, resulting in emotional isolation to repair the mood.[91] They suggest that this dynamic results in behaviors that appear to be socially insensitive, narcissistic, and independence-based self-enhancement, and lead to extreme self-sufficiency behaviors or dissociation from family or social connection.[92]

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[89]Ann Macaskill, "Differentiating Dispositional Self-Forgiveness from Other-Forgiveness: Associations with Mental Health and Life Satisfaction," *Journal of Social and Clinical Psychology* 31, no. 1 (2012): 30; David J. Y. Combs, Gordon Campbell, Mark Jackson, and Richard H. Smith, "Exploring the Consequences of Humiliation of a Moral Transgressor," *Basic and Applied Social Psychology* 32 (2010): 128; Gausel and Leach, "Concern for Self-Image and Social Image," 474; and Wolf, Cohen, Panter, and Insko, "Shame Proneness and Guilt Proneness," 360. Macaskill, "Differentiating Dispositional Self-Forgiveness," 39, discusses research indicating a negative relationship between shame levels and one's ability to forgive themselves.

[90]Carter, Knox, McFadden, and West, "Panel," 337; Combs, Campbell, Jackson, and Smith, "Exploring the Consequences," 128, and Gausel and Leach, "Concern for Self-Image and Social Image," 474.

[91]Chao, Cheng, and Chiou, "Psychological Consequence," 203.

[92]Ibid.

In this summary of psychological literature, shame has been defined as one's sense of intrinsic value based on his or her ability/potential to meet expectations of self, family, society, and God, or in other words, how they see themselves, how they perceive others to see them, and how they desire to be seen.[93] Experience of the emotion is thought possible as adaptive or maladaptive, depending on how it is expressed/processed.[94] This research is conducted as an effort to clarify associations between maladaptive processing and mental health disorders with the intention of contributing foundational data for future development of effective treatment interventions that help patients/clients move from perceived powerlessness into adaptive shame-processing skills.

Psychological Conceptualizations Internalized Shame in Historical Theories

Darwin presented several theories on the evolution of general emotion expression, each disproved by the same issues that continue to challenge contemporary researchers.[95] Until the late nineteenth century, the prevailing conceptualization of emotion process was the "common sense theory," which proposed that an external trigger caused an experience of emotion (i.e., shame), and the emotion, in turn, caused a

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[93]Elison and Partridge, "College Athletes," 20; and Tracy and Robins, "Self in Self-Conscious Emotions," 9.

[94]Elison and Partridge, "College Athletes," 20.

[95]Kalat and Shiota, *Emotion*, 15; Pinel, *Biopsychology*, 444; and Thorne and Henley, *Connections*, 238-39. Darwin proposed three principles to account for expressions in humans and animals: servicable habits (behaviors that used to be associated with an event but no longer functional are carried over into modern expressions, wrinkled nose of sneer as carryover from generations of response to offensive smells), antithesis (submissive act of a dog bowing its back as response to aggressive act of dog arching its back), and direct nervous system action. Darwin's nervous system expression theory that suggested when a person was unable to perform an action incited by sympathetic arousal, their behaviors are visible (e.g., trembling hands); however, this theory was never able to explain diversity in emotion expression.

behavioral response (crying and halted breathing): "event -> emotional 'feeling' -> physiological and behavioral response."[96] In 1884/1885, James and Lange individually proposed an alternative: emotions represent cognitive awareness of one's behavioral response to an environmental stimulus, effectively reversing the common-sense theory to event -> behavioral response -> emotional feeling.[97]

In 1962, Schachter and Singer modified the James/Lang theory into two factors: the first factor being the physiological arousal of the body incited by an external stimulus; the second, cognitive labeling of the physiological arousal energy. The suggestion was that the emotional feeling experienced was dependent on which cognitive label the arousal was assigned.[98] In 1983, Zillman expanded on the two-factor theory to suggest that arousal energy could be transferred from one event to another (e.g., excitement triggered watching a sports event is mistaken by teenage spectators as sexual excitement at home after the game).[99] His concept paralleled the defense mechanism theory posed by Anna Freud at the beginning of the twentieth century.

According to Freud, the sublimation defense mechanism represented a strategy to avoid painful anxiety-producing events by redirecting the energy into beneficial or

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[96]Kalat and Shiota, *Emotion*, 16; Pinel, *Biopsychology*, 444; and Thorne and Henley, *Connections*, 258.

[97]William James, *The Principles of Psychology*, vol. 2, 2 vols. (New York: Henry Holt, 1890), 449-50, quoted in Thorne and Henley, *Connections*, 258; Kalat and Shiota, *Emotion*, 16; and Pinel, *Biopsychology*, 444. Thus, a person physically responds to a situation, and their awareness of their response is the emotion (i.e., one runs away from an attacker, James labeled the cognitive awareness that they are running away as the fear emotion). "Not that we strike because we are angry," but "we are sorry because we cry, we are angry because we strike." Later, as a result of peer rebuttal, James revised his theory to include an appraisal function: "Event -> Appraisal -> Action -> Emotional feeling as cognitive awareness."

[98]Kalat and Shiota, *Emotion*, 16; and Thorne and Henley, *Connections*, 259.

[99]Thorne and Henley, *Connections*, 518.

socially acceptable behaviors.[100] The concept of internalized shame represents a combination of the theories of Zillman and Freud to suggest that the shame experience is especially painful and, thus, subject to pathological attempts by the subject to express other emotions instead, especially anger and fear, in attempts to avoid it.[101]

Erikson ascribed relevance to shame as one of the earliest crises in human psychosocial development. He theorized that if parents encouraged their children to explore interests, they would develop a sense of autonomy and confidence to learn new tasks and to learn about their environment. Additionally, he suggested that parents had the power to apply shame in a pathological or toxic way when they established boundaries and guidelines that were too restrictive.[102]

Psychological Conceptualization: Internalized Shame in Developmental and Biological Theories

Historical and developmental theories suggest connections between internalized shame and associated defense mechanisms to clinical pathology.[103] Erikson

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[100]James Fadiman and Robert Frager, *Personality & Personal Growth* (Upper Saddle River, NJ: Personality and Personal Growth, 2002), 54.

[101]Carter, Knox, McFadden, and West, "Panel," 336; and Cook, *Internalized Shame Scale*, 28.

[102]Erikson, "Identity and the Life Cycle," 66; Fadiman and Frager, *Personality & Personal Growth*, 222; and Tracy and Robins, "Self in Self-Conscious Emotions," 6. Erikson suggested the second stage was about control and release and was based on Freud's anal stage of development relating to the sphincter's retention and release training. From this perspective, Erikson proposed that one shamed would turn against society (with anger or anti-social behaviors when not observed) or against oneself (attempts to "overmanipulate" themselves as in obsessions, or hold onto items as in hoarding. Erikson, "Identity and the Life Cycle," 70.

[103]Earl D. Bland, "The Divided Self: Courage and Grace as Agents of Change," *Journal of Psychology and Christianity* 28, no. 4 (2009): 327; Patrick Carnes, "Should I Stay or Should I Go?," in *Mending a Shattered Heart: A Guide for Partners of Sex Addicts*, ed. Stephanie Carnes (Carefree, AZ: Gentle Path Press, 2009), 63; Lisa M. Hathaway, Adriel Boals, and Johnathan B. Banks, "PTSD Symptoms and Dominant Emotional Response to a Traumatic Event: an Examination of DSM-IV Criterion A2," *Anxiety, Stress, & Coping* 23, no. 1 (January 2010): 119; Jose Pinto-Gouveia and Marcela Matos, "Shame as a Traumatic Memory," *Clinical Psychology and Psychotherapy* 17 (2010): 299; Nathanson, "About

ascribed relevance to shame as one of the earliest crises in human psychosocial development. He theorized that if parents encouraged their children to explore interests, they would develop a sense of autonomy and confidence to learn new tasks and to learn about their environments. He suggested that parents further possessed the power to apply shame in a pathological or toxic way when they established boundaries and guidelines that were too restrictive.[104] More specifically, if children were disallowed to perform tasks of which they were capable, they were ridiculed in their attempts to perform tasks for themselves, or if age-inappropriate/unattainable expectations were set for children, the likely result would be a sense of shame and doubt about their own capabilities, manifest as fear, anxiety, and/or anger.[105]

Current developmental theorists are reticent to ascribe distinct emotion labels (e.g., disgust, shame, anger, or fear) to observations of infants because of the generic nature of newborn facial expressions. Infant protest behaviors are initially labeled distress until differentiating facial distinctions for discrete emotions are clearly observable.[106] Smiling and frowning tend to emerge around two-to-three months of age. Facial expressions for fear begin around six months, and facial expressions for anger are

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Emotion," 545; and Thorne and Henley, *Connections*, 258.

[104]Erikson, "Identity and the Life Cycle," 66; Fadiman and Frager, *Personality & Personal Growth*, 222; Tracy and Robins, "Self in Self-Conscious Emotions," 6. From this perspective, Erikson proposed one shamed would turn against society (with anger or anti-social behaviors when not observed) or against oneself (attempts to "overmanipulate" themselves as in obsessions, or hold onto items as in hoarding. Erikson, "Identity and the Life Cycle," 70.

[105]Eph 6:4; Erikson, *Insight and Freedom*, 9. "Dogmatic moralism splits man into a cruel judge and a hopeless sinner." "The most frightening aspect of pseudo-speciation as a self-fulfilling prophecy is the fact that a group living under the economic and moral dominance of another is apt to incorporate the world-image of the masters into its own self-estimation, it permits itself to become infantilized, storing up within (and often against itself) a rage which it dare not vent against the oppressor and indeed, often dare not feel." Erikson's characterization is likely unwittingly similar to Eph 6:4.

[106]Kalat and Shiota, *Emotion*, 32.

distinguishable (from general distress) at eighteen months of age.[107] Newborns will spit out bitter or sour food, but facial expressions of disgust are not clearly visible until they are between twelve and twenty-four months of age.[108]

This one-to-two year-old timeframe of disgust development is the same span Erikson identified as the second stage of development that he called crisis of autonomy versus shame and doubt.[109] One key event he identified for this crisis was control over fecal excretion during what some parents call "potty training."[110] According to Kalat and Shiota, rejection of feces appears to be the first disgusting event, normally occurring at eighteen-to-thirty-six months of age.[111] Kalat and Shiota suggest that the reason as to why this rejection develops remains a mystery.[112] The consistent timing of the occurrence, and

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[107]Ibid. Kalat and Shiota are not clear regarding their distinction of "distress" from fear, anxiety, or surprise.

[108]Ibid.; and Pinto-Gouveia and Matos, "Shame Memories," 281.

[109]Erikson, "Identity and the Life Cycle," 68; Fadiman and Frager, *Personality & Personal Growth*, 222; and Tracy and Robins, "Self in Self-Conscious Emotions," 6. Erikson suggested the crisis at this stage was to gain a sense of self-control without loss of self-esteem "from a sense of self-control without loss of self-esteem comes a lasting sense of authomy and pride; from a sense of muscular and anal impotence, of loss of self-control, and of parental overcontrol comes a lasting sense of doubt and shame."

[110]Erikson, "Identity and the Life Cycle," 66; Fadiman and Frager, *Personality & Personal Growth*, 222; and Tracy and Robins, "Self in Self-Conscious Emotions," 6. Erikson suggested the second stage was about control and release, based on the Freudian anal stage relating to the sphincter's retention and release training during this phase.

[111]Thompson, *Anatomy of the Soul*, 214, Kalat and Shiota, *Emotion*, 223; and Trevarthen, "Functions of Emotion in Infancy," 61. Kalat and Shiota describe the developmental process of disgust with an example: infants will put anything into their mouths, and unless it tastes bad, will chew and swallow it; even if it tastes bad, they will try it again; as they grow older they will reject foods that taste bad, later reject foods they believe dangerous, later reject foods because of the idea they are contaminated: apple juice with dog feces, preschool children will reject the drink. Spoon out the feces, and children less than seven years of age will drink, children older than seven will refuse to drink, but will drink if poured out juice and refill glass, while preadolescents and adolescents will refuse unless the glass is washed first. Adults sometimes refuse no matter how many times the glass is washed, demanding the glass be thrown away, and others quit drinking apple juice, even from new containers.

[112]Thompson, *Anatomy of the Soul*, 214; and Kalat and Shiota, *Emotion*, 223.

the fact that the rejection manifests similarly crossculturally, has confounded theories that have suggested the rejection occurs as a result of parental training.[113]

Developmental observations indicate that frequency and intensity of disgust and shame expressions continue to increase until they peak during adolescence where subsequent shame expressions and the ability to regulate them continue to develop into adult life at less severe rates.[114] One area for future research may include the exploration as to whether toddlerhood (eighteen-to-thirty-six-month-old children) and adolescence are specifically susceptible to internalization of shame messages or associated with specific mental health disorders.[115] Presence of internalized shame messages in automatic negative thoughts, trait-shame social expectations, and defensive-mechanism responses (e.g., avoidance, withdrawal, anger-in, anger-out), are considered conditioned responses

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[113]Cozolino, *Neuroscience*, 86; Kalat and Shiota, *Emotion*, 233; Gausel and Leach, "Concern for Self-Image and Social Image," 469; Kevin S. LaBar and Roberto Cabeza, "Cognitive Neuroscience of Emotional Memory," *Nature* 7 (January 2006): 58; Pinel, *Biopsychology*, 450; Siegel, "Emotion as Integration," 166; and Thompson, *Anatomy of the Soul*, 134. Erikson's third stage of development in his model is "initiative versus guilt" and lasts from age three-to-age six; if guilt and shame are mediated by the same cerebral nuclei, one might wonder if this is a period of marked insula and posterior-superior-parietal-lobe development.

[114]Sally S. Dickerson, Tara L. Gruenewald and Margaret E. Kemeny, "Psychobiological Responses to Social Self Threat: Functional or Detrimental?," *Self and Identity* 8 (2009): 275; Kevin F. W. Dyer, *et al.*, "Anger, Aggression, and Self-Harm in PTSD and Complex PTSD," *Journal of Clinical Psychology* 65, no. 10 (October 2009): 1100; Paolo Fusar-Poli, *et al.*, "Functional Atlas of Emotional Faces Processing: A Voxel-Based Meta-Analysis of 105 Functional Magnetic Resonance Imaging Studies," *J Psychiatry Neurosci* 34, no. 6 (June 2009): 419; Eric Lis, Brian Greenfield, Melissa Henry, Jean Marc Guile, and Geoffrey Dougherty, "Neuroimaging and Genetics of Borderline Personality Disorder: A Review," *Journal Psychiatry Neurosci* 32, no. 3 (2007): 163; Geri M. Lotze, Neeraja Ravindran and Barbara J. Myers, "Moral Emotions, Emotion Self-Regulation, Callous-Unemotional Traits and Problem Behavior in Children of Incarcerated Mothers," *Journal of Child and Family Studies* 19 (2010): 703; Mary L. Phillips, C. D. Ladoucer, and Wayne C. Drevets, "A Neural Model of Voluntary and Automatic Emotion Regulation: Implications for Understanding the Pathophysiology and Neurodevelopment of Bipolar Disorder," *Molecular Psychiatry* 13 (2008): 837; and Robert C. Roberts, *Spiritual Emotions: A Psychology of Christian Virtues* (Grand Rapids: William B. Eerdmans Publishing Co., 2007) 25.

[115]Kalat and Shiota, *Emotion*, 207, 233.

to "emotion memories" of chronic conditioned stimulus of being ridiculed, abandoned, and abused.[116]

Theories on learning and memory describe these conditioned-response associations as made during associative learning during development and suggest the associations are physically encoded in neurons located in the brain.[117] Observations made in recent neurobiological research have indicated similarities in brain-segment activation during guilt, embarrassment, shame, and disgust with slight differences in peripheral connections.[118] Additionally, many of these same cortical structures are associated with one's sense of self and are thought to be related closely to physical sensation and pain networks.[119] Conclusions have suggested the possibility of shame as some form of

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[116]William C. Pedersen, *et al.*, "The Impact of Rumination on Aggressive Thoughts, Feelings, Arousal, and Behavior," *British Journal of Social Psychology* 50 (2011): 281; and Pinto-Gouveia and Matos, "Shame Memories," 282.

[117]Rudy, *Neurobiology*, 310. Encoding is theorized to occur in N-methyl-D-aspartate (NMDA) receptors of neural dendrites.

[118]H. Henrik Ehrsson, Nicholas P. Holmes, and Richard E. Passingham, "Touching a Rubber Hand: Feeling of Body Ownership Is Associated with Activity in Multisensory Brain Areas," *Journal of Neuroscience* 25, no. 45 (November 2005): 10564-73; Kalat and Shiota, *Emotion*, 47; David Mataix-Cols, *et al.*, "Individual Differences in Disgust Sensitivity Modulate Neural Responses to Aversive/Disgusting Stimuli," *European Journal of Neuroscience* 27 (2008): 3050; and Andrew B. Newberg, Eugene G. d'Aquili, Stephanie K. Newberg, and Verushka deMarici, "The Neurophychological Correlates of Forgiveness," in *Forgiveness: Theory, Research, and Practice*, ed. Michael E. McCullough, Kenneth I. Pargament, and Carl E. Thoresen (New York: Guilford Press, 2000), 92. The anterior insular cortex (Insula) has not only been observed as highly active during shame, disgust, embarrassment, and guilt experiences, but victims of damage to the area have suffered an inability to recognize disgust input.

[119]Newberg, *et al.*, "Neurophychological Correlates," 93. Activity in the insular region is strongly correlated with Posterior Superior Parietal Lobe (PSPL) shown to be highly active in processing issues regarding self-concept. Inferior Parietal Lobe (IPL) input (sensory) is compared to memories of the "self" and the environment held by the Posterior Superior Parietal Lobe (PSPL). Incongruences are signaled to the limbic system (amygdale and hypothalamus), which cause release of neurotransmitters and hormones to trigger body responses of increased heart rate and muscle tension recognized as emotion expression or "upsetness." Sensory input from the IPL and memories from Hippocampus are processed by the preFrontal Cortex and temporal lobes. The incongruence is analyzed in an effort to produce an action toward resolution. Eventually, the Cerebral Cortex assists the PSPL to establish a new understanding or map of the self, and the surrounding environment. When resolution occurs, there is a discharge from the Right Hemisphere that triggers the biochemical energy associated with "happiness/relief." "Phenomenologically, the act of forgiveness is often described as a revelation, which is precisely the type of experience associated with the problem-solving ability of the right hemisphere." This positive effect

internal disgust emotion.[120] In this capacity, shame could serve as an affective approach-avoid indicator for relational movement toward spiritual, cognitive, and social health and purity or pollution and decay.

Observations related to internal and external sensory and pain networks suggest the experience of shame as an actual physical event able to incite physical pain.[121] Further, these physical connections represent the biological substrate for behavior habituation and developmental decision delegation/automation.[122] The physical pain of internalized shame messages can thus result in habituated defensive behaviors, thought processes, and defense mechanisms, and because these defense habits are encoded in neural flesh, they are not easily extinguished.[123]

"may" be directed at an offending object (or the subject's mental representation of the offending object). These newly released chemicals have a de-stressing effect on the body beneficial to long-term health including decreases in heart rate, muscle tension, breathing (HPA network), increases in self-esteem, decreases in depression (balance within PSPL), and cessation of feelings of anger (glands stop releasing biochemical "anger" energy into the body). Incongruences between internal synthesis and external input processed in PSPL are thought to be signaled to the limbic system as "upsetness," injury, or injustice. In one study, the dominant hemisphere portion of the PSPL was anesthetized; subjects became depressed and struggled with their sense of self; when the nondominant hemisphere was blocked, the subjects became euphoric and ultimately manic, producing a grandiose sense of self.

[120]Ehrsson, Holmes and Passingham, "Touching a Rubber Hand," 10564-73; Kalat and Shiota, *Emotion*, 47; Mataix-Cols, *et al.*, "Individual Differences," 3050; and Newberg, *et al.*, "Neurophychological Correlates," 92.

[121]Cozolino, *Neuroscience*, 30; Gausel and Leach, "Concern for Self-Image and Social Image," 474; Jaak Panksepp, "Brain Emotional Systems and Qualities of Mental Life: From Animal Models of Affect to Implications for Psychotherapeutics," in *The Healing Power of Emotion*, ed. Diana Fosha, Daniel J. Siegel and Marion F. Solomon (New York: W. W. Norton & Co., 2009), 20; Pinel, *Biopsychology*, 57; Phillip J. Quartana, *et al.*, "Anger Suppression Predicts Pain, Emotional, and Cardiovascular Responses to the Cold Pressor," *Annals of Behavioral Medicine* 39 (2010): 211; Barbara A. Steffens and Robyn L. Rennie, "Traumatic Nature of Disclosure for Wives of Sexual Addicts," *Addiction & Compulsivity* 13 (2006): 262; and Thompson, *Anatomy of the Soul*, 30. As with other emotions, shame has been correlated with activity in the sensory and motor systems of the primary- and pre-motor cortices. Lost limbs have resulted in the brain sending "ghost pain" signals. In this way, experience of social devaluation can involve the same physiological systems as physical pain.

[122]Ibid.

[123]Ibid.

Internalized Shame in Cognitive and Social Theories

Influence of the proceeding historical, developmental, and biological theories is found throughout cognitive and social theories on shame. Historically, Erikson also alluded to social implications of internalized shame messages. He believed that when a victim of chronic shame was shamed as an adult, they would likely turn against society or against themselves rather than toward reconciliation behaviors as was the assumed response of the culture in his generation.[124] His proposition found some support in a research study by Combs, Campbell, Jackson, and Smith, in which shame appropriately levied "ignited the individual's internal motivations to make amends." However, when severely inflicted, social shame was related to behaviors "destructive to healthy functioning of the self and or the community."[125]

Combs, *et al.*, identified distinguishing characteristics for appropriateness versus inappropriateness as intentionality, severity, and publicity of the condemnation. "Unintentional publicity and mild reprimand generally enhanced both moral emotion and intentions to apologize without increasing hostility."[126] Intentional and severe forms of public condemnation resulted in wrongdoers believing they had been treated in an undignified, inappropriate, and unfair way. Subjects exhibited angry and vengeful responses to the crime of disproportionate punishment severity rather than contrition for the crime itself.[127] Additionally, Combs, *et al.*, found that, in subjects suffering from

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[124]Erikson, *Insight and Freedom*, 9.

[125]Combs, Campbell, Jackson, and Smith, "Exploring the Consequences," 128.

[126]Ibid.

[127]Ibid., 130.

internalized shame, even appropriate levels of punishment incited reactive anger, resistance, and retaliation behaviors against making amends.[128] Their conclusions suggest the need to address the immediate wrongdoing and the developmental internalized shame messages as separate issues requiring distinct treatments.

Habituated defense mechanisms discussed in biological theories have led researchers to explore the possibility that the protective behaviors are subject to denial by those persons exhibiting them. In studies by Levin, Shiv, Bechara, and Weller, physiological and behavioral changes were measured in subjects exposed to stress conditions before the subject reported being cognitively aware of a threat; in other words, the subject did not know they were being defensive or, once made aware of the defensive behavior, why they were responding that way.[129] Farmer and Andrews have suggested that "anger may replace shame quickly so that it is never attended to, resulting in a consciousness but lack of awareness of shame."[130] Research outcomes reported by

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[128]Ibid., 128; and Carter, Knox, McFadden, and West, "Panel," 336.

[129]Irwin P. Levin, Baba Shiv, Antoine Bechara, and Joshua A. Weller, "Neural Correlates of Adaptive Decision Making for Risky Gain and Losses," *Psychological Science* 18, no. 11 (2007): 959; Nasir Naqvi, Baba Shiv, and Antoine Bechara, "The Role of Emotion in Decision Making: A Cognitive Neuroscience Perspective," *Current Directions in Psychological Science* 15, no. 5 (2006): 261; Peter H. Rudebeck, *et al.*, "Separate Neural Pathways Process Different Decision Costs," *Nature Neuroscience* 9, no. 9 (September 2006): 1161; Rudy, *Neurobiology*, 159; Alan G. Sanfey, "Decision Neuroscience: New Directions in Studies of Judgment and Decision," *Current Directions in Psychological Science* 16, no. 3 (2007): 151; Steffens and Rennie, "Traumatic Nature of Disclosure," 272; and Drew Westen, *et al.*, "Neural Bases of Motivated Reasoning: An MRI Study of Emotional Constraints on Partisan Political Judgment in the 2004 U.S. Presidential Election," *Journal of Cognitive Neuroscience* 18, no. 11 (2006): 1955.

[130]Peggy Chekroun and Armelle Nugier, "'I'm Ashamed Because of You, so Please, Don't Do That!': Reactions to Deviance as a Protection Against a Threat to Social Image," *European Journal of Social Psychology* 41 (2011): 479-88. 479; Elly Farmer and Bernice Andrews, "Shameless Yet Angry: Shame and its Relationship to Anger in Male Young Offenders and Undergraduate Controls," *Journal of Forensic Psychiatry & Psychology* 20, no. 1 (February 2009): 59. Farmer and Andrews, 48, continued to state: "Despite significantly higher levels of anger and depression, the young offenders displayed significantly lower levels of shame than the undergraduates. Furthermore, while a significant relationship existed between shame and anger in the undergraduates, this was not apparent in the offenders. Neither defensiveness nor depression could account for these differences. Possible explanations, including the

Macaskill indicated that shame was a more significant contributor to self-unforgiveness than anger, and anger was a more significant contributor to other-forgiveness.[131] The sublimation suggested by Farmer and Andrews could thus have implications regarding course of treatment.

Some debate exists over shame as an internal self-conscious emotion versus a social one. Several recent articles have described shame as a "social" or "self-conscious" emotion measured against social standards or self-analysis, as distinct from "basic" emotions (i.e. fear, anger, sadness) supposed to be the result of nonsocial environmental stimulus.[132] Tracy suggests that shame requires a sense of self, from three perspectives: observatory self-appraisal, ideal/desire self-appraisal (individual expectations, I want), and obligatory (social/duty expectation, should) self-appraisal.[133]

In this theory, the long-term constructs of ideal-self and actual-self-representations are used to create a baseline from which to evaluate observed behaviors and events.[134] Thus, trauma to ideal-self or actual-self-representations could negatively

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social dynamics of inner-city youth subcultures, are drawn upon in considering why shame is low and uncorrelated with anger in young offenders."

[131]Macaskill, "Differentiating Dispositional Self-Forgiveness," 44.

[132]Cozolino, *Neuroscience*, 86; Gausel and Leach, "Concern for Self-Image and Social Image," 473; Kalat and Shiota, *Emotion*, 226; Pinel, *Biopsychology*; Thompson, *Anatomy of the Soul*; Trevarthen, "Functions of Emotion in Infancy," 61; and Tracy and Robins, "Self in Self-Conscious Emotions," 11.

[133]Ibid. Observatory self-appraisal was defined as who one believes themselves to be, ideal/desire self-appraisal or who one wants to become. Obligatory self-appraisal was defined as the image of what one is expected or required to be (duty). This proposal begs the question: if this "self" or "I" assumes the presence of an "other," then is it not a social-process model between objects? The process structure inherently requires not only a sense of self, but also a sense of others, and a conceptualization of the expectations (obligatory goals) of both, and finally an ability to make comparisons between self, others, and expectations. This appears to parallel child development and current concepts regarding individuation that occur at approximately two years of age.

[134]Ibid.

impact how the subject evaluates and responds to experienced events.[135] Barrett's Functionalist theory suggests that emotions are facial and behavioral communications necessitated by survival of the social structure, which are developed and can only be deciphered within the context of socialization.[136]

Gausel and Leach combine these two concepts in their suggestion that emotional arousal is triggered when individual, and also social, survival is at stake, and as such cannot be disconnected from the cultural and developmental influence.[137] From this perspective, shame behavior (e.g. withdrawal, avoidance, attack) is thus based on a concern for survival of "social self" and a fear of social punishment or rejection/ abandonment.[138] Conroy and Pincus suggest that the fear of failure that results from anticipation of shame is exhibited in either appeasing behavior most often seen in females, or aggressive behavior most often seen in males.[139] Chao and Cheng observed that both males and females exhibited similar isolating behavior in response to shame.[140]

According to this theory, if the subject believes his/her social image has already been damaged, they will anticipate condemnation, devaluation, and isolation, and

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[135]Pinto-Gouveia and Matos, "Shame Memories," 282.

[136]Barrett, "Nonverbal Communication," 145-69. This late reference is included, because it is often cited in subject articles, especially in the field of child development.

[137]Gausel and Leach, "Concern for Self-Image and Social Image," 473; and Cankaya, "Anger as a Mediator," 936. This definition is very similar to Cankaya's definition of anger as the emotion normally present in response to one's perception that he or she is being suppressed, attacked, threatened, deprived, or limited.

[138]Chao, Cheng, and Chiou, "Psychological Consequence," 203; and Gausel and Leach, "Concern for Self-Image and Social Image," 473.

[139]David E. Conroy and Aaron L. Pincus, "Interpersonal Impact Messages Associated with Different Forms of Achievement Motivation," *Journal of Personality* 79, no. 4 (2011): 677.

[140]Chao, Cheng, and Chiou, "Psychological Consequence," 206.

are likely to initiate withdrawal-focused defensive behavior.[141] This explanation appears to replicate behavioral expectation described in the biblical concept of fear of punishment (Genesis 3, 1 John). If social-image damage is thought to be the result of a perceived self-defect, they are likely to initiate either reparative or avoidance behaviors depending on whether they believe the defect to be specific and potentially repairable, or global and presumably permanent, respectively.[142] This polarization between withdrawal and avoidance, with reparative behaviors in the center, establishes the north and south poles of what Nathanson called the "Shame Compass" of defense mechanisms to hide the experience of shame.[143]

Nathanson's Shame Compass model proposes that four maladaptive defensive behaviors are generally implemented to reduce, hide, or redirect one's painful experiences without having to address the source issues triggering the shame emotion itself. The four behaviors represent the endpoints of two perpendicular axes, anger and fear. He described these four points as: attack self, attack others, avoidance, and withdrawal.[144]

Attack-self behavior is precipitated by the belief that the experience of the shame emotion is evidence that one is unable to meet the expectations they believe others require of them. The attack-self response to the shame experience is characterized by anger, contempt, or disgust toward oneself, expressed in derogatory or demeaning language labels of oneself, or self-punishing behaviors. The goal of attack-self behavior

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[141]Gausel and Leach, "Concern for Self-Image and Social Image," 473.

[142]Ibid.

[143]Cook, *Internalized Shame Scale*, 28.

[144]Ibid., and Elison and Partridge, "College Athletes," 20.

is usually to gain acceptance or avoid rejection from others via preemptive self-punishment. Attack-self behavior is proposed to be associated with anxiety.

Attack-others behavior is believed precipitated by denial as an unwillingness to admit to others or self that shame could be a valid consequence to source behaviors. It is characterized by efforts to externalize ownership of failure to achieve expectations by blaming others for outcomes. Attack-others expression of internalized shame is proposed to be associated closely with anti-social and avoidance behaviors designed to protect self and prevent others from seeing the perceived weakness or decay. Avoidance behavior is characterized by denial, deceit, or contradictory behavior in attempts to ignore or distract self and others from source behaviors or consequential shame experiences.

Withdrawal expressions of internalized shame are characterized by a subject's attempt to escape or hide from pain or the consequences of an event for which they believe shame is a valid and necessary result.[145] Withdrawal expressions are proposed to be associated closely with depression and isolation behaviors in efforts to protect self. The ISS instrument used in this study is based on this Shame Compass conceptualization for defensive behavioral expressions of habituated, self-directed, internal, devaluation messages.

Psychological Observation: Internalized Shame in Psychopathology Research

Wolf, Cohen, and Insko observed an inverse correlation between internalized shame message levels and problem-solving abilities. Results suggested an increased

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[145]Ibid.

vulnerability to psychopathology.[146] When shame-based negative thoughts were combined with reduced problem resolution skills, subjects were reported to develop beliefs of powerlessness or hopelessness regarding their abilities to change, and attributed the negative characteristics to the essence of their identities.[147] Those reporting this experience of shame were observed to express depression, anxiety, anger, and/or rage directed toward themselves or others.[148] Gambetti and Giusberti termed the anger expressed toward others as anger-out, suggesting it functioned as a defense against anyone who might call attention to the subject's self-perceived defect.[149] They concluded that because subjects believed the faults to be innate weaknesses and, thus unchangeable or foundational to their beings, they were essentially defending their identities.[150]

Two studies that specifically examined the relationship between internal shame messages and clinical mental health diagnosis include research by Pinto-Gouveia and Matos, and Vikan, *et al.*, Pinto-Gouveia and Matos studied a population of eight hundred subjects from the general population. Results indicated a significant correlation between shame memories from childhood and how subjects perceived themselves in the present

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[146]Paul Gilbert, *et al.*, "Self-Harm in a Mixed Clinical Population," *British Journal of Clinical Psychology* 49 (2010): 563; Jason B. Luoma, *et al.*, "Reducing Self-Stigma in Substance Abuse Through Acceptance and Commitment Therapy: Model, Manual Development, and Pilot Outcomes," *Addiction Research and Theory* 16, no. 2 (April 2008): 150; Pinto-Gouveia and Matos, "Shame Memories," 282; and Rory C. Reid, James M. Harper, and Emily H. Anderson, "Coping Strategies Used by Hypersexual Patients to Defend Against the Painful Effects of Shame," *Clinical Psychology and Psychotherapy* 16 (March 2009): 126.

[147]Chao, Cheng, and Chiou, "Psychological Consequence," 203; and Combs, Campbell, Jackson, and Smith, "Exploring the Consequences," 128. This dynamic is in parallel with the theory suggested by Gausel and Leach in which anger is the expected response when a self-defect is supposed as global and, thus, irreparable.

[148]Cook, *Internalized Shame Scale*, 28.

[149]Wolf, Cohen, Panter, and Insko, "Shame Proneness and Guilt Proneness," 360.

[150]Ibid.

day ($r = .32$, $p < .01$), and how they perceived others as likely to shame them ($r = .34$, $p < .01$).[151]

Additionally, their research suggested significant correlations between shame memories and depression ($r = .31$, $p < .01$), and shame memories and anxiety ($r = .32$, $p < .01$).[152] Although use of a sample drawn from the general population limited results from being generalized to a clinical population, the data appears to suggest a possibility of significant relationships between shame memories, internalized shame messages, current behaviors, and vulnerability to pathology.[153] Matos and Pinto-Gouveia suggested a need for additional research regarding the relationship between internalized shame and pathology, especially within a clinical population.[154] Pinto and Matos held reservations about using the interview-based measurement instrument they selected and recommended use of the ISS instead.[155]

Vikan, *et al.*, used the ISS instrument with four hundred university students; two hundred received outpatient treatment at the university clinic, and two hundred did not. The internalized shame instrument was compared to two other published self-report scales with known reliability and validity, the Beck Depression Inventory (BDI), and the Beck Anxiety Inventory (BAI).[156] One hundred outpatients were diagnosed with

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[151]Matos and Pinto-Gouveia, "Shame as a Traumatic Memory," 285.

[152]Ibid., 286.

[153]Ibid., 288. Results could not be generalized to a clinical population, because they were taken from the general populace. Results could not be generalized to an American pouliation, because the poplation lived in Portugal.

[154]Ibid., 309.

[155]Ibid., 288. Pinto-Gouveia and Matos had selected the Experience of Shame Scale (ESS) developed by Andrews and Hunter in 1997 as one of their instruments.

[156]Ibid., 196.

depression, and the other hundred patients were diagnosed with anxiety based on their BDI and BAI scores.[157] A Mann-Whitney test indicated a higher correlation of internalized shame scores with depression scores ($z = 2.67$, $P < .01$) than anxiety scores ($z = 2.31$, $P = .02$).[158] Additionally, results indicated higher shame scores for depressive patients (mean score = 53) than anxiety patients (mean score = 47).[159]

In their discussion Vikan, *et al.*, reported concerns that group divisions may not have been as precise as possible, because the Beck inventories may not have been powerful enough to distinguish the differences necessary for the complexity of shame.[160] The team recommended further research to explore these possible differences, suggesting the use of more stringent diagnostic procedures than self-report inventories, possibly by the inclusion of assessments performed by a qualified psychiatrist. Finally, because the anxiety and depression population consisted of outpatients at a university clinic, they recommended that future studies should include a population with an extended age range and duration of problems.[161]

Cook referred to several studies pairing psychological testing with the ISS to establish convergent validity. The studies identified used MCMI Axis-II results in comparisons with ISS scores, and Axis-I indications from the Symptom Checklist Inventory (SCL-90), and other tests specifically to compare ISS scores with fear and

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[157]Ibid.

[158]Ibid.

[159]Ibid.

[160]Vikan, *et al.*, "Test of Shame," 201.

[161]Ibid. The group identified the majority of subjects as highly educated and young (18-35 years of age). The study called for more extended distribution of age, education, and debut and duration of problems.

anger measures. This assessment proposes to compare ISS scores with Axis-I diagnosis by medical psychiatrists as called for by previous research, and explore the proposed possibility of a defensive mechanism indicated by very low ISS scores.[162]

Psychological Synthesis and Summary

Shame experiences have been closely associated with one's sense of their own power and expectations, and toxic or pathological shame has been closely associated with self-depreciation messages resulting from attempts to meet expectations that are unrealistically high or numerous.[163] Abuse of authority in which one intentionally and continually communicates personally devaluing labels, or criticisms for failing to meet unrealistic expectations to another with the intention of eliciting anger-out behavior has been termed "toxic-shame."[164]

The state in which the receiver of the toxic shame messages begins to believe the repeated negative characterization labels as "the truth" of who they are and then begins to repeat the devaluation messages to themselves repeatedly is called internalized shame.[165] The state in which the subject automatically responds to neutral or even positive input with defensiveness or attack is termed "shame-proneness" or trait-shame.[166] The use of anger and fear expressions to conceal or deny the presence of shame

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[162]Cook, *Internalized Shame Scale*, 12.

[163]Elison and Partridge, "College Athletes," 24.

[164]Bradshaw, *Healing the Shame*, 109.

[165]Cook, *Internalized Shame Scale*, 29. This is the behavior intended to be measured by the ISS instrument.

[166]Kenneth Goss and Steven Allan, "Shame, Pride, and Eating Disorders," *Clinical Psychology and Psychotherapy* 16 (2009): 306; and Wolf, Cohen, Panter, and Insko, "Shame Proneness and Guilt Proneness," 338.

is called defense-mechanism sublimation, and is a key component of Nathanson's shame compass.[167]

Presence of internalized shame messages in automatic negative thoughts, trait-shame expectations that all communications are shaming to them, and defensive-mechanism responses (e.g. avoidance, withdrawal, anger-in, anger-out) are considered conditioned responses to "emotion memories" of chronic conditioned stimulus of being ridiculed, abandoned, and abused.[168] These habituated social response behaviors are encoded in neural flesh, (re)experienced as physical pain, and thus not immediately or easily extinguished. Untreated internalized shame becomes a challenge to therapy and salvation in that subjects may reject healing or freedom messages, because they consistently anticipate ridicule and abandonment in current events when input triggers are neutral or even positive.[169]

This research study represents a two-pronged effort: first, to add to the body of knowledge regarding current understanding of the relationship between internalized shame and mental health pathology, and second, to build on the foundation for future study into the possibility of positive health influences of shame expressions. This effort is expended with the intention of establishing a basis for development of future effective clinical interventions and to dislodge footholds interfering with individual access to, and

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[167]Cook, *Internalized Shame Scale*, 29; and Fadiman and Frager, *Personality & Personal Growth*, 54. The ISS instrument is designed to measure the frequency of internalized shame thoughts a person repeats, suggested to have a direct impact on which defensive mechanisms the person exhibits.

[168]Pinto-Gouveia and Matos, "Shame Memories," 282.

[169]Ibid.; and Rudy, *Neurobiology*, 43.

freewill choice regarding, acceptance of the Gospel of Jesus Christ (Luke 4:18; Rom 1:25).[170]

[170]Johnson, *Foundations for Soul Care*, 14.

CHAPTER 3

PROCEDURE FOR COLLECTING THE DATA

Population

The population of this study included patients who required IOP treatment and desired to be treated in a Christian faith-based format at one of two name-recognized clinics in the United States: Richardson, Texas, and Wheaton, Illinois. Patients within diagnostic groups that did not achieve the minimum thirty members per group were removed from the sample.

On average, five patients per week are accepted into these clinics. Patients treated are adults, eighteen years of age and older, who travel to these clinics from various locations locally and around the United States seeking PHP (partial hospitalization program) mental health treatment in a Christian environment when faith-based intensive or inpatient facilities are not otherwise available.[1] Costs of treatment are paid by either insurance, self-pay, family, employer, or other benefactor-provided funds. Travel and lodging are usually paid with personal funds.

Sample

This study was performed over a six-month period. During this six-month period, two hundred patients passed through both clinics. All qualifying records were

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[1]Generally, PHP treatment can occur five days per week, from 8 a.m. to 5 p.m.

included in the study, resulting in a sample of 150 subject records. Enough subjects were in each category (minimum 30 subjects each) of the diagnostic grouping variable to perform analysis on all five groups: mood, anxiety, substance dependence, psychosis, and dissociation.[2]

Instrument

Two of the most often used shame and guilt research instruments have been the Internalized Shame Scale (ISS), and the Test of Self-Conscious Affect (TOSCA). The TOSCA uses situational statements to measure shame and guilt, and has shown divergent validity in measuring differences between situational (state) guilt and situational shame. Because TOSCA measures situational shame and guilt, and not internalized or trait shame, as does the ISS, the TOSCA was not selected for use in this study. The ISS uses trait statements to measure internalized shame messages and is intended to measure an individual's long-term exposure and anticipation of shame, even for events that do not normally produce shame.[3]

Internalized Shame Scale (ISS)

The instrument selected for this study is the internalized shame scale (ISS) (Appendix 5), developed by David R. Cook, in 1984, specifically as a clinical and research instrument to identify internalized shame in mental health populations.[4] The

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[2]Julie Pallant, *SPSS Survival Manual: A Step-By-Step Guide to Data Analysis Using SPSS Version 15*, 3rd ed. (New York: McGraw-Hill, 2007), 148; and Craig A. Mertler and Rachel A. Vannatta, *Advanced and Multivariate Statistical Methods: Practical Application and Interpretation*, 4th ed. (Glendale, CA: Pyrczak Publishing, 2010), 15.

[3]Vikan, *et al.*, "Test of Shame," 197.

[4]Cook, *Internalized Shame Scale*, 1, 12.

instrument is designed to identify the level to which a subject's perception of self is conceptualized as intrinsically incompetent or worthless.[5] The thirty-item version used in this study has been in use since 1989 and consists of twenty-three shame questions interspersed with seven self-esteem questions rated on a five-point Likert scale ranging from 0 (never) to 4 (almost always). The total shame score is derived from twenty-three negatively phrased shame statements. The positively phrased self-esteem questions are included to decrease the possibility of a negative response set developed from all questions phrased in the same format.

Several of the shame instruments available at the time of this study were developed for research and utilized university students as the standard populations. The ISS psychometric screening instrument was developed for clinical application and normed using clinical populations.[6] ISS shame results have shown to be "highly and negatively correlated" with self-esteem.[7] Internal consistency (alpha) reliability consistently ranged from .94 to .96 (self-esteem reliability was .88), and test-retest correlation coefficients for internalized shame questions ranged from .84 to .94 after five weeks (self-esteem ranged from .69 to .71).[8] Construct and discriminate validity are regularly reported as very high.[9] False negatives on this instrument have been thought to occur when the subject used avoidance as a primary defense mechanism.

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[5]Ibid., 2; and Vikan, *et al.*, "Test of Shame," 196. Vikan describes internalized shame as "enduring results of shame scenes that have become part of the self-concept."

[6]Cook, *Internalized Shame Scale*, 2-3. Normative comparison sample totals include 499 clinical adult respondents, and 1130 nonclinical adult respondents.

[7]Ibid., 64. Correlations between self-esteem scale and internalized shame scale range from -.90 to -.95.

[8]Ibid., 60.

[9]Ibid., 81.

The test is based on Nathanson's Shame Compass concept in which he suggests internalized shame results in one of four maladaptive defensive behaviors implemented to reduce, hide, or redirect one's painful shame experiences without having to address the source issue. The four behaviors represent the points of perpendicular axes of anger and fear axis: anger at self, anger at others, anxiety/avoidance, and withdrawal/depression.[10] The basis of this study was to examine whether, across two axes, these four behavioral expression types could be validated or refined, making appropriate interventions and distinctly effective treatment protocol adaptation or improvement, possibly based on differing presentations of shame, guilt, fear, and anger.[11]

The score reported is total raw score, and is used as a barometer of how acutely the patient experiences shame when it is triggered. The self-esteem questions, while not an independent measure, are used to verify validity of responses. If the shame score is above 50, self-esteem scores are expected to be below 18; if this is not the case, discrepancies may be indicated as in the possibility of the subject attempting to conceal his or her internal thought process.[12]

The test takes approximately fifteen minutes to administer, is written for adults and adolescents older than thirteen years of age with a minimum of a fourth-grade reading level. Scoring range is from 0 to 96, scores above 45 are categorized as "high" and are indicative of relatively frequent occurrences of internalized shame usually

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[10]Ibid.; and Elison and Partridge, "College Athletes," 20.

[11]Cook, *Internalized Shame Scale*, 30. Currently, Cook proposes that attack-other is present when shame and anger are combined and anger is greater than shame, avoidance is present when shame is greater than anger, withdrawal is present when fear is greater than shame, and attack-self is present when shame is greater than fear. High effect interventions for shame have been suggested as integrity and acknowledgement (Carnes), for fear = courage/exposure (CBT), and for anger = interrupt and distraction.

[12]Ibid., 12.

associated with anxiety. Scores above 60 are categorized as "very high" and indicate a likelihood of depression and relationship problems. Scores above 70 are categorized as "extremely high" and may indicate clinical symptoms of emotional or behavioral problems. Scores below 34 are considered "very low," suggesting the possibility of avoidance (e.g., narcissistic) defense mechanisms. Scores between 35 and 44 are categorized as "normal" and may indicate shame expressions in nonclinical subjects. The test requires all answers to be completed; scores are not viable if more than three questions remain unanswered.

MMPI-2

The Minnesota Multiphasic Personality Inventory-2 (MMPI-2) is a diagnostic personality test consisting of 567 items and takes approximately ninety minutes to complete.[13] Introduced in 1989, the MMPI-2 was designed to identify psychopathology and Axis-I disorders. The MMPI-2 report provides scores on three validity scales, ten clinical (basic) scales, fifteen content scales, and forty supplementary scores. Scale significance is indicated by T-scores of 65 or higher.[14] The MMPI-2 has shown a .98 correlation to the MMPI; however, it was later standardized to a population of 2600 nonclinical subjects across seven states representative of the 1980 United States census.[15] Test-re-test reliability assessments have indicated ranges between .67 and .92 for males,

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[13]Edward S. Neukrug and R. Charles Fawcett, *Essentials of Testing and Assessent: A Practical Guide for Counselors, Social Workers, and Psychologists* (Belmont, CA: Thomson Brooks/Cole, 2006), 170.

[14]Ibid., 172; and Bagby, *et al.*, "Assessing Underreporting and Overreporting," 45.

[15]Neukrug and Fawcett, *Essentials of Testing and Assessment*, 173. "Hispanics and Asian-Americans were slightly underrepresented in the sample.

and .58 and .91 for females.[16] Internal consistency scores for the basic scales have ranged between .34 and .87 using Cronbach's alpha.[17]

Additional clarity in distinguishing these emotions may add to the effectiveness of clinical treatment. In this study, the comparison of very-low ISS scores (< 34) with MMPI-2 L, K, and S scales has represented an effort to test the validity of the ISS tool to identify defensiveness responses based on recommendations for further study after using the instrument in clinical research. This study further examined MMPI-2 content scales for fear (FRS), anxiety (ANX), and obsessiveness (OBS), as well as supplementary scales of anxiety (A) and repression (R) to explain presence or absence of differences in high ISS scores associated with anxiety, and very high ISS scores associated with depression, and very low ISS scores thought to be associated with defensiveness.

The motivation for the research design and instruments selected was exploration for a differentiator, possibly described in terms of fear toward avoidance and fear toward withdrawal, which could be used to measure, or distinguish between "fear of reprisal" (guilt) and fear of corruption/powerlessness (shame), and thus provide a basis for future research.[18]

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[16]Ibid.

[17]Ibid. This figure is for basic scales. Intercorrelations between scales were found to be high in discriminate validity testing, because many of the scales use the same questions.

[18]Cook, *Internalized Shame Scale*, 30. A hypothesis that guilt is associated with fear of punishment may also be related to 1 John 4:18.

Limitations

1. This study was conducted with a clinical mental-health treatment patient population. No assurance was present that all diagnostic groups would be represented overall or in both clinics.

2. No assurance was present that MMPI-2 defensiveness patterns would be represented in the population.

3. This study was conducted on a population older than seventeen years of age. Results are not appropriate for generalization to child or adolescent clinical populations.

Assumptions

1. This research was conducted with a population suffering from severe mental-health pathology. It was assumed questions would be answered appropriately. Tests with pattern responses (e.g., all one column, or sequential columns) were excluded.

2. The intake process at these clinics included two large personality tests administered to patients. It was assumed that patient responses on the ISS would not be affected by the order in which the tests were administered. The ISS was administered after all personality testing, except of the first thirty patients (first fifteen from each clinic) to whom the ISS test was administered first. Differences between this subset and the sample population were performed to confirm no covariance.

3. ISS score distributions were assumed to have a normal distribution. The statistical technique and the sample size to be collected were calculated to allow tolerance for non-normal distributions.[19]

4. Because individual diagnoses were translated into diagnostic groups, inter-rater reliability of specific Axis-I diagnosis was not an issue.

5. Bipolar disorder is listed in the DSM-IV-TR as a mood disorder. The diagnosis has aspects of depression and mania, sometimes experienced as anxiety. Previous research showed ISS scores have been lower with this population than with other mood-disorder testing.[20] The assumption of this study was that the population with this disorder would test similarly to other mood disorders. Tests were repeated, excluding this population, to verify no significant impact occurred.

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[19]Mertler and Vannatta, *Advanced and Multivariate Statistical Methods*, 30; and Pallant, *SPSS Survival Manual*, 206.

[20]Julie Highfield, Dominic Markham, Martin Skinner, and Adrain Neal, "An Investigation into the Experience of Self-Conscious Emotions in Individuals with Bi-Polar Disorder," *Clinical Psychology*

6. Morris, Milner, Trower, and Peters have proposed a distinction between "poor-me" and "bad-me" paranoia associated with psychosis.[21] If this distinction is valid, a difference could exist in ISS scores between paranoia associated with perceived bad behavior versus bad essence. The assumption is that no difference would exist. Tests were repeated to verify that this distinction did not have a significant impact on results.

Definitions

Diagnosis: Axis-I mental-health diagnosis based on observed symptom constellations identified in accordance with the DSM-IV-TR, as assigned by a qualified psychiatrist.

Diagnostic Group: One of five categorical families identified as mood, anxiety, substance dependence, psychosis, and dissociation, as they appear in disorder sections of the *Diagnostic and Statistical Manual of Mental Disorders*, Text Revision, 4th ed. (DSM-IV-TR).[22]

Internalized Shame: A constant, self-regenerating state in which a person observes all internal and external stimuli through a circular schema in which the person believes himself or herself to be broken intrinsically or polluted, powerless or hopeless in his or her ability to change, and attributes the negative characteristics to the essence of his or her identity. Experience of this state is represented by self-repeated, self-descriptive thoughts of self as incompetent, inferior, impotent, worthless, and/or rejected. This state

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and Psychotherapy; An International Journal of Theory and Practice 17, no. 5 (September 2010): 402.

[21]Emma Morris, Philip Milner, Peter Trower, and Emmanuelle Peters, "Clinical Presentation and Early Care Relationships in 'Poor-Me' and 'Bad-Me' Paranoia," *British Journal of Clinical Psychology* 50 (2011): 211. Morris, *et al.*, research suggested "bad-me" paranoia (persecution is deserved) was more associated with shame and depression, and less associated with grandiose delusions that patients identified with "poor-me" (persecution is unjustified) paranoia. Additionally, "bad-me" paranoia patients were more associated with over-protective parents; however "poor-me" paranoia patients were NOT characterized by neglect.

[22]American Psychiatric Association, *DSM-IV-TR*, 231.

is thought to occur as a result of chronic disparaging or abusive treatment by others thought to be of position, authority, or worthy of respect.

The following terms are used in special ways in the context of this study, and are defined as follows.

Anger-in/Attack-self: The consistent act of self-ridicule or harming oneself in order to protect oneself from being shamed by another. Examples include passivity, masochism, conformity, and deference. Anger-in expressions are thought to be the result of fear of abandonment.

Anger-out/Attack-others: Behaviors intended to reduce the self-worth or respect of others. Examples include abuse, harmful physical actions, or loud verbalizations of remarks intended to be shaming or disrespectful. Thought to be the result of fear of inferiority, weakness, or vulnerability to another.

Avoidance: Attempts to find alternative activities or distracters in order not to feel shame or deal with its causes. Some examples include alcohol abuse, drug abuse, sexual promiscuity, work hyper-focus, or religious obsession.

Defense Mechanism: A strategy to avoid anxiety producing painful events through the use of behaviors that are socially acceptable.

Disgust: Sensory response to the presence of physical or biological decay or corruption, presumably to aid in avoidance of the consumption of harmful contaminants that could result in death.

Guilt: The emotion resulting from actions out of alignment to a forensic system (e.g. family rules, civil laws, personal beliefs).

Guilt-proneness (Trait-guilt): The tendency to respond based on the expected guilt message, rather than the present situation.

Shame: A disgust response toward self. A response to the perception of cognitive, spiritual, or social corruption/pollution in one's self that would interfere with one's ability to perform at expected levels, or one's desirability by self, God, or others. The emotion is experienced as a state of powerlessness or contamination (dirty). The emotion is considered adaptive or maladaptive, depending on how it is experienced, processed, and expressed.

Shame-proneness (Trait-shame): The tendency to respond based on the expected shame message, rather than the present situation.

Situational or State-guilt: The tendency to respond appropriately to existing guilt input based on current events and social or environmental input.

Situational or State-shame: The tendency to respond appropriately to existing shame input based on current events and social or environmental input.

Withdrawal: The act of retreating or from an offending stimulus. Some examples include hiding oneself (seclusion), averting one's eyes, becoming silent or falling asleep during perceived interrogation. Withdrawal expression behaviors are thought to be the result of fear of reprisal.

Research Design

This study employed a descriptive design. Records were categorized into diagnostic groups (anxiety, depression, substance dependence, psychosis, dissociation) based on primary Axis-I diagnoses. A one-way analysis of variance (ANOVA) was utilized to determine differences between Internalized Shame Scale scores of diagnostic

groups based on primary psychiatric diagnosis of patients attending IOP treatment at two Christian counseling clinics, one in Texas and the other in Illinois (hypothesis 1). Post hoc tests were run on results indicating significant differences in order to make mean score comparisons between groups (hypothesis 2).

A Chi-square test of independence was utilized to determine whether Internalized Shame Scale score categories (very low, high, very high, extremely high) were related to the presence of defensiveness as indicated by MMPI-2 clinical and supplementary scale-score patterns (hypothesis 3).

Procedure for Collecting Data

Both clinics administered the MMPI-2 personality test as part of their existing IOP admissions process.

1. The two facilities were contacted requesting permission to administer the ISS test as part of their normal test battery administration, and to include the results into patient treatment records for the duration of the study. The request was for:
    a. Addition of the ISS instrument in existing intake testing processes (Appendix 5)
    b. Addition of a historical data-collection form (Appendix 8) consisting of three questions to be asked by therapists during their initial therapy sessions
    c. Inclusion of ISS test results, demographic questions, and informed consent forms (Appendix 2) into patient treatment records for the duration of the study
    d. Use of MMPI-2 scores from Basic (clinical), Content, and Supplementary scales
2. The researcher obtained appropriate consent from each facility and provided a consent form to allow patients to decline or agree voluntarily to participate in the study (Appendix 2).
3. The researcher provided staff training on administration and evaluation of the ISS instrument (Appendix 6) and the historical data collection form (Appendix 8).
4. During the training session with clinic staff, discussions occurred to identify modifications necessary to comply with individual facility policy and procedures.

Topics discussed addressed administration of the ISS test and informed consent forms, identification of which staff position would score the ISS, and how the additional demographic information questionnaire was to be administered and answered.

5. Administrators were instructed on the three items that would need to be added to each file: completed ISS test, demographic questions, and signed informed consent form.

6. The historical data collection form included three survey questions (Appendix 8) completed by patients during intake.

7. Psychiatric diagnostic information (Axes I-V) was collected from the physician's intake assessment completed by the site day-program psychiatrist.

8. Personality test scores were collected from the MMPI-2 profile charts in the patient's record.
9. Instructions for completion of the ISS instrument and its scoring were included on the standardized answer forms which were provided by the researcher. The intake coordinator at each clinic administered ISS tests and attached them to the patient treatment chart.

10. The attending therapists scored ISS tests for their use in patient treatment. The results were reviewed before data entry by the researcher. The researcher scored all tests not scored by the therapists. Records with incomplete tests or without informed consent signatures were not included. Completed ISS tests in records without informed consent signatures, were not included in the research; however, they were available to therapists for treatment.

11. The attending psychiatrist made diagnoses in face-to-face assessment sessions as a normal process of clinic intake. When multiple Axis-I diagnosis were given, only the primary diagnosis was used in the analysis.

12. Primary diagnosis and ISS score data were be transferred from patient records and placed directly into the SPSS application on the research laptop by the researcher during on-site visits at each of the clinics. Descriptive statistics were run on the data to ensure all entries contained data, and to make adjustments necessary for data normalization required by statistical procedures.

13. Additional demographic information was collected from record patient information forms by the researcher during the on-site visits for the following characteristics described by ISS test booklet as diagnostic effects.[23]

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[23]Cook, *Internalized Shame Scale*, 20.

a. Age

b. Gender

c. Race (as designated by MMPI)

d. Highest education level (as designated by MMPI)

e. Nationality (as designated by MMPI): nation of origin, or current citizenship

f. Current city of residence

g. Current state of residence

14. Assignment of diagnostic groups was performed by the researcher at the end of data collection, in accordance with DSM-IV-TR sections, and inspected by an external assessor.

15. Assessment of MMPI-2 score patterns was performed by the researcher after data collection, in accordance with MMPI-2 treatment literature, and they were inspected by an external assessor.

16. The IBM SPSS 19.0v® (SPSS) application was used on the research laptop to perform ANOVA and Chi-square analyses.

CHAPTER 4

ANALYSIS OF THE DATA

This chapter describes analyses performed as part of the current study. In review, a one-way analysis of variance was to be used to test the first hypothesis that a significant difference would occur between clinical diagnostic groups in Internalized Shame Scale (ISS) scores. A Fisher-protected least significant difference (FSLD) post-test was to be used to test the second hypothesis, that substance abuse group scores would be significantly lower than the other groups.[1] The third hypothesis would be calculated by a Chi-square test of independence to explore associations between occurrences of "defensive" profile patterns, indicated in MMPI-2 L-, F-, and K-scale scores, with frequencies of ISS test scores in extremely high or very low categories.[2]

Procedure for Analyzing Data

A total of 123 patients participated in intensive outpatient (IOP) treatment at the Richardson, Texas, and Wheaton, Illinois, clinics during the six months of data collection.[3] Sixty-six patients were treated in Richardson, and 57 were treated in Wheaton. Of that number, three declined to participate in the study, six entries were

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[1]Bagby, *et al.*, "Assessing Underreporting and Overreporting," 45; Graham, *MMPI-2*, 54; and William R. Yount, *Research Design and Statistical Analysis in Christian Ministry*, 4th ed. (Fort Worth, TX: W. R. Yount, 2006), 26.

[2]Ibid.

[3]Data collection was performed from 15 July 2012 to 15 January 2013.

invalid, and ten entries had partial data, leaving 104 complete records for analyses. Data from the 104 records were manually entered into the SPSS® statistical analysis application.[4]

Psychiatrists' Axis-I diagnoses were copied from the Physician's Intake Forms in the patient's treatment records. MMPI-2 T-scores for clinical, content, and supplementary scales were entered into SPSS fields using the corresponding MMPI-2 standard abbreviations as field identifiers (Appendix 9). Additional demographic information was copied from the treatment record into various fields of SPSS for each record, including clinic record-tracking number, age, gender, race, highest education level, and current city and state of residence. Where available, clinic record-tracking numbers were used as record identifiers in the data set where available; when not available, a unique tracking number was assigned. Missing data were excluded pairwise. Homogeneity of variance for analysis of variance (ANOVA) was evaluated using Levene's test for homogeneity of variances, and effect size was determined using a partial eta-squared statistic.

Demographic Data

The 104 patient records reviewed included 32 male patients (30.8 percent) and 72 female patients (69.2 percent). Fifty-six of the patients (53.8 percent) lived within fifty miles of the clinic where they were treated, 46 (44.2 percent) traveled to the clinic from out of state, and one was from a neighboring country. The mean age of the patient population was 38.3 years (SD = 13.65); the youngest patient was eighteen years old, and

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[4]Mertler and Vannatta, *Advanced and Multivariate Statistical Methods*, 68; and Pallant, *SPSS Survival Manual*, 206.

the oldest was seventy-two. Almost 90 percent (89.4 percent) of the patients were identified on the MMPI-2 ethnicity entry as white, 4 percent black, and 4 percent Hispanic. Sixty-four percent of the total population was married, half of these (33.7 percent) were in their first marriage, 31.7 percent of the population had never been married, and 4 percent identified themselves as divorced. According to clinic estimates, 80-90 percent of participants attending intensive outpatient treatment at both clinics identified themselves as Christian.[5]

Almost half (fifty-one records, 49 percent) of the records included education information ranging from a minimum of two years to a maximum of twenty years. Within the 51 records, the largest group reported sixteen years of education (seventeen patients), the second largest group reported fourteen years of education (ten patients), and seven reported high school (twelve years) education.

Descriptive Data

Preliminary analysis of internalized shame scores for the first and second hypotheses. Individual ISS-item scores were entered into SPSS manually, and a summing function was used to establish total shame and esteem scores. The population size of 104 was larger than the suggested minimum of thirty, indicating analysis of variance (ANOVA) would be robust to violations of the normal distribution assumption.[6] However, a Kolmogorov-Smirnov analysis performed as a precaution indicated a

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[5]The definition for "Christian" in this instance was "a faith in the 'saving' work of Jesus Christ for entrance into heaven."

[6]Mertler and Vannatta, *Advanced and Multivariate Statistical Methods*, 72; and Pallant, *SPSS Survival Manual*, 206.

negative skew in the dependent variable (DV) distribution: ISS score M = 56.9, SD = 19.1, Skew = -.524, Kurtosis = -.398. ISS scores ranged from 11 to 89 (Figure 1).

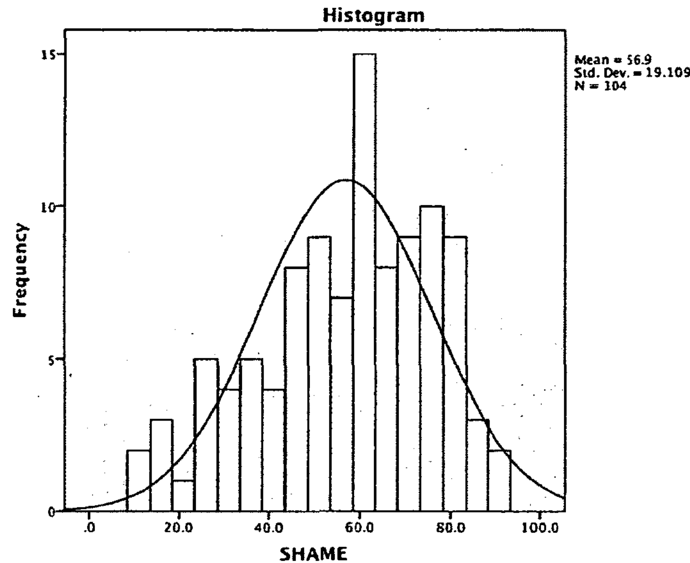

Figure 1. ISS score distribution.

While the negative skew was not anticipated to interfere with analysis of variance, the dependent variable was transformed using a reflect-and-square-root equation to adjust for negative skew, allowing for analysis to be performed on both raw and transformed data as due diligence. The transformed score distribution (Appendix 10) ranged from 2 to 10 (M = 6.15, SD = 1.5, and Skew = .023). Analysis of variance was run using both transformed and untransformed data; however, because negative skew adjustment was precautionary, only raw data results were reported in this study unless there was a significant difference to present.

Several peaks were noticed in the raw distribution histogram, just below 80, just above 60 one close to 50, and two just above and below 20. To confirm the three

peaks were not indicative of a problem with ISS instrument integrity, a Cronbach's alpha coefficient analysis was performed on the items that specifically measured internalized shame.[7] Cronbach's alpha analysis of the Internalized Shame Scale items showed a high internal consistency of .947 so analysis proceeded, but the decision was made to perform post-test analyses to identify alternative influencing factors.[8]

Preliminary analysis of the independent variable for the first and second hypotheses. Records were to be assigned to one of five diagnostic groups based on psychiatric diagnosis and therapeutic focus. Two of the groups, psychosis and dissociation, were removed due to zero subjects. The remaining three groups represented the independent variable (IV) categories for the first and second hypotheses. Inspection of the IV data revealed forty cases (38.4 percent) of the study population were given co-morbid diagnoses of both mood and anxiety disorder. The mediation plan for co-morbid diagnoses, identified in the statement of the problem, was to group records by primary psychiatric diagnosis. This plan was insufficient; however, as further investigation showed, eighty-three cases (79.8 percent) of the study population were given a primary diagnosis of mood disorder, specifically major depressive disorder.

Instead, participants were divided into five independent groups developed by separating records into observed patterns of all Axis-I diagnoses identified for each patient. Group assignment was made using a decision process in which all Axis-I diagnoses identified by the attending psychiatrist were recorded for each record, verified

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[7]Cook, *Internalized Shame Scale*, 12. Items tested included1-30 excluding items 4, 9, 14, 18, 21, and 28 that measure self-esteem.

[8]Ibid. According to Cook, the Internalized Shame Scale regularly presents an internal consistency close to .96, Cronbach alpha coefficient, in a clinical environment.

by MMPI-2 scales and associated psychological assessment, and prioritized by therapeutic priority listed in the master treatment plan. MMPI-2 scale verification was initiated when depression and anxiety were both diagnosed and used Nichols and Crowhurst's "rule of thumb" to determine whether anxiety or depression was primary.[9] When Nichols and Crowhurst's "rule of thumb" was insufficient to make a determination between anxiety and depression primacy, which occurred in all but four occasions, the determination was made by primary treatment focus of the therapist's master treatment plan.

The resultant five groups were Anxiety Alone with nine records (8 percent), mood disorder(s) alone (Mood Alone) with 30 records (28.8 percent), mood and anxiety disorder combinations where the mood disorder was the primary therapeutic focus (MA-M) with thirty records (28.8 percent), mood and anxiety disorder combinations where the anxiety disorder was the primary therapeutic focus (MA-A) with ten records (9.6 percent), and any combinations in which abuse or addiction were currently manifest (SA) with twenty-five records (24 percent). Mean ISS scores for each category are listed in Table 1. To establish group size ratio of 1.5 necessary for analysis of the variance assumptions of homogeneity of variance, the nine anxiety-alone cases were added to the ten MA-A cases to create the MA-A Combined (MA-AC) group (Table 2).[10]

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[9]Nichols and Crowhurst, "Inpatient Mental Health Settings," 238; Green, "Outpatient Mental Health Settings," 253; and Graham, *MMPI-2*, 221.The process used the A scale as a base line. If both ANX and DEP sores are 10T points above the A-scale score, then whichever scale, DEP or ANX, indicates a score 10T points above the other is the primary diagnosis. The A-scale measures the amount of anxiety the patient is experiencing at the time of testing. High A-scale scores with presenting problems indicate concern over issues and readiness for change. Low A-scale scores with presenting problems can indicate low motivation for change. The ANX content scale measures chronic anxiety, tension, worry, and fears.

[10]American Psychiatric Association, *DSM-IV-TR*, 291; and Pallant, *SPSS Survival Manual*, 207, 253, 285. Analyses in this study will be performed on diagnostic groups with the combined (MA-AC) group, and uncombined categories (MA-A, and Anxiety Alone). The Brown-Forsythe (ANOVA), or

Table 1: Mean ISS scores by primary diagnosis group.

Diagnostic Group with Anxiety Alone	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Min	Max
					Lower Bound	Upper Bound		
Anxiety Alone	9	45.000	28.4385	9.4795	23.140	66.860	11.0	80.0
Mood Alone	30	53.467	17.1217	3.1260	47.073	59.860	17.0	85.0
MA-M	30	60.633	16.9309	3.0911	54.311	66.955	26.0	89.0
MA-A	10	52.900	22.1933	7.0182	37.024	68.776	15.0	81.0
SA	25	62.440	16.9806	3.3961	55.431	69.449	23.0	89.0
Total	104	56.904	19.1090	1.8738	53.188	60.620	11.0	89.0

Table 2: Mean ISS scores by diagnostic groups with MA-AC.

Diagnostic Group	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Min.	Max.
					Lower Bound	Upper Bound		
Mood Alone	30	53.467	17.1217	3.1260	47.073	59.860	17.0	85.0
MA-M	30	60.633	16.9309	3.0911	54.311	66.955	26.0	89.0
MA-AC	19	49.158	24.9427	5.7223	37.136	61.180	11.0	81.0
SA	25	62.440	16.9806	3.3961	55.431	69.449	23.0	89.0
Total	104	56.904	19.1090	1.8738	53.188	60.620	11.0	89.0

Preliminary analysis of the dependent variable for the third hypotheses. The current study used the defensive pattern limits defined by Bagby, *et al.*, because they established the most stringent levels: significantly high T-scores (> 65) on the MMPI-2 L- and K-scales, in combination with a lower-than-significant T-score (< 55) on the F-scale.[11] Graham defines defensiveness pattern limits as L- and K-scores above 50T with F-scores below 50T, with the assertion that T-point differences of less than 5 should not

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Pallai's Trace (MANOVA) tests for equity of means will be used for analyses with the "uncombined" categories, because they violate the assumption of homogeneity of variance. To prevent confusion, results of analyses with the combined MA-AC group will be presented unless a significant result is found when the categories are not combined.

[11]Bagby, *et al.*, "Assessing Underreporting and Overreporting," 45; and Graham, *MMPI-2*, 54.

be considered meaningful. Of the 104 records examined, one indicated a "defensive" pattern.[12] Using the limits suggested by Graham, four records indicated a defensive pattern.[13] The record fitting the Bagby, *et al*., limits was not included in the four identified by the Graham limits because the F-scale score was lower than 55 (Bagby minimum) and higher than 50 (Graham minimum). Neither total was enough data to perform the design analysis.

Testing the Hypotheses

The first hypothesis of this study was that a significant difference in ISS scores would occur between Axis-I diagnostic groups. To explore this hypothesis, a one-way between-groups ANOVA was performed at the $\alpha = .05$ level. A Levene's test for homogeneity of variances indicated a nonsignificant result, $p = .183 > \alpha = .05$, indicating no violation of the assumption. Results of the one-way between groups ANOVA indicated no significant difference in ISS scores between the four diagnostic groups at the $\alpha = .05$ level: $F(3, 100) = 2.297$, $p = .082$ (Table 3).[14] The null hypothesis was retained: No significant differences were found in ISS test scores between diagnostic groups.[15]

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[12]The record represented one out of the eleven patients seeking treatment for eating disorders.

[13]In the study population, only three records were diagnosed as adjustment disorder. Two of the three indicated a defensiveness pattern according to Graham. In the study population, twenty-two patients that admitted to previous suicide attempts were diagnosed with major depression. Applying Graham's limits, of the twenty-two patients diagnosed with major depression and that admitted to previous suicide attempts, two indicated defensiveness patterns.

[14]Analysis with non-transformed data violated Leven's Statistic, and the Brown-Forsythe test of Equality of Means showed a Statistic = 2.35, $p = .08$.

[15]Results showed no significant difference for transformed and nontransformed scores, or for four-, or five-category diagnostic groups (five-category: anxiety and MA-A as separate categories).

Table 3: ANOVA Results: ISS score differences between diagnostic groups.*

ISS Score	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	15.624	3	5.208	2.297	.082
Within Groups	226.762	100	2.268		
Total	242.386	103			

* Numbers represent transformed dependent variable data.

The absence of a significant difference between groups indicated analysis of the second hypothesis was not warranted. The null hypothesis was retained: the ISS score mean for the substance-abuse diagnostic group was not significantly larger than means of the anxiety or mood-disorder diagnostic groups.[16]

The third null hypothesis stated that no significant association would exist between frequencies of scores within ISS categories and presence or absence of defensiveness patterns in MMPI-2 L-, F-, and K-scale scores.[17] Preliminary analysis indicated only one record showed an MMPI-2 defensiveness pattern using the limits set by Bagby, *et al.* The low number of records prevented hypothesis three from being tested.[18]

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[16]Mertler and Vannatta, *Advanced and Multivariate Statistical Methods*, 76.

[17]Graham, *MMPI-2*, 58; and Julia N. Perry, Kathryn B. Miller, and Kelly Klump, "Treatment Planning with the MMPI-2," in *MMPI-2: A Practitioner's Guide*, ed. James N. Butcher (Washington, D.C.: American Psychological Association, 2006),148. The L-, K-, and F- scales are considered validity scales. Very high scores on the K-scale can indicate defensiveness, intolerance, and lack of insight. Additionally, high scores on the K-scale have been associated with high education or economic status. Further, very low scores on the K-scale can indicate poor self-concept and distrust of others. High scores on the L-scale represent the tendency to create a favorable impression and a susceptibility to response bias or denial. Very high F-scale scores represent random or exaggerated answering. Very low scores have been associated with a "faking good" profile.

[18]Ibid.

Post-Analysis

The null was retained for the first two current research hypotheses, while lack of data prevented hypothesis three from being tested. However, several questions arose as to whether anomalies in the data influenced these results. With regard to DV distribution observations, the first question was whether the observed peaks were simply the result of noise. The second question was, if peaks in the data distribution were not the result of noise, were they indicators of a lack of precision in the ISS instrument in the current population of 104 subjects? In other words, did multiple components exist within the test instrument itself that created a co-variance in participant scores competing with Axis-I diagnostic categories?[19]

Third, would use of the MMPI-2 instrument alone have made a difference in distinguishing between IV depression and anxiety categories? Fourth, was another observable factor influencing the elevated ISS scores?[20] Fifth, given that an insufficient number of records presented the defensiveness patterns necessary to measure a relationship, the research question was expanded to: What was the relationship between ISS scores and MMPI-2 L-, F-, and K-scale scores? Sixth, previous research and the ISS test manual have reported gender as an influential factor in ISS scores, MMPI-2 scores,

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[19]Yount, *Research Design and Statistical Analysis*, 18-5. Yount defines "noise" as "extraneous, unsystematic variability" that adversly impacts statistical power and risk of committing a type-1 (rejecting a true null), or type-2 (retaining a false null) error.

[20]This question was based on the observation that the majority of ISS scores were elevated across the population, and no significant difference was found in ISS scores between Axis-I diagnostic groups.

and Axis-I diagnosis; so, was gender a factor in this study?[21] Seventh, previous research has suggested differences could exist in shame and guilt responses, were guilt- and shame-differences a factor in this study?[22] The following analyses were performed to explore these questions.

Question 1: Was the Presence of Frequency Peaks in the Dependent Variable Distribution the Result of Noise?

Preliminary analysis indicated three peaks in the DV distribution occurring within the extremely high, high, and very low ISS score categories. Descriptive statistics showed seventeen records (16.3 percent) with scores in the very low category, seven records in the normal category (6.7 percent), twenty-six records (25 percent) in the high category, twenty-three records (22.1 percent) in the very high category, and thirty-one records (29.8 percent) in the category of extremely high. Cook identified very high ISS scores as associated with depression, high category scores to be associated with anxiety, and scores below 45 as "normal," although he speculated that very low scores could present an indication of pathology.[23]

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[21]Brene Brown, *Men, Women & Worthiness*, Audio CD Set (Boulder, CO: Sounds True, 2012), Session 2.2; Kristen P. Lindgren, Yuichi Schoda and William H. George, "Sexual or Friendly? Associations about Women, Men and Self," *Psychology of Women Quarterly* (*American Psychological Association*) 31 (2007): 191; Marie Hoffman, "From Libido to Love: Relational Psychoanalysis and the Redemption of Sexuality," *Journal of Psychology and Theology* (Rosemead School of Psychology, Biola University) 35, no. 1 (2007): 82; and Megan R. Yost and Eileen L. Zurbriggen, "Gender Differences in the Enactment of Sociosexuality: An Examination of Implicit Social Motives, Sexual Fantasies, Coercive Sexual Attitudes and Aggressive Sexual Behavior," *Journal of Sex Research* (Society for the Scientific Study of Sexuality) 43, no. 2 (May 2006): 164.

[22]Carter, Knox, McFadden, and West, "Panel," 336; Chekroun and Nugier, "I'm Ashamed Because of You," 479; Cook, *Internalized Shame Scale*, 28; Erikson, *Insight and Freedom*, 9; Farmer and Andrews, "Shameless Yet Angry," 59; Kalat and Shiota, *Emotion*, 32; Pedersen, *et al.*, "Impact of Rumination," 281; and Pinto-Gouveia and Matos, "Shame Memories," 282.

[23]Cook, *Internalized Shame Scale*, 12.

Given the expected association between anxiety, depression, and ISS scores, elevated high scores were expected; a peak of very low scores was not. The very low peak was tested using a Chi-square goodness of fit to confirm the peak was a significant departure from score anomalies expected in a random sampling.[24] If frequencies were significantly different than equal frequencies, or proportional expectations of escalated high scores and low "normal" scores in a clinical environment, then further analysis would be warranted.

Chi-square test for goodness of fit indicated a significant difference between observed and expected frequencies of ISS scores in each ISS category when all categories were given equal probability of occurring: $X^2 = 16.39$, DF = 4, N = 104, p = .003.[25] Observation of the results indicated the greatest differences occurred between observed and expected frequencies in the Normal and Extremely High categories (Table 4).

Table 4: Chi-square: Observed-expected frequencies of ISS scores given equal probability of occurrence for all ISS score categories.

ISS Categories	Observed N	Expected N	Residual
Very Low	17	20.8	-3.8
Normal	7	20.8	-13.8
High	26	20.8	5.2
Very High	23	20.8	2.2
Extremely High	31	20.8	10.2
Total	104		

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[24]Yount, *Research Design and Statistical Analysis*, 23-2.

[25]Pallant, *SPSS Survival Manual*, 216; and Yount, *Research Design and Statistical Analysis*, 23-4. No effect size (phi coefficient or Cramer's V) statistics are indicated in a X^2 Goodness of fit with proportional expected frequencies.

A second Chi-square goodness of fit test was run with the assumption that scores below 45, categorized as "normal," would not be expected in a clinical intensive outpatient setting.[26] Results indicated a significant difference and observed values did not fit expected frequencies: $X^2 = 30.42$, DF = 4, N=104, $p < .001$. Observation of the results indicated the greatest differences between observed and expected frequencies were in the very low category (Table 5).

Table 5: Chi-Square: Observed-expected frequencies of ISS scores given probability of occurrence for escalated ISS score categories.

ISS Categories	Observed N	Expected N	Residual
Very Low	17	5.2	11.8
Normal	7	5.2	1.8
High	26	31.2	-5.2
Very High	23	31.2	-8.2
Extremely High	31	31.2	-.2
Total	104		

A third Chi-square was run with the assumption that scores between 34-45 were in a normal range and not expected in a clinical setting, while scores below 34 indicated something other than normal, and thus would be expected in a clinical setting. Results indicated no significant difference between observed and expected values: $X^2 = 6.14$, DF = 4, N=104, p = .189 (Table 6) suggesting the frequency of ISS scores below 35 and above 45 occurred at a significant level and were not likely the result of high or low scores associated with random noise.[27]

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[26]Cook, *Internalized Shame Scale*, 12.

[27]Yount, *Research Design and Statistical Analysis*, 18-5.

Table 6: Chi-square: Observed-expected frequencies of ISS scores probability for escalated and very-low scores.

ISS Categories	Observed N	Expected N	Residual
Very Low	17	25.0	-8.0
Normal	7	4.2	2.8
High	26	25.0	1.0
Very High	23	25.0	-2.0
Extremely High	31	25.0	6.0
Total	104		

Question 2: Did ISS Precision in the Current Population Influence the Outcomes of this Study?

Previous research outcomes have suggested the possibility that the ISS may not be a unidimensional instrument.[28] Participants in this study varied in number and type of diagnosis assigned. Was multidimensionality of the instrument an issue, and if so, was it pronounced enough that scores of patients in different diagnostic groups would vary significantly between those dimensions? A principal component analysis (PCA) was performed to examine whether factors within the ISS could have influenced outcomes, and factor scores of the resultant components were tested for significant variance between diagnostic groups. Of the thirty items in the ISS test, twenty-four are specifically associated with internalized shame. These twenty-four shame items were subjected to PCA.[29]

Prior to initiating the PCA, the data was examined for component-analysis suitability. While the population size was considered small for PCA, and ratio of

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[28]Vikan, *et al.*, "Test of Shame," 198. Vikan, *et al.*, grouped the questions according to the factors they identified as: factor 1, test items 1-3, 6-8, 10-13, and 15-16; factor 2 items were 26-27 and 29-30; and factor 3 items 5, 17, 19-20 and 22-25. The names identified for each group were factor 1, inadequacy; factor 2, emptiness; and factor 3, vulnerability.

[29]Mertler and Vannatta, *Advanced and Multivariate Statistical Methods*, 234.

participants to items was less than 5:1 (4.33:1), several high-loading marker variables (>.80) were present.[30] Kaiser Meyer-Olkin value was .89, greater than the required value of .6.[31] Bartlett's Test of Sphericity was significant (< .001) indicating the factorability of the correlation matrix. Additionally, analysis indicated that a one-component model did not fit empirical correlations well, 160 (51 percent) of the residuals, correlations between reproduced and empirical correlations, had an absolute value greater than .05, indicating the probability of a greater-than-one component model.[32]

PCA was conducted using an Oblimin rotation, because component correlation was anticipated as aspects of the common concept, Internalized Shame. Four criteria were used to determine the number of components to retain: percent of total variability, eiganvalue, scree plot, and residuals model fit.[33] Using the Mertler and Vanatta "rule of thumb" of retaining factors accounting for 70 percent of total variability, a model of six components was indicated.[34] At six components, all but six of the twenty-four items showed communalities greater than .70. Kaizer's rule indicated four components with eigenvalues greater than 1.[35] At four components, Kaizer eiganvalues became suspect

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[30]Pallant, *SPSS Survival Manual*, 183.

[31]Ibid., 199.

[32]Mertler and Vannatta, *Advanced and Multivariate Statistical Methods*, 237. ISS score distributions indicated outliers for questions 1-3, 7, 15-16, 27, and 29. Additional investigation showed the outliers were the result of "0" answers on the ISS Likert scale for the "never" response. Because of the number of responses, and the importance of distinction of "never" versus "seldom" in this study, no adjustments to the data were made.

[33]Ibid., 249; and Pallant, *SPSS Survival Manual*, 199.

[34]Mertler and Vannatta, *Advanced and Multivariate Statistical Methods*, 235.

[35]Ibid., 234; and Pallant, *SPSS Survival Manual*, 199.

because, while fewer than thirty variables were present as recommended for Kaiser's rule, only six of the twenty-four communalities were > .70.[36]

Analysis of the Scree plot (Appendix 11, Figure 5) indicated a break after the third component, indicating two or three factors; however, the two-component solution showed a poor model fit with 118 (42 percent) of the residuals showing an absolute value greater than .05. Mertler and Vanatta have suggested that components with four or more loadings above .60 can be considered reliable, even in small sample sizes.[37] This pattern of loading began to occur between three and five components. Five components showed the best model fit, with 85 (30 percent) of residuals showing absolute values greater than .05, and accounted for 67.6 percent of total variation. Based on best balance of model fit and frequency of loading items per component, PCA was performed with five components using Oblimin rotation.

The five-component model explained 67.6 percent of variance, with Component 1 contributing 45.5 percent, Component 2 contributing 8 percent, component 3 contributing 5.5 percent, component 4 contributing 4.5 percent, and component 5 contributing 4 percent. Oblimin rotation was performed further to interpret the components. The rotated solution indicated strong loadings in all five components, which is consistent with previous research suggesting the ISS is a multidimensional instrument (Table 7).[38]

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[36]Mertler and Vannatta, *Advanced and Multivariate Statistical Methods*, 248; and Pallant, *SPSS Survival Manual*, 65.

[37]Mertler and Vannatta, *Advanced and Multivariate Statistical Methods*, 238, 242. Model fit for component extractions were: 3 components, model fit, 40 percent, 4 = 36 percent, and 5 = 30 percent.

[38]Vikan, *et al.*, "Test of Shame," 198. Vikan, *et al.*, grouped the questions according to the factors they identified as: factor 1, test items 1-3, 6-8, 10-13, and 15-16; factor 2 items were 26-27 and 29-30; and factor 3 items 5, 17, 19-20 and 22-25. The names identified for each group were factor 1,

Table 7: Pattern and structure matrix for PCA with Oblimin rotation of five-factor solution of ISS items.

Item #	Pattern coefficients					Structure coefficients					Comm.
	Components					Components					
	1	2	3	4	5	1	2	3	4	5	
I19	**.782**	-.003	-.158	-.047	.002	**.827**	.358	-.301	-.379	-.428	.710
I6	**.699**	-.012	.035	-.415	.118	**.797**	.337	-.112	-.647	-.364	.775
I13	**.668**	-.024	-.132	.001	-.083	**.723**	.305	-.260	-.306	-.427	.546
I20	**.562**	.250	-.247	-.010	.050	**.683**	.518	-.404	-.327	-.378	.598
I5	**.559**	.127	.321	-.078	-.187	**.675**	.362	.145	-.374	-.482	.589
I17	**.552**	-.004	-.174	.242	-.353	**.657**	.322	-.307	-.126	-.569	.585
I7	**.484**	.242	.234	-.205	-.137	**.687**	.492	.036	-.500	-.504	.632
I1	.375	.203	.323	-.277	-.288	.651	.470	.118	-.559	-.594	.703
I29	.038	**.937**	.046	.028	.094	.339	**.893**	-.185	-.248	-.284	.807
I30	-.094	**.882**	-.040	.244	-.155	.237	**.841**	-.254	-.061	-.385	.775
I27	.008	**.733**	-.085	-.217	-.078	.436	**.859**	-.317	-.493	-.472	.804
I26	.041	**.711**	-.175	-.215	.061	.406	**.816**	-.381	-.457	-.355	.740
I22	.149	.245	**-.640**	-.053	.063	.349	.462	**-.725**	-.243	-.247	.626
I24	.118	.079	**-.545**	-.082	-.312	.432	.419	**-.654**	-.329	-.532	.633
I25	.329	.121	**-.540**	-.097	-.161	.590	.487	**-.671**	-.388	-.507	.735
I3	.060	-.004	-.172	**-.718**	-.102	.428	.335	-.283	**-.797**	-.419	.688
I2	-.115	.006	-.157	**-.587**	-.426	.362	.362	-.285	**-.714**	-.612	.685
I16	.230	.037	.166	**-.585**	-.042	.472	.288	.040	**-.685**	-.350	.542
I23	-.032	.213	-.435	**-.462**	-.069	.348	.490	-.551	**-.593**	-.385	.633
I10	.272	.211	.081	-.339	-.281	.615	.519	-.114	-.608	-.607	.645
I15	-.051	.012	.000	-.093	**-.816**	.393	.351	-.156	-.369	**-.829**	.694
I11	.026	.260	.087	-.059	**-.637**	.450	.523	-.109	-.370	**-.759**	.644
I12	.260	-.002	-.192	-.122	**-.576**	.627	.422	-.358	-.455	**-.782**	.737
I8	.413	.011	-.094	.007	**-.522**	.688	.405	-.265	-.360	**-.745**	.699

Note: major loadings for each item are bolded.

Components were named based on the statements of the items assigned. Item statements appeared generally to possess characteristics similar to what Tracy identified as self-concept/other-concept. Component titles represent the person's attitude toward self, joined with the person's expectations of others. Component 1 (45.5 percent of variance contribution) included items 1, 5-7, 13, 17, and 19-20. These "Punish-

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inadequacy; factor 2, emptiness; and factor 3, vulnerability.

Self/Judgment Pending," items appeared related to an attitude of self-punishment, inadequate to self-imposed expectations of perfection, in which judgment is inevitable, but still pending in the future. Component 2 (8 percent) included items 26-27, and 29-30. This component was designated "Empty-Self" in the sense that items included statements regarding some external meaning as missing within the person. Component 3 (5.5 percent) included items 22 and 24-25. This component was designated "Fragile-Self/Exposed," as items included statements in which the person believed they would break at any moment, and their weakness was visible to others, but not yet observed. Component 4 (4.5 percent) included items 2-3, 10, 16, and 23 was designated "Powerless-Self/Under-Judgment" in that they indicate powerlessness to and obligated by other-imposed expectations of perfection. These statements suggested the person's faults were seen by all, and included a punished-by-others aspect, presently occurring. Component 5 (4 percent) included "Defective-Self/Inferior" items 8, 11-12, and 15. Items included statements like, "I see myself as small," "I am defective, something's wrong with me," "I am not as important as others," and "I strive for perfection, and continually fall short."

The component correlation matrix indicated the presence of a medium positive correlation between the Punish-Self and Empty-Self Components ($r = .391$), small and medium positive correlations between the Powerless/Under Judgment Component and the Fragile-Self ($r = .116$), and Defective-Self ($r = .358$) components, medium negative correlations between the Powerless/Under Judgment Component and the Punish-Self ($r = -.403$), and Empty-Self ($r = -.320$) components respectively, small negative correlations between the Fragile-Self/Exposed component with Punish-Self ($r = -.177$),

and Empty-Self (r = -.261) components, and large and medium negative correlations between Defective-Self/Inferior component with the Punish-Self (r = -.493), and Fragile-Self (-.404) components, respectively. The presence of medium and large correlations between components confirmed the use of Oblimin rotation in the analysis.

To validate if the original ISS peaks were associated with the components would have required subjecting each component to a Chi-Square analysis to search for the presence of significant peaks compared to proportions identified in question 1. If significant peaks were observed, component data would then be subjected to an analysis of variance to consider if the peaks revealed a significant difference between Axis-I diagnoses, which represents the ultimate concern of this investigation. The decision was made to reduce the number of analyses by going directly to the question of interest: did the presence of multiple components influence whether differences were found between Axis-I diagnoses groups for ISS scores?

A multivariate analysis of variance (MANOVA) was performed to explore if significant differences between diagnostic groups would occur for scores on the ISS questions associated with PCA-identified components. The independent variable consisted of Axis-I diagnostic group categories. Factor scores, score means for variables loading on each component, were calculated and used as the four dependent variables for the MANOVA (Table 8).[39]

Assumption testing was performed to verify normality, linearity, univariate and multivariate outliers, homogeneity of variance-covariance matrices, and multicollinearity, with no serious violations noted. A significant difference was found in Component scores

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[39]Mertler and Vannatta, *Advanced and Multivariate Statistical Methods*, 241.

Table 8: Descriptive statistics for MANOVA
of ISS components and diagnostic groups.

Descriptive Statistics

	DXGRP	Mean	Std. Dev.	N
Component 1: Punish-Self/ Judgment Pending	Mood Alone	20.0741	5.69700	27
	MA-M	21.0800	6.38305	25
	MA-AC	17.7333	8.78690	15
	SA	22.0417	6.64948	24
	Total	20.4835	6.75337	91
Component 2: Empty-Self	Mood Alone	8.4444	4.32642	27
	MA-M	11.3200	3.37540	25
	MA-AC	9.0667	5.62478	15
	SA	11.7917	3.32290	24
	Total	10.2198	4.28383	91
Component 3: Fragile-Self/Exposed	Mood Alone	4.1111	3.35506	27
	MA-M	6.6000	2.98608	25
	MA-AC	4.6000	3.18030	15
	SA	5.5000	3.38796	24
	Total	5.2418	3.33447	91
Component 4: Powerless-Self/ Under-Judgment	Mood Alone	10.8519	4.12966	27
	MA-M	12.8000	4.52769	25
	MA-AC	11.0667	5.14735	15
	SA	13.6667	3.34491	24
	Total	12.1648	4.33657	91
Component 5: Defective Self/ Inferior	Mood Alone	9.3333	3.76216	27
	MA-M	9.9200	3.68465	25
	MA-AC	9.2000	4.70865	15
	SA	9.9167	4.02078	24
	Total	9.6264	3.92329	91

between Axis-I diagnostic groups, $F(15, 230) = 1.87$, $p = .027$; Wilks's Lambda = .728, and medium effect size, partial eta-squared = .101.[40] When the component dependent variables were examined individually, using a Bonferroni adjusted $\alpha = .012$, none reached a significant difference. The significant, medium effect size difference indicated some set of questions might have been more aligned to one of the diagnostic groups than the others. The lack of power to identify which group in post-analysis component differences

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[40]Pallant, *SPSS Survival Manual*, 254, 296.

suggests that, in the current population of 104, the multiple components were likely not a significant factor influencing retention of null hypotheses in this study.

Question 3: Would a Significant Difference in ISS Scores Have Occurred Between Anxiety and Depression Defined Solely by Use of MMPI-2 Scales as the IV?

Co-morbidity of anxiety and depression diagnoses resulted in the creation of an alternate method for categorization of records into IV diagnostic groups. The following analysis was performed to explore whether sole use of the MMPI-2 instrument to establish IV categories, versus clinic diagnostic protocol, would have resulted in different outcomes.

Clinical scales 2 (D) for depression, and 7 (Pt) for psychesthenia, in combination with content scales DEP (depression), and ANX (anxiety), are the MMPI-2 scales most associated with depression and anxiety.[41] However, the use of individual scales to establish a distinction between depression and anxiety is discouraged in MMPI-2 test documentation. Graham has proposed an alternative analysis method that makes use of MMPI-2 clinical-scale two-point code types to establish diagnostic groupings. Two-point groups were identified for the population of the current study; however, many category frequencies contained two or three records in each category. Because the analysis interest was mainly in the distinction between anxiety and depression, two-point

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[41]Nichols and Crowhurst, "Inpatient Mental Health Settings," 238; Green, "Outpatient Mental Health Settings," 253; and Graham, *MMPI-2*, 221. The OBS content scale, associated with high rumination of mistakes and problems, was not included for clarity, because it was not identified by Nichols and Crowhurst's recommendations. High scores can correlate with obsessive or compulsive behaviors like counting or checking. The ANX scale has been found to be correlated highly ($r = .8$) with the A-scale and with Scale-7 (Ps) discussed earlier.

groups were combined based on the highest D, Pt, or Other highest point scores to increase sample size and normal distribution in each category (Table 9).[42]

Table 9: ISS score descriptive data by MMPI-2 two-point code categories.

2 Point Codes	N	Combined 2pt Groups	Combined 2Pt Group N
72	4	Pt	20*
73	3		
74	4		
76	4		
78	6		
21	5	D	30
23	8		
24	7		
26	8		
28	2		
27	17	D > Pt	17
08	2	Other	31
14	3		
31	3		
34	8		
36	2		
46	5		
48	4		
68	3		
93	1		
94	1		
Total	99**		98*

*As result of descriptive analysis, one 72 outlier was removed.
** Records missing data = 5

A One-way between-groups ANOVA was performed to explore ISS score differences between MMPI-2 two-point code groups. No significant difference was

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[42]Nichols and Crowhurst, "Inpatient Mental Health Settings," 238; Green, "Outpatient Mental Health Settings," 253; and Graham, *MMPI-2*, 114. The 27/72 high-low order was maintained, because the intention was to test whether depression high or anxiety high could be a differentiating factor.

indicated in the distribution of ISS scores across MMPI two-point category groups: F (3, 94) = 2.496, p = .065. The nonsignificant results suggest that exclusive use of MMPI-2 scores in this study would likely not have clarified differences in ISS scores between depression and anxiety diagnosis groups.

Question 4: Were ISS Scores Related to the Number of Axis-I Diagnoses, Rather than Diagnosis Type?

In their research, Vikan, *et al.*, suggested that co-morbidity between depression and anxiety could be the result of shame levels in the participants, and indicative of the number of symptoms they present.[43] The current study did not have access to symptom specific input, but instead observed number of Axis-I diagnoses identified for each record, which were based on symptom observation. This proposal by Vikan, *et al.*, led to the question as to whether the frequency of Axis-I diagnoses, rather than the disorder type, could be related to internalized shame scores. The current study did not have access to symptom-specific input, but instead observed number of Axis-I diagnoses identified for each record, which were based on symptom observation. To examine this possibility, a tally was made of identified Axis-I diagnoses for each record, representing the total number of symptom clusters identified by practitioners for each patient. A Spearman's rho correlation revealed a small positive relationship between ISS scores and number of Axis-I diagnoses: r = .28, n = 102, p = .005 (Table 10). The small positive correlation indicated the number of symptoms could have been a factor in ISS scores. A larger population would likely be required to investigate further.

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[43]Vikan, *et al.*, "Test of Shame," 196.

Table 10: Correlation of number of Axis-I diagnosis to ISS shame scores.

			DxSUM	SHAME
Spearman's rho	Axis-I Tally	Correlation Coefficient	1.000	.276**
		Sig. (2-tailed)	.	.005
		N	102	102
	ISS Score	Correlation Coefficient	.276**	1.000
		Sig. (2-tailed)	.005	.
		N	102	104

**Correlation is significant at the 0.01 level (2-tailed).

Question 5: Did Any Relationship Exist Between ISS scores and MMPI-2 F-, K-, and L-scale Scores?

Absence of defensiveness patterns in MMPI-2 L-, F-, and K-scale scores prevented testing for associations with ISS categories. A Pearson's r correlation was run to explore if any relationship existed between ISS scores and the L-, F-, and K-scales. ISS scores revealed a large positive correlation to F-scale scores, $r = .52$, $n = 99$, $p < .0005$, representing 26.6 percent of shared variance, with high ISS scores associated with exaggerated answering, and low scores associated with "faking good."[44] ISS scores showed a large negative correlation to K-scale scores, $r = -.54$, $n = 99$, $p < .005$, representing 28.6 percent of shared variance, with high ISS scores associated with poor self-concept and distrust of others, while low ISS scores would be associated with defensiveness and intolerance. ISS scores showed a small negative correlation to L-Scale

[44]Bagby, *et al.*, "Assessing Underreporting and Overreporting," 48; and Pallant, *SPSS Survival Manual*, 132-4. In review: K-scale, very high scores can indicate defensiveness, intolerance, and lack of insight. K-scale, very low scores can indicate poor self-concept and distrust of others. L-scale, high scores represent the tendency to create a favorable impression and a susceptibility to response bias or denial. F-scale, very high scores represent random or exaggerated answering. F-scale very low scores have been associated with a "faking good" profile.

scores, r = -.29, n = 99, and p = .004, representing only 8 percent of shared variance (Table 11). The results indicate that, while associations exist between ISS scores and MMPI-2 validity scales, the relationship is primarily associated with the F- and K-scales, and is not contingent on the escalation of both K- and L-scales necessary for the defined "defensiveness" pattern.

Table 11: Correlations between ISS scores and MMPI-2 clinical F-, L-, and K-scales.

		f	l	k
ISS Score	Pearson Correlation	.516**	-.287**	-.535**
	Sig. (2-tailed)	.000	.004	.000
	N	99	99	99

**Correlation is significant at the 0.01 level (2-tailed).

Question 6: Did Male and Female Differences Influence ISS Scores Between Axis-I Diagnostic Groups?

Gender differences have been identified as an influential factor in MMPI-2 testing, ISS testing, and Axis-I diagnosis.[45] To examine whether gender differences were a factor in the current research, a two-way analysis of variance was initiated to examine differences between in diagnostic groups for ISS scores by gender (Table 12). Levine statistic was not significant (F (7, 96) = 1.14, p = .344) indicating the assumption of equal error variance of the dependent variable across diagnostic groups was not violated. Interaction effect between gender and diagnostic group was not statistically significant

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[45]Brown, "Men, Women and Worthiness," Session 2.2; Cook, *Internalized Shame Scale*, 14; Lindgren, Schoda, and George, "Sexual or Friendly," 191; Hoffman, "From Libido to Love," 82; and Yost and Zurbriggen, "Gender Differences in the Enactment of Sociosexuality," 164.

F (3, 96) = .322, p = .809 (Table 13). No statistically significant main effect was shown for diagnostic groups, F (3, 96) = 2.3, p = .081. The analysis did indicate female respondents had significantly higher ISS scores than male respondents: F (1, 96) = 8.36, p = .005, partial eta-squared = .08 indicating a medium effect size.[46] While female scores were significantly higher than male scores there was no significant interaction between diagnostic group and gender, suggesting gender was likely not a factor in ISS score differences between diagnostic groups in the current study.

Table 12: Descriptive statistics for ISS scores between diagnostic groups separated by gender.

Dependent Variable: ISS Score

Diagnostic Group	Gender	Mean	Std. Deviation	N
Mood Alone	Male	42.727	13.8209	11
	Female	59.684	15.9654	19
	Total	53.467	17.1217	30
MA-M	Male	54.000	19.1137	4
	Female	61.654	16.7498	26
	Total	60.633	16.9309	30
MA-AC	Male	41.000	25.4222	8
	Female	55.091	23.9894	11
	Total	49.158	24.9427	19
SA	Male	56.889	14.7516	9
	Female	65.563	17.7875	16
	Total	62.440	16.9806	25
Total	Male	47.688	18.6832	32
	Female	61.000	17.9451	72
	Total	56.904	19.1090	104

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[46]Pallant, *SPSS Survival Manual*, 254.

Table 13: Two-way ANOVA: Gender Differences for ISS scores between Axis-I diagnosis groups.

Dependent Variable: ISS Score

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta-squared
Corrected Model	6237.131[a]	7	891.019	2.726	.013	.166
Intercept	232040.195	1	232040.195	710.012	.000	.881
Diagnostic Group	2268.666	3	756.222	2.314	.081	.067
Gender	2732.025	1	2732.025	8.360	.005	.080
Diagnostic Group * Gender	315.851	3	105.284	.322	.809	.010
Error	31373.907	96	326.812			
Total	374368.000	104				
Corrected Total	37611.038	103				

a. R Squared = .166 (Adjusted R Squared = .105)

Question 7: Did Shame and Guilt Differences Influence ISS Scores Between Axis-I Diagnostic Groups?

Nichols and Crowhurst suggested the possibility that the MMPI-2 self-alienation (Pd_5) and Self-Depreciation (DEP_3) subscales, in concert with the Negative Emotionality/Neuroticism (NEGE) supplementary scale, could be used as measures for guilt.[47] Sweezy has suggested shame and guilt are separate emotions with distinct functions, whereas Chao, Cheng, and Chiou have proposed the two names represent two

[47]Nichols and Crowhurst, "Inpatient Mental Health Settings," 224. The Pd_5 scale is a clinical subscale of the Psychopathic Deviate clinical scale (Pd). High scores on the Pd scale identify narcissism, externalization of blame, exploitiveness, and hostility. The Pd_5 subscale represents the level to which the subject self-alienates or ruminates on past mistakes, "brooding and apathy scale." The DEP_3 scale is a subscale of the DEP (depression) content scale. High scores on the DEP scale represent depression ideation, brooding, pessimism, guilt, remorse, feelings of worthlessness, and suicidal ideation. The DEP_3 scale represents the subset of questions associated with self-depreciation. The NEGE scale is one of five scales collectively called the personality psychopathology five, or PSY-5. High scores on the NEGE scale represents negative emotional dysregulation, worry, stress, and hypersensitivity.

aspects of the same emotion.[48] The following assessments were performed to explore similarities between interactions of the Pd_5, DEP_3, and NEGE scale scores alleged to be associated with guilt, and ISS scores proposed to be associated with shame. Additionally, differences were explored in scale score differences between Axis-I diagnostic groups.[49]

A Pearson's r statistic revealed large positive correlations between ISS scores for all three scales: DEP_3 $r = .691$, $n = 98$, $p < .001$, Pd_5 $r = .668$, $n = 98$, $p < .001$, and NEGE $r = .630$, $n = 98$, $p < .001$. The correlation results indicated high ISS scores were associated with high levels of self-alienation, brooding, and rumination (Pd_5), self-depreciation (DEP_3), emotion dysregulation, stress, and hypersensitivity (NEGE).

A one-way between groups MANOVA was used to examine differences between Axis-I diagnostic group IV categories, for DV Pd_5, DEP_3, and NEGE content scale scores. Preliminary assumption tests were performed to check normality, linearity, univariate, and multivariate outliers, homogeneity of variance-covariance matrices, and multicollinearity with no serious violations. Levene's test of equality of error variances was less than .05 for all three dependent variables, so alpha levels were reduced to .01 to adjust for a more conservative significance level.[50] Descriptive statistics for the MANOVA are included in Table 14.

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[48]Chao, Cheng, and Chiou, "Psychological Consequence," 203; Elison and Partridge, "College Athletes," 20; Stiebert, *Construction of Shame*, 50; and Sweezy, "Teenager's Confession," 179.

[49]Pallant, *SPSS Survival Manual*, 135. An analysis of the relationship between MMPI scale scores and ISS categories was included in the spirit of the third hypothesis: to examine factors influencing the presence of extremely high and low ISS test scores.

[50]Ibid., 294.

Table 14: MANOVA descriptive statistics for Pd_5, DEP_3, and NEGE scale scores between diagnostic groups.

Descriptive Statistics

Content Scale	Diagnostic Group	Mean	Std. Deviation	N
	Mood Alone	67.000	10.8755	30
	MA-M	69.444	10.7679	27
Pd_5	MA-AC	66.250	15.1239	16
	SA	79.800	7.6594	25
	Total	70.816	12.0663	98
	Mood Alone	64.400	9.2311	30
	MA-M	66.852	10.5892	27
DEP_3	MA-AC	63.188	14.8738	16
	SA	71.480	11.0872	25
	Total	66.684	11.3896	98
	Mood Alone	59.133	11.2671	30
	MA-M	62.481	9.3987	27
NEGE	MA-AC	60.938	16.7550	16
	SA	68.360	9.1918	25
	Total	62.704	11.7756	98

MMPI-2 scale scores between diagnostic groups were significantly different, $F(9,282) = 2.8$, $p = .004$; Pillai's Trace = .25; partial eta-squared = .082 (Table 15).[51] When the dependent variables were considered separately Pd_5 was the only subscale to show significance at the adjusted $\alpha = .01$, $F(3, 94) = 7.88$, $p <. 001$, partial eta-squared = .20 (Table 16).[52]

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[51]Ibid. Pallant suggests the Pillai's Trace is more robust in the case of assumption violations.

[52]Significance for NEGE subscale did not achieve the adjusted level of .001.

Table 15: MANOVA Multivariate results for Pd_5, DEP_3, and NEGE scale scores between diagnostic groups.

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta-squared
Intercept	Pillai's Trace	.979	1404.203[b]	3.000	92.000	.000	.979
	Wilks's Lambda	.021	1404.203[b]	3.000	92.000	.000	.979
	Hotelling's Trace	45.789	1404.203[b]	3.000	92.000	.000	.979
	Roy's Largest Root	45.789	1404.203[b]	3.000	92.000	.000	.979
Diagnostic Group	Pillai's Trace	.246	2.802	9.000	282.000	.004	.082
	Wilks's Lambda	.758	3.005	9.000	224.054	.002	.088
	Hotelling's Trace	.314	3.167	9.000	272.000	.001	.095
	Roy's Largest Root	.297	9.299[c]	3.000	94.000	.000	.229

a. Design: Intercept + Diagnostic Group

b. Exact statistic

c. The statistic is an upper bound on F that yields a lower bound on the significance level.

Table 16: MANOVA Between-subjects effects for Pd_5, DEP_3, and NEGE scale scores between diagnostic groups.

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta-squared
Corrected Model	Pd_5	2839.027[a]	3	946.342	7.884	.000	.201
	DEP_3	927.909[b]	3	309.303	2.495	.065	.074
	NEGE	1233.513[c]	3	411.171	3.164	.028	.092
Intercept	Pd_5	461635.565	1	461635.565	3845.713	.000	.976
	DEP_3	409052.757	1	409052.757	3299.015	.000	.972
	NEGE	364186.122	1	364186.122	2802.141	.000	.968
Diagnostic Group	Pd_5	2839.027	3	946.342	7.884	.000	.201
	DEP_3	927.909	3	309.303	2.495	.065	.074
	NEGE	1233.513	3	411.171	3.164	.028	.092
Error	Pd_5	11283.667	94	120.039			
	DEP_3	11655.285	94	123.992			
	NEGE	12216.905	94	129.967			
Total	Pd_5	505588.000	98				
	DEP_3	448361.000	98				
	NEGE	398767.000	98				
Corrected Total	Pd_5	14122.694	97				
	DEP_3	12583.194	97				
	NEGE	13450.418	97				

a. R Squared = .201 (Adjusted R Squared = .176)

b. R Squared = .074 (Adjusted R Squared = .044)

c. R Squared = .092 (Adjusted R Squared = .063)

To determine where significant differences between Axis-I diagnostic groups occurred in Pd_5 subscale scores, a one-way analysis of variance was executed (Table 17).[53] Levine statistic was significant (F (3, 94) = 2.87, p = .040) indicating the assumption of equal error variance of the dependent variable across diagnostic groups was violated; therefore, a Brown-Forsythe test for equity of means was used. A statistically significant main effect was indicated, F (3,53) = 7.1, p < .001 (Brown-Forsythe). Calculated eta-squared value of .201 indicated a large effect size difference between group mean scores.[54]

Table 17: ANOVA Descriptive statistics for Pd_5 scores between Axis-I diagnostic groups.

Pd_5	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Min.	Max.
					Lower Bound	Upper Bound		
Mood Alone	30	67.000	10.8755	1.9856	62.939	71.061	38.0	82.0
MA-M	27	69.444	10.7679	2.0723	65.185	73.704	48.0	87.0
MA-AC	16	66.250	15.1239	3.7810	58.191	74.309	43.0	91.0
SA	25	79.800	7.6594	1.5319	76.638	82.962	67.0	92.0
Total	98	70.816	12.0663	1.2189	68.397	73.235	38.0	92.0

Post hoc comparisons of mean scores using Fischer-protected LSD test indicated Pd_5 scores for the SA group (M = 79.8, SD = 7.66) were significantly higher than the mood alone (M = 67, SD = 10.88), MA-M (M = 69.44, SD = 10.77), and MA-AC (M = 66.25, SD = 15.12) groups. Pd_5 mean score comparisons are shown in Table 18 and Figure 2.

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[53]Pallant, *SPSS Survival Manual*, 254.

[54]Ibid.

Table 18: One-way ANOVA post-hoc comparisons of Pd_5 subscale scores between Axis-I diagnosis groups.

Dependent Variable: Pd_5
FLSD

(I) Diagnostic Group	(J) Diagnostic Group	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Mood Alone	MA-M	-2.4444	2.9064	.402	-8.215	3.326
	MA-AC	.7500	3.3917	.825	-5.984	7.484
	SA	-12.8000*	2.9670	.000	-18.691	-6.909
MA-M	Mood Alone	2.4444	2.9064	.402	-3.326	8.215
	MA-AC	3.1944	3.4566	.358	-3.669	10.058
	SA	-10.3556*	3.0410	.001	-16.393	-4.318
MA-AC	Mood Alone	-.7500	3.3917	.825	-7.484	5.984
	MA-M	-3.1944	3.4566	.358	-10.058	3.669
	SA	-13.5500*	3.5077	.000	-20.515	-6.585
SA	Mood Alone	12.8000*	2.9670	.000	6.909	18.691
	MA-M	10.3556*	3.0410	.001	4.318	16.393
	MA-AC	13.5500*	3.5077	.000	6.585	20.515

*. The mean difference is significant at the 0.05 level.

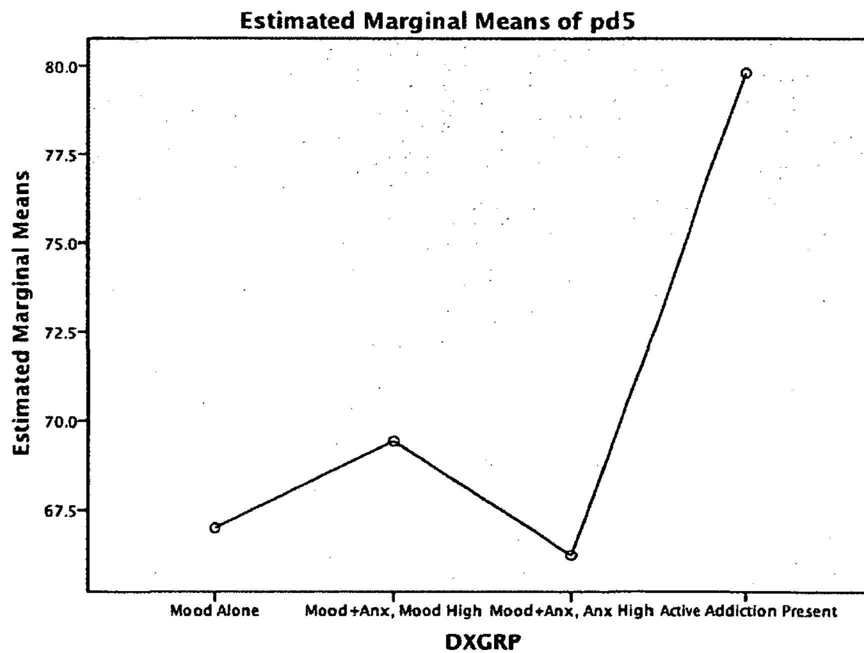

Figure 2. MANOVA means plot for MMPI-2 Pd_5 scale between Axis-I diagnostic groups.

When the MANOVA was repeated using individual Anxiety Alone and MA-A diagnostic groups as IV categories, instead of the combined MA-AC group, an additional observation was made.[55] Because splitting the MA-AC group into the component MA-A and Anxiety Alone categories reduced the frequencies for each cell, special care was taken to confirm that cell frequencies were greater than the minimum of 3, representing the number of dependent variables in this analysis (Table 19).[56]

Table 19: MANOVA Descriptive statistics for Pd_5, DEP3, and NEGE scale scores between diagnostic groups with MA-A and Anxiety Alone.

	Diagnostic Group w/ Anx Alone	Mean	Std. Deviation	N
Pd_5	Anxiety Alone	60.556	14.3101	9
	Mood Alone	67.000	10.8755	30
	MA-M	69.444	10.7679	27
	MA-A	73.571	13.6974	7
	SA	79.800	7.6594	25
	Total	70.816	12.0663	98
DEP_3	Anxiety Alone	59.000	13.7568	9
	Mood Alone	64.400	9.2311	30
	MA-M	66.852	10.5892	27
	MA-A	68.571	15.5119	7
	SA	71.480	11.0872	25
	Total	66.684	11.3896	98
NEGE	Anxiety Alone	59.889	18.7779	9
	Mood Alone	59.133	11.2671	30
	MA-M	62.481	9.3987	27
	MA-A	62.286	15.0965	7
	SA	68.360	9.1918	25
	Total	62.704	11.7756	98

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[55]Chapter 4, fn. 8. "Analyses in this study will be performed on diagnostic groups with the combined (MA-AC) group, and not combined categories (MA-A, and Anxiety Alone). To prevent confusion, results of analyses with the combined MA-AC group will be presented, unless a significant result is found when the categories are not combined."

[56]Pallant, *SPSS Survival Manual*, 285.

The dependent variable remained the three MMPI-2 scales: Pd_5, DEP_3, and NEGE. Unlike the previous MANOVA, the Levene's test was not significant, indicating the assumption of equal error variance was not violated.[57] A statistically significant difference existed in Pd_5 scores between diagnostic groups using individual anxiety categories MA-A and Anxiety Alone, F (12, 279) = 2.7, p = .002; Pillai's Trace = .312; partial eta-squared = .104 (Table 20).[58]

Table 20: MANOVA multivariate results for Pd_5, DEP_3, and NEGE scale scores between diagnostic groups with MA-A and Anxiety Alone.

Multivariate Tests[a]

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta-squared
Intercept	Pillai's Trace	.972	1055.560[b]	3.000	91.000	.000	.972
	Wilks's Lambda	.028	1055.560[b]	3.000	91.000	.000	.972
	Hotelling's Trace	34.799	1055.560[b]	3.000	91.000	.000	.972
	Roy's Largest Root	34.799	1055.560[b]	3.000	91.000	.000	.972
Diagnostic Group w/ Anx Alone	Pillai's Trace	.312	2.695	12.000	279.000	.002	.104
	Wilks's Lambda	.699	2.910	12.000	241.055	.001	.112
	Hotelling's Trace	.415	3.101	12.000	269.000	.000	.122
	Roy's Largest Root	.375	8.717[c]	4.000	93.000	.000	.273

a. Design: Intercept + Dxgrp_w_AnxOnly
b. Exact statistic
c. The statistic is an upper bound on F that yields a lower bound on the significance level.

When the results for the dependent variables were considered separately, differences in both Pd_5 and DEP_3 subscales showed significance at an alpha of .05; Pd_5 F

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[57]Ibid., 294.

[58]Although Box's test and Levene's test indicated no violation of equality of error-variances and covariances, Pillai's Trace was used for this as due diligence to the reduced category frequencies when Anxiety and MA-A categories were used in place of MA-AC.

(4, 93) = 7.68, p <. 001, with a large effect size, partial eta-squared = .248, and DEP_3 F (4,93) = 2.65, p = .038, with a medium effect size, partial eta-square = .102 (Table 21).[59]

Table 21: MANOVA Between-subjects effects for Pd_5, DEP_3, and NEGE scale scores between diagnostic groups with MA-A and Anxiety Alone.

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta-squared
	Pd_5	3506.091[a]	4	876.523	7.678	.000	.248
Corrected Model	DEP_3	1288.632[b]	4	322.158	2.653	.038	.102
	NEGE	1256.133[c]	4	314.033	2.395	.056	.093
	Pd_5	336939.676	1	336939.676	2951.546	.000	.969
Intercept	DEP_3	299447.409	1	299447.409	2465.665	.000	.964
	NEGE	267435.986	1	267435.986	2039.607	.000	.956
Diagnostic Group	Pd_5	3506.091	4	876.523	7.678	.000	.248
w/ MA-A and	DEP_3	1288.632	4	322.158	2.653	.038	.102
Anxiety Alone	NEGE	1256.133	4	314.033	2.395	.056	.093
	Pd_5	10616.603	93	114.157			
Error	DEP_3	11294.562	93	121.447			
	NEGE	12194.285	93	131.121			
	Pd_5	505588.000	98				
Total	DEP_3	448361.000	98				
	NEGE	398767.000	98				
	Pd_5	14122.694	97				
Corrected Total	DEP_3	12583.194	97				
	NEGE	13450.418	97				

a. R Squared = .248 (Adjusted R Squared = .216)
b. R Squared = .102 (Adjusted R Squared = .064)
c. R Squared = .093 (Adjusted R Squared = .054)

To determine where significant differences in Pd_5 and DEP_3 scores occurred between Axis-I diagnostic groups including MA-A and Anxiety Alone, two one-way analyses of variance were executed (Tables 22-23). Because an analysis was required for each subscale, a Bonferroni adjustment was made by setting $\alpha = .025$.[60]

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[59]Pallant, *SPSS Survival Manual*, 254.

[60]Ibid.

Table 22: Descriptive statistics for Pd_5 scores between Axis-I diagnostic groups including MA-A and Anxiety Alone.

Pd_5	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Min.	Max.
					Lower Bound	Upper Bound		
Mood Alone	30	67.000	10.8755	1.9856	62.939	71.061	38.0	82.0
MA-M	27	69.444	10.7679	2.0723	65.185	73.704	48.0	87.0
MA-A	7	73.571	13.6974	5.1771	60.903	86.239	53.0	91.0
SA	25	79.800	7.6594	1.5319	76.638	82.962	67.0	92.0
Anxiety Alone	9	60.556	14.3101	4.7700	49.556	71.555	43.0	87.0
Total	98	70.816	12.0663	1.2189	68.397	73.235	38.0	92.0

Table 23: Descriptive statistics for DEP_3 scores between Axis-I diagnostic groups including MA-A and Anxiety Alone.

DEP_3	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Min.	Max
					Lower Bound	Upper Bound		
Anxiety Alone	9	59.000	13.7568	4.5856	48.426	69.574	41.0	82.0
Mood Alone	30	64.400	9.2311	1.6854	60.953	67.847	41.0	83.0
MA-M	27	66.852	10.5892	2.0379	62.663	71.041	47.0	83.0
MA-A	7	68.571	15.5119	5.8629	54.225	82.918	41.0	83.0
SA	25	71.480	11.0872	2.2174	66.903	76.057	48.0	91.0
Total	98	66.684	11.3896	1.1505	64.400	68.967	41.0	91.0

Levine's statistic was not significant for either analysis, indicating the assumption of equal error variance of the dependent variable across diagnostic groups was not violated. A statistically significant main effect was indicated for Pd_5, $F (4, 93) = 7.68$, $p < .001$ (Table 24). Calculated eta-squared value of .248 indicated a large effect

size in the actual difference between mean scores.[61] Main effects for the DEP_3 subscale did not show significance with the Bonferroni adjustment of $\alpha = .025$, DEP_3 $F(4, 93) = 2.65$, $p = .038$.

Table 24: One-way ANOVA: Pd_5 subscale scores between Axis-I diagnostic groups including MA-A and Anxiety Alone.

Pd_5	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	3506.091	4	876.523	7.678	.000
Within Groups	10616.603	93	114.157		
Total	14122.694	97			

Post hoc comparisons of mean scores using Hochberg's GT2 test indicated Pd_5 scores for the SA group (M = 79.8, SD = 7.66) were significantly higher than the mood alone (M = 67, SD = 10.88), MA-M (M = 69.44, SD = 10.77), MA-A (M = 73.57, SD = 13.70), and Anxiety Alone (M = 60.56, SD = 14.31) groups. Pd_5 comparisons are shown in Table 25 and Figure 3.[62] Results indicated that, while both scales are largely correlated, they are different enough to show different outcomes between diagnostic groups. Further research into the nature of these MMPI scales is warranted.

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[61]Ibid.

[62]Andy Field, *Discovering Statistics Using SPSS*, 3rd ed. (Thousand Oaks, CA: Sage Publications, 2009), 374; and Pallant, *SPSS Survival Manual*, 205. Splitting IV categories created category size differences that were larger than the 1.5 ratio identified by Pallant. To address these differences, a Hochburg GT2 post-hoc test was used. Statistic was also significant using Dunnet's T3 post-hoc for analysis, assuming differences in group sizes.

Table 25: One-way ANOVA Post-hoc Comparisons of Pd_5 subscale scores between Axis-I diagnosis groups including MA-A and Anxiety Alone.

Dependent Variable: Pd_5

(I) Diagnostic Groups w/ MA-A and Anxiety Alone	(J) Diagnostic Groups w/ MA-A and Anxiety Alone	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Anxiety Alone	Mood Alone	-6.4444	4.0607	1.000	-18.121	5.232
	MA-M	-8.8889	4.1124	.332	-20.714	2.937
	MA-A	-13.0159	5.3844	.176	-28.499	2.467
	SA	-19.2444*	4.1534	.000	-31.188	-7.301
Mood Alone	Anxiety Alone	6.4444	4.0607	1.000	-5.232	18.121
	MA-M	-2.4444	2.8343	1.000	-10.595	5.706
	MA-A	-6.5714	4.4848	1.000	-19.468	6.325
	SA	-12.8000*	2.8934	.000	-21.120	-4.480
MA-M	Anxiety Alone	8.8889	4.1124	.332	-2.937	20.714
	Mood Alone	2.4444	2.8343	1.000	-5.706	10.595
	MA-A	-4.1270	4.5317	1.000	-17.158	8.904
	SA	-10.3556*	2.9655	.007	-18.883	-1.828
MA-A	Anxiety Alone	13.0159	5.3844	.176	-2.467	28.499
	Mood Alone	6.5714	4.4848	1.000	-6.325	19.468
	MA-M	4.1270	4.5317	1.000	-8.904	17.158
	SA	-6.2286	4.5689	1.000	-19.367	6.909
SA	Anxiety Alone	19.2444*	4.1534	.000	7.301	31.188
	Mood Alone	12.8000*	2.8934	.000	4.480	21.120
	MA-M	10.3556*	2.9655	.007	1.828	18.883
	MA-A	6.2286	4.5689	1.000	-6.909	19.367

*. The mean difference is significant at the 0.05 level.

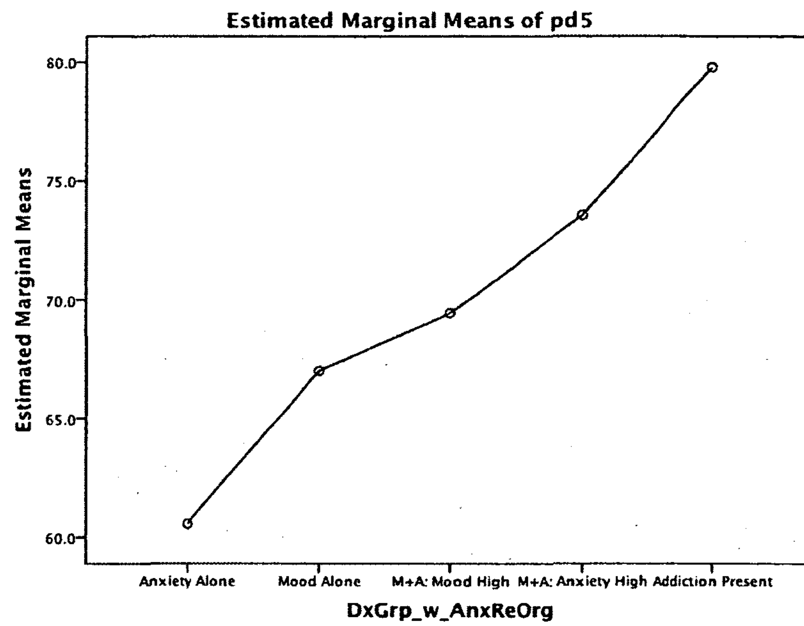

Figure 3. MANOVA means plot for MMPI-2 Pd_5 subscale scores between diagnostic groups with MA-A and Anxiety Alone.

CHAPTER 5

FINDINGS AND RECOMMENDATIONS FOR FUTURE RESEARCH

Findings

The purpose of this study was to determine the differences in ISS scores between DSM-IV-TR-based diagnostic category groups, and to add to the knowledge base of clinical mental healthcare and biblically based Christian psychology. The intent of the first hypothesis was to explore differences in internalized shame experience, represented by ISS scores, between Axis-I diagnostic groups of depression, anxiety, and substance abuse. The intent of the second hypothesis was to explore whether the Avoidance characteristics identified in the ISS manual, as associated with substance abuse, would result in significantly different ISS scores from other Axis-I diagnostic groups.[1] The intent of the third hypothesis was to explore whether extreme high and low scores, reported in previous research, held any association with MMPI-2 identified defensiveness patterns.[2]

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[1]Cook, *Internalized Shame Scale*, 30. The Avoidance pole was thought to involve typical substance-abuse behaviors.

[2]Cozolino, *Neuroscience*, 86; Gausel and Leach, "Concern for Self-Image and Social Image," 468-78; Pinto-Gouveia and Matos, "Shame Memories," 282; Pinel, *Biopsychology*, 450; Siegel, "Emotion as Integration," 166; Thompson, *Anatomy of the Soul*, 134; Tracy and Robins, "Self in Self-Conscious Emotions," 3; Policar, "Shadow of the American Dream," 20; and Vikan, *et al.*, "Test of Shame," 196-202. Defensiveness and withdrawal have been identified as characteristic of internalized shame behaviors.

No significant differences were found in ISS scores across Axis-I diagnostic groups, and as a result an analysis of between groups variance was not indicated. The null hypothesis was retained for both first and second analyses. The number of records indicating a defensive pattern (one record) was too small to allow analysis, and as a result a third analysis could not be performed. The fact that the null hypothesis for the first two analyses were retained, and the third analysis could not be executed, opened alternative avenues of thought regarding presentation and course of internalized shame as a pathology.

Post-Analysis: Absence of Significant Findings

The first outcome of this research revealed no significant difference of ISS scores between Axis-I disorder categories ($F (3, 100) = 2.297$, $p = .082$. (Table 3). A large presence of trait-based internalized shame indicated by elevated scores (> 45) also occurred in 77 percent of the study population.[3] Score outcomes, combined with preliminary data analysis concerns, suggested the possible presence of unanticipated internalized shame factors in the clinical study population, or confounding components in the study design. Several topics were investigated to seek an understanding regarding these outcomes: (1) Peaks in the dependent variable (DV) distribution, (2) Precision of the ISS instrument in clinical populations of one hundred, (3) co-morbidity of anxiety and depression presented in the current study population (IV), (4) possibility of internalized shame as a cross-Axis-I diagnosis group experience, (5) possible alternate "faking-good"

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[3]Cook, *Internalized Shame Scale*, 12. Scores between 45 and 59 have been associated with anxiety, scores above 60 have been associated with depression, and scores considered normal range from 35 to 44. It has been suggested that scores below 34 may indicate forms of defensiveness and attempts to conceal internal thought processes.

relationship between ISS scores and MMPI-2 validity scale scores, (6) gender differences, and (7) reconsideration of guilt and shame differences.

Discussion: The Dependent Variable Distribution (ISS Scores)

Preliminary analysis of internalized shame scale scores indicated clusters of patients scoring in the extremely high, high, and very low categories, with minimal numbers of scores in the "normal" range. Extremely high and high clusters of scores have been identified as associated with depression and anxiety, respectively, and are addressed in more detail in the guilt-and-shame section of this chapter. Scale descriptions and research outcomes by Cook, Elison, and Partridge, and Vikan, *et al.*, have proposed very low scores could provide an indication of pathology in a clinical environment.[4] Outcomes of this study appear to support their proposal.

When first observed in the visual inspection of the data, and because the sample size was larger than thirty, the clusters of patient scores in the very-low range were thought to be an anomaly and not expected to be significant.[5] The researcher was surprised to find that frequency of category scores was significant and not likely to result from chance: $X^2 = 30.42$, DF = 4, N = 104, $p < .001$ (Table 5).

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[4]Ibid., 30; Elison and Partridge, "College Athletes," 24-26; and Vikan, *et al.*, "Test of Shame," 196. Elison and Partridge suggested Shame-Compass pole behaviors would be present in differing order, high to low, for given mood experiences (i.e., non-diagnosed depressed mood or anxiety). Vikan, *et al.*, suggested uncategorized score ranges in ISS result meta-analysis.

[5]Mertler and Vannatta, *Advanced and Multivariate Statistical Methods*, 72; and Pallant, *SPSS Survival Manual*, 206.

Inclusion of very low category scores as an expected proportion in the clinical population supports consideration of the very low category as an indicator of something other than health. Participants in this study were attending an intensive outpatient program for treatment of severe symptoms, taking time away from work and family five days a week, from 8 a.m. to 5 p.m., for an average of three weeks concurrently.

Other outcomes of the current study, discussed in more detail in the following sections, also indicate the ISS very low category may represent a dysfunctional presentation of internalized shame. Large positive correlations were shown between ISS scores such that when ISS scores were in the very low range, they would be associated with low F-scale scores ($r = .52$), which are considered an indication of "faking good," and high K-scale scores ($r = -.54$) associated with defensiveness.[6]

Additionally, large positive correlation was found between very low internalized shame scores and scores on MMPI-2 scales thought by Nichols and Crowhurst to be associated with guilt: Self-Alienation (Pd_5), $r = .627$), Self-Depreciation (DEP_3, $r = .526$), and Negative Emotionality (NEGE, $r = .498$). These correlations associate very low internalized shame scores with symptoms of self-alienation, brooding, and rumination (Pd_5), self-depreciation (DEP_3), emotion dysregulation, stress, and hypersensitivity (NEGE).[7]

The conclusion of this study was that the observed frequency of very low scores in the current clinical population, and large positive correlations with MMPI-2

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[6]Bagby, *et al.*, "Assessing Underreporting and Overreporting," 48; and Pallant, *SPSS Survival Manual*, 132-4.

[7]Nichols and Crowhurst, "Inpatient Mental Health Settings," 224.

scales associated with guilt, appear to suggest that very low ISS scores (< 34) may serve as an indication of dysfunctional internalized shame expression.

The ISS Instrument

Previous research has suggested the ISS scale is likely not a unidimensional instrument.[8] The principal components analysis (PCA) in this study indicated the presence of five possible factors within the ISS instrument: Empty-Self, Fragile-Self/Exposed to Others, Punish-Self/Judgment Pending, Powerless-Self/Under-Judgment, and Defective-Self/Inferior to Others. Post-analysis testing revealed no differences between Axis-I diagnostic groups in score means when questions were grouped by PCA-indicated components. However, similarities and differences with previous research presented interesting insights.

In their research, Vikan, *et al.*, identified three factors, designating them "emptiness," "vulnerability," and "inadequacy."[9] The principal components analysis (PCA) in this current study revealed a similar breakdown of items, but five components appeared to be a better model fit than three, 30 percent versus 40 percent, respectively. Components were named to capture three basic aspects indicated in the scale statements: attitude toward or evaluation of self, expectation of others, and a temporal component of future humiliation versus current humiliation.

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[8]Vikan, *et al.*, "Test of Shame," 198.

[9]Ibid. Vikan, *et al.*, grouped the questions according to the factors they identified as: factor 1, test items 1-3, 6-8, 10-13, and 15-16; factor 2 items were 26-27 and 29-30; and factor 3 items 5, 17, 19-20 and 22-25. The names identified for each group were factor 1, inadequacy; factor 2, emptiness; and factor 3, vulnerability.

The same items identified by Vikan, *et al.*, as "emptiness" were found in the current study and called "Empty-Self," because they all contained statements regarding a missing ingredient and an emptiness within the person. The items (26-27 and 29-30) explained 8 percent of variance, none were phrased in relation to others, all were in the form of present-tense experiences, and all suggested an internal locus of pain/threat.[10] Phrases like "I feel empty and unfulfilled," "like something is missing," and "a painful gap I have been unable to fill," suggest an inner pain of emptiness and a sense of powerlessness to fill the void, an internal perspective in relation to something outside of themselves that should be present and is not. This could allude to a subhuman perception of self, combined with a not-yet-seen or invisibility to others. This component presented a large positive correlation with the "Punish-Self" component and appears to indicate an internal perspective, as in one's own evaluation of self.

The items identified by Vikan, *et al.*, as "inadequacy" split in to two components in the current study, and were named "Fragile-Self/Exposed to Others," and "Punish-Self/Judgment Pending." "Fragile-Self/Exposed" items (22 and 24-25), explained 5.5 percent of variance and included statements in which the person believed they would break at any moment, and the wish that "the earth would open up and swallow me." The term "exposed" was intended to capture the statements indicating the person felt vulnerable to the observations of others, an external source of pain, in the present tense. The perspective of the statements in this component could be considered an

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[10]Pallant, *SPSS Survival Manual*, 199.

internal perspective of self as fragile, in the presence of an external pain, the fear of outside forces and power.

The "Punish-Self/Judgment Pending," items (1, 5-7, 13, 17, and 19-20) explained 45.5 percent of variance in the model, and had in common an internal locus of pain aspect of ruminating, scolding, or hitting one's self over failures, while they wait for an external perspective (judgment) of future-based inevitable, and unpredictable, exposure of all their failures to others. These items included phrases like "I shrink when I make mistakes," "I feel like hitting myself when I make mistakes," and "I replay painful events," suggesting a focus of perfectionism that results in self-punishment when the internal expectation is not achieved. Additionally, items were included regarding an impending, but not yet occurring exposure of the person's perceived faults, "I dread others will see my faults," and "I feel insecure of the opinions of others." These statements appear to suggest more than inadequacy, but an internal superhuman expectation of self, combined with the temporal aspect of a fault not-yet-seen by others.[11] The perspectives of these statements seem to be external, concern over the thoughts of others.

The remaining questions related to the factor designated "inadequacy" by Vikan, *et al.*, loaded into two other components, "Powerless-Self/Under-Judgment" (4.5 percent) and "Defective-Self/Inferior" (4 percent). The Powerless-Self/Under-Judgment component included items 2-3, 10, 16, and 23, which all seemed to suggest powerlessness to achieve, and powerlessness to refuse the expectations of perfection

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[11]Ibid., and Bradshaw, *Healing the Shame*, 26. "Superhuman" and "Subhuman" are terms Bradsahw used to identify what he called "toxic shame." They represet levels of performance beyond human capacity to maintain consistently.

imposed by others. Made in the present tense, these statements describe an environment in which the person is presently rejected or abandoned, because others see all their faults. They present an external perspective on an external locus of pain in phrases like "I'm left out," "others can see my defect," and "others look down on me." The phrases suggest rejection for not meeting superhuman expectations of others in the present tense.

The Defective-Self/Inferior Component (4 percent) included items 8, 11-12, and 15 statements, such as: "I see myself as small," "I am defective, something's wrong with me," "I am not as important as others," and "I strive for perfection, and continually fall short." These items suggest a present-tense internal perspective of hopelessness, self as already broken or defective, on an external locus of pain.

The common points of observation used to compare component items (e.g. self, others, perspective, etc.) were similar to those identified by Tracy and Goss and Allan: self-image, other-image, internal evaluation, external evaluation, comparison to the environment, and expectations.[12] The additional points were identified as perceived power to achieve expectations, locus of punishment (either from self or others), and a temporal dimension as to whether others "can see me" now versus "might see me" in the future. In the case of power, the description was not with regard to one's ability to overcome adversity, as the majority of internalized shame statements alluded to an ultimate failure whether an attempt was made or not. This characteristic of fatalism is similar to descriptions by Stafford and Todd suggesting poverty as a pairing of fatalism and economics, and futility of efficacy and relationship efforts described by Allender and

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[12]Goss and Allan, "Shame, Pride, and Eating Disorders," 304; and Tracy and Robins, "Self in Self-Conscious Emotions," 9.

Dempster in dominion and dynasty concepts.[13] One question raised was whether internalization of shame was a result of a similar pairing of fatalism with the emotion.[14]

When these comparison points of perspective, failure type, pain source, timeframe, and power/expectation of effort are strung together, they almost create a "shame sentence": (I, They) think I (can't win/am broken/am empty) and (I/They) (will/ now) must punish me, and because I can never win I must (fight/surrender). One might speculate if certain combinations of this sentence like "I think I am empty, and I must punish myself, because I can never win, I must now surrender" could lead to extreme behaviors of self-harm of suicide.

Reflection of these common points and the PCA Component Correlation Matrix (Appendix 11, Table 27) inspired a question for future study. After observation of component-item statement similarities, examining component correlation relationships, and similarities to the previous study completed by Vikan, *et al.*, a pattern was observed. The component correlations matrix indicated small and medium-sized correlations between the Powerless, Fragile ($r = .116$), and Defective ($r = .358$) components.[15] Additionally, the matrix revealed a medium positive correlation ($r = .391$) between Punish and Empty components. These two sets of components possessed negative

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[13]Allender, *Feeding Your Enemy*, Internet; Dempster, *Dominion and Dynasty*, 49; Neyrey, *Honor and Shame*, 3; and Stiebert, *Construction of Shame*, 50.

[14]Todd Scott, "Poverty Is a Lie," *Mission Frontiers: The News and Issues Journal from the U.S. Center for World Mission, U.S. Center for World Mission* (July-August 2011) [on-line]; accessed February 20, 2013; available at www.missionfrontiers.org/issue/article/poverty-is-a-lie; Internet.

[15]The correlation between Fragile and Defective components was $r = .185$.

correlations to the other (Appendix 11, Table 27).[16] These correlation relationships were found to be similar to observations made regarding the external versus internal executor of pain and punishment. The question for future research inspired by the observation was whether a schema that identifies a required pain executor, as punisher, of self or others could be a defining factor in the experience of internalized shame.

Several possibilities could account for differences observed between the current study and that of Vikan, *et al.* One possibility was that the population observed in the current study was from North America, while the study population observed by Vikan, *et al.*, was Scandinavian.[17] Another possibility could be the sample size of the current study of 104 subjects was smaller than the population size of 300 observed in Vikan, *et al.* Possibly in a larger population, factor differences could become more defined.

The conclusion of this analysis was that while the ISS instrument has been shown to identify trait-shame successfully, there appear to be multiple facets of internalized shame expression that are not yet clearly distinguishable using the ISS instrument in the current study population size of one hundred. While this could indicate a lower-end sample size limitation to the ISS, it could also represent a foundation for additional effort to improve the precision of the instrument.

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[16]The matrix revealed large negative correlations between Defective Component with Punish ($r = -.493$) and Empty ($r = -.493$), large and medium negative correlations between the Powerless component with Punish ($r = -.403$) and Empty ($r = -.320$) respectively, and small negative correlations between the Fragile Component with Punish ($r = .261$), and Empty ($r = -.177$) components.

[17]Ibid. One participant in this study was from Canada, and two were from Mexico residing in the U.S. The remaining population was from locations across the continental United States and Alaska.

Depression and Anxiety Co-morbidity

The co-morbidity of anxiety and depression diagnoses observed in this study's IV were similar to those reported in previous research using different instruments.[18] Vikan, *et al.*, used the Beck Depression and Anxiety Inventories, BDI and BAI respectively. Their concern was that by using the tools alone some patients might have been classified as suffering from depression rather than anxiety and vice-versa. Pinto-Gouveia and Matos recommended future research use of instruments that were not dependent on patient self-report.[19] These recommendations to use a "formal psychiatric diagnostic procedure" formed the basis for use of clinical psychiatric diagnosis in Axis-I diagnostic group assignment decisions for the current study.[20] Further, the intention of the researcher was to maintain alignment with the clinic's formal diagnostic procedure and the influence of the direct psychiatric assessment process.[21]

With these factors in mind, when co-morbidity was found in the current study diagnoses, the decision was made to modify the diagnostic group assignment method by using patterns observed in the existing diagnostic process rather than applying MMPI-2 scale measurements alone. As indicated earlier, assignment was made recording all Axis-I diagnoses for each record assigned by the attending psychiatrist, verified by MMPI-2 scales and associated psychological assessment, and prioritized by therapeutic priority listed in the master treatment plan.

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[18]Vikan, *et al.*, "Test of Shame," 196; Nichols and Crowhurst, "Inpatient Mental Health Settings," 238; Green, "Outpatient Mental Health Settings," 253; and Graham, *MMPI-2*, 114.

[19]Pinto-Gouveia and Matos, "Shame Memories," 282.

[20]Vikan, *et al.*, "Test of Shame," 196.

[21]Ibid.

The use of a treatment protocol combining the physician's diagnosis, diagnostic instrument, and therapeutic priority, while effective for patient treatment, resulted in an overlap of diagnoses that was not easily separated for the empirical purposes of this study. One limitation not considered in advance of this research was that primary treatment focus for the psychiatrist is medication management, whereas for the therapist, the primary focus is amenability to intervention.[22]

Ultimately the decision to use current diagnostic protocol without modification for research precision resulted in what may have been unnecessary confusion. One possible remedy for future research could be to use "primary treatment focus," with the addition of a diagnostic impression question to be answered by physicians, psychologists, and therapists: "Do you believe the primary treatment focus in this case is depression or anxiety?" Another recommendation for future research is to use the therapeutic diagnostic impression process, given the differences in medication management versus intervention management foci in clinical treatment.

Alternative Factor: Relationship Between ISS Scores and Co-morbidity of Diagnoses

ISS score variance was not significantly different between Axis-I diagnosis groups, and escalated ISS scores were observed across all groups, including the anxiety-only, depression-only, and co-morbid groups (Table 1). As suggested earlier, Vikan, *et al.*, proposed that co-morbidity between depression and anxiety could have been the result of shame levels in the participants and indicative of the number of symptoms they

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[22]Amy Morrison, interview by Luigi Leos, December 12, 2012.

presented.[23] In an effort to explore possible alternative relationships associated with the escalated ISS scores, a Spearman's rho was performed on ISS scores and frequencies of Axis-I diagnoses across the study population (Table 9). A small, positive correlation was found between shame scores and overall co-morbidity of diagnosis ($r = .28$, $n = 102$, $p = .005$). The positive nature of the correlation suggested higher ISS scores were observed as the number of Axis-I diagnoses increased, and is similar to observations of strong relationships between shame and mental health pathology in previous research with larger sample sizes.[24]

Positive correlation between internalized shame and Axis-I symptom co-morbidity, in this and previous research suggests that the presence of internalized shame may indicate a need for increased priority in clinical treatment.[25] Future research verification of the existence of this correlation in larger sample sizes or populations would be informative. If increases in internalized shame severity were associated with increased complexities in symptom presentation, it would be interesting to see what impact intervention skills targeted at reducing dysregulation or replacing dysfunctional processing of shame experiences, might have on treatment.

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[23]Vikan, *et al.*, "Test of Shame," 196.

[24]Pinto-Gouveia and Matos, "Shame Memories," 282, and 196.

[25]Levin, Shiv, Bechara, and Weller, "Neural Correlates," 959; Naqvi, Shiv, and Bechara, "Role of Emotion in Decision Making," 261; Rudebeck, *et al.*, "Separate Neural Pathways," 1161; Rudy, *Neurobiology*, 159; Sanfey, "Decision Neuroscience," 151; Steffens and Rennie, "Traumatic Nature of Disclosure," 272; Westen, *et al.*, "Neural Bases of Motivated Reasoning," 1955. Chekroun and Nugier, "I'm Ashamed Because of You," 479; and Farmer and Andrews, "Shameless Yet Angry," 59.

Alternative Factor: Relationship Between ISS Scores and MMPI-2 Validity Scales

Several authors have suggested defensiveness as a common internalized shame symptom, expressed in either attack-others or hide-self behaviors.[26] Cook suggested that very low ISS scores would likely be an indication of avoidance behaviors.[27] The second hypothesis of this study was founded on his proposition that avoidance would likely be associated with "defensively hedonistic behavior," including alcohol and drug addiction.[28] Interestingly, of the seventeen patients scoring in the very low category, only four records (16 percent) showed substance-abuse behavior. Of the twenty-five patients presenting with substance-abuse behaviors, eighteen records (72 percent) scored in the Very High and Extremely High ISS categories. This data did not support Cook's connection between all three characteristics of very low ISS scores, avoidance, and addiction.

What was unclear at the beginning of the current study was how defensiveness would fit with regard to internalized shame measures. The desire to explore the fit between ISS scores and defensiveness measures represented the foundation of the third hypothesis in the current study. However, only one record presented a defensiveness

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[26]Cozolino, *Neuroscience*, 86; Gausel and Leach, "Concern for Self-Image and Social Image," 468-78; Goss and Allan, "Shame, Pride, and Eating Disorders," 306; Pinto-Gouveia and Matos, "Shame Memories," 282; Pinel, *Biopsychology*, 450; Siegel, "Emotion as Integration," 166; Thompson, *Anatomy of the Soul*, 134; Tracy and Robins, "Self in Self-Conscious Emotions," 3; Policar, "Shadow of the American Dream," 20; Vikan, *et al.*, "Test of Shame," 196-202; and Wolf, Cohen, Panter, and Insko, "Shame Proneness and Guilt Proneness," 338.

[27]Cook, *Internalized Shame Scale*, 12.

[28]Ibid. Second Hypothesis: the Addiction Group would score significantly lower on the ISS than on the other diagnostic groups.

pattern using Bagby, *et al.*, criteria, and as a result, the analysis could not be performed.[29] Because prior research suggested defensiveness as a common expression of escalated internalized shame, combined with the fact that escalated internalized shame scores were present, and defensiveness patterns measured by the MMPI-2 validity scales were absent, an analysis was performed to examine general relationships between scores of the ISS and MMPI-2 validity scales. As indicated before, the F-, L-, and K-scales represent some of the scales used in the MMPI-2 to verify validity of the test-takers' input, and represent the scales associated with defensiveness.

When Graham's defensiveness pattern limits were applied to the data, L- and K-scales above 50 combined with F-Scale scores below 50, a total of four patient records showed defensiveness patterns. Two patient records showed diagnoses of adjustment disorder with anxiety, and the other two were being treated for major depression recursive severe where both patients had previously attempted suicide. Several possibilities existed for the absence of defensiveness in the current study population. One possibility was that the nature of the intensive outpatient treatment program, as a bridge between residential crisis treatment and outpatient maintenance treatment, received patients after they had moved beyond defensiveness symptoms measured in MMPI-2 validity scales.

Additional post-analysis, however, indicated the use of defensiveness patterns as a comparison for internalized shame scores might not have been accurate. ISS scores

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[29]Bagby, *et al.*, "Assessing Underreporting and Overreporting," 48; and Pallant, *SPSS Survival Manual*, 132-4. In review, according to Bagby, *et al.*, a pattern in which both K- and L-scales indicate significantly escalated scores (> 65), and F-scale scores are within the normal range (< 50 + 5), has been associated with defensiveness, or attempts to conceal negative information from others. Only one record in the study population met this standard, one of the twelve patients receiving treatment for eating disorders.

revealed a large positive correlation to F-scale scores, r = .52, and a large negative correlation to K-scale scores, r = -.54, however, only a small negative correlation to L-scale scores, r = -.29 (Table 10). These correlations indicate low ISS scores were associated with high K-scale indicatons of defensiveness, intolerance, and lack of insight. High ISS scores would be related to low K-scale symptoms of poor self-concept and distrust of others. High ISS scores were related to high F-scale scores representing random or exaggerated answering, whereas low scores on ISS and F-scales were associated with a "faking good" profile.[30]

These associations, in concert with the small negative correlation with the L-scale would suggest that if both K- and L- scales were escalated and the F-scale were low, characteristic of the "defensiveness" pattern, that ISS scores would also be low, but not necessarily because of defensiveness. Further investigation appears warranted to clarify the relationship between ISS scores and MMPI-2 scales like the F-, L-, and K-scales. Understanding correlation differences like the positive and negative relationship between internalized shame and MMPI-2 F-, and K-scales may help to clarify either characteristics of internalized shame, characteristics of the ISS instrument, or both.

Higher Females Scores than Male Scores

ISS scores for men and women were anticipated to be different, because of similar observations in previous research and in the ISS manual.[31] ISS scores for women were significantly higher than the scores for men. On the surface, this outcome appears to

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[30]Bagby, *et al.*, "Assessing Underreporting and Overreporting," 48; and Pallant, *SPSS Survival Manual*, 132-4.

[31]Chao, Cheng, and Chiou, "Psychological Consequence," 202; Elison and Partridge, "College Athletes," 35; and Neukrug and Fawcett, *Essentials of Testing and Assessment*, 173.

support prior research by authors like Brown, who have suggested differences occur in the ways men and women experience and communicate shame.[32] However, care must be taken in this analysis before conclusions can be drawn.

The Internalized Shame Scale is an assessment for the presence of internalized shame, not a measure of actual shame experienced or the difference between experience and expression. Brown has suggested men and women use distinctly different language when expressing shame. Thus, are the significantly higher women's scores an indication of more shame experienced by women than men, or an indication of something else? The ISS uses a Likert scale, meaning the difference could also suggest females use more expressive language to report similar experiences than men. Additionally, these scores could mean the shame statements are set in a language more associated with feminine communication; recent research results have supported the concept of gender-based differences in use of language.[33]

Research by Conroy and Pincus identified significant differences in masculine and feminine methods of communication that were recognizable in text format without

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[32]Brown, "Men, Women and Worthiness," Session 2.2.

[33]K. Hussey and A. N. Katz, "Perception of the Use of Metaphore by an Interlocutor in Discourse," *Metaphor and Symbol* 209 (2004): 204; Allender, "Sexual Problems in Marriage," m10:30; Heidi M. Reeder, "Exploring Male-Female Communication: Three Lessons on Gender," *Journal of School Health* 75, no. 3 (2005): 117; Heather Arthur, Gail Johnson, and Adena Young, "Gender Differences and Color: Content and Emotion of Written Descriptions," *Social Behavior and Personality: An International Journal* 35, no. 6 (2007): 828; J. Guiller and A. Durndell, "'I Totally Agree With You': Gender Interactions in Educational Online Discussion Groups," *Journal of Computer Assisted Learning* 22 (2006): 369; U. Lanvers, "Gender in Discourse Behaviour in Parent-Child Dyads: A Liturature Review," *Child: Care, Health & Development* (2004): 492; and J. B. Parks and M. A. Robertson, "Attitudes Toward Women Mediate the Gender Effect on Attitudes Toward Sexist Language," *Psychology of Women Quarterly* 28 (2004): 234.

prior knowledge of the author's gender.[34] The conclusion of this study with regard to female scores being significantly higher than male scores is that further research is indicated. One alternative to self-report bias would be to use some measure of physiological response, like galvanic skin conductance, as respondents take the test in order to gauge differences in male and female physiological responses during the shame test and discover whether physiological differences match score differences.[35] A qualitative study of male and female expressions of guilt, shame, and internalized shame would be highly beneficial.

Shame and Guilt Differences

As suggested previously, some controversy currently exists regarding distinctions between shame and guilt.[36] Nichols and Crowhurst suggested the possibility that the self-alienation (Pd_5), Self-Depreciation (DEP_3), and Negative Emotionality/ Neuroticism (NEGE) scales of the MMPI-2 could be used as measures for guilt.[37] These scales were examined in the current study to explore their relationship to the ISS scores,

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[34]Cozolino, *Neuroscience*, 86; Gausel and Leach, "Concern for Self-Image and Social Image," 473; Guiller and Durndell, "I Totally Agree With You," 369; Kalat and Shiota, *Emotion*, 226; Lanvers, "Gender in Discourse Behaviour," 481-93; Pinel, *Biopsychology*, 450; Thompson, *Anatomy of the Soul*, 134; Trevarthen, "Functions of Emotion in Infancy," 61; and Tracy and Robins, "Self in Self-Conscious Emotions," 11.

[35]Mataix-Cols, *et al.*, "Individual Differences," 3057.

[36]Chao, Cheng, and Chiou, "Psychological Consequence," 203; Elison and Partridge, "College Athletes," 20; and Sweezy, "Teenager's Confession," 179.

[37]Nichols and Crowhurst, "Inpatient Mental Health Settings," 224. The Pd_5 scale is a clinical subscale of the Psychopathic Deviate clinical scale (Pd). High scores on the Pd scale identify narcissism, externalization of blame, exploitiveness, and hostility. The Pd_5 subscale represents the level to which the subject self-alienates or ruminates on past mistakes, "brooding and apathy scale." The DEP_3 scale is a subscale of the DEP (depression) content scale. High scores on the DEP scale represent depression ideation, brooding, pessimism, guilt, remorse, feelings of worthlessness, and suicidal ideation. The DEP_3 scale represents the subset of questions associated with self-depreciation. The NEGE scale is one of five scales collectively called the personality psychopathology five, or PSY-5. High scores on the NEGE scale represent negative emotional dysregulation, worry, stress, and hypersensitivity.

and whether e differences would exist between Axis-I diagnostic groups not found using the internalized shame measure.

A Pearson's r statistic revealed large positive correlations between internalized shame scores on all three MMPI scales: negative emotionality, $r = .630$; self-alienation, $r = .668$; and self-deprecation, $r = .691$. As discussed previously, the correlation results associated high internalized shame scores with high levels of self-alienation, brooding, rumination (Pd_5), self-depreciation (DEP_3), emotion dysregulation, stress, and hypersensitivity (NEGE). Analysis of variance results in the current study indicated no significant differences between Axis-I diagnostic groups for internalized shame scores, $F (3, 100) = 2.297$, and $p = .082$ (Table 3). However, significant differences between diagnostic groups were found in analysis of the MMPI-2 "guilt" scales, $F (9, 282) = 2.8$, $p = .004$; Pillai's Trace = .25; partial eta-squared = .082. The Self-Alienation (Pd_5) subscale revealed significantly higher scores in the substance abuse group than the other three Axis-I diagnostic groups, $F (3, 94) = 7.88$, $p < .001$, partial eta-squared = .20.

Significant differences between diagnostic groups in the Self-Alienation subscale combined with the absence of significant differences in ISS scores suggest that, while the Self-Alienation and Internalized Shame Scales are related ($r = .668$), they are different enough that one showed a statistically significant difference between Axis-I diagnosis groups (Self-Alienation), while the other (Internalized Shame Scale) did not.

The conclusion of this research is that additional research is necessary to explore whether the MMPI-2 scales are valid measures of guilt, whether the scales could be used to differentiate shame and guilt in a clinical population, and whether any associations or differences between the scales exist with mood or anxiety disorders.

Further investigation appears warranted to clarify the relationships between Axis-I disorders and MMPI-2 scales like self-alienation (Pd_5), Self-Depreciation (DEP_3), and Negative Emotionality/Neuroticism (NEGE).

Conclusions and Counseling Implications

Current study observations of internalized shame expressions in a clinical population seeking Christian faith-based mental health treatment were different from those in previous research with general populations. While research hypotheses revealed no significant results, post-analysis investigation provided information contributing to the advancement of the study of shame. Each finding invited reevaluation of conceptualizations for course and impact of internalized shame from the perspectives of clinical treatment and Christian ministry. Shame is a powerful and complex emotion, Further, it would follow that dysfunctional expression, or disregulation of shame, would have powerful consequences and is not to be taken lightly. This position is considered important in both psychological treatment and spiritual discipleship, as efforts to provide access to healing and to do no harm.

Clinical Treatment

By definition, internalized shame is pathological. Given that the focus of these thoughts is self-devaluation, high correlations of internalized shame measures to mental health diagnostic tests like the MMPI-2 scales are not surprising.[38] Consequences of untreated internalized pathological methods for processing shame have been documented

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[38]Chao, Cheng, and Chiou, "Psychological Consequence," 203; and Gausel and Leach, "Concern for Self-Image and Social Image," 473.

in research: triggered survival response that bypasses cognitive processing, decreased ability for problem solving, and defensive and resistant approaches to treatment that include expressions of sudden anger.[39] In the test manual, Cook suggested that very low ISS scores could be indicative of a pathological defense response versus an indication of high functioning test participants.[40] Results of this study appear to support his suspicion (Table 6)

The significant number of elevated ISS test scores across all Axis-I diagnosis groups implicates internalized shame as present in clinical psychopathology. In her discussion on "Men, Women, and Worthlessness," Brene Brown describes two general responses to shame, attack or hide, which she describes as "puff up" or "shrink."[41] These extremes in behavior, triggered by shame, align easily with Bradshaw's concepts of superhuman versus subhuman, Horney's concepts of approach versus avoid, as well as the dominion and dynasty theological concept discussed in the next chapter.[42]

Results of the current study indicated a small, but statistically significant correlation between shame levels and number of co-morbid clinical Axis-I diagnoses (Table 18). This result could suggest the possibility of a cross-diagnosis occurrence of shame and a deeper, common factor characteristic of internalized shame with regard to symptom presentation in a clinical population. Several authors have characterized shame

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[39]Levin, Shiv, Bechara, and Weller, "Neural Correlates," 959; Naqvi, Shiv, and Bechara, "Role of Emotion in Decision Making," 261; Rudebeck, *et al.*, "Separate Neural Pathways," 1161; Rudy, *Neurobiology*, 159; Sanfey, "Decision Neuroscience," 151; Steffens and Rennie, "Traumatic Nature of Disclosure," 272; and Westen, *et al.*, "Neural Bases of Motivated Reasoning," 1955; Chekroun and Nugier, "I'm Ashamed Because of You," 479; and Farmer and Andrews, "Shameless Yet Angry," 59.

[40]Cook, *Internalized Shame Scale*, 12.

[41]Brown, *Men, Women & Worthiness*, Session 2.2.

[42]Ibid., and Bradshaw, *Healing the Shame*, 26.

as a negative emotion, requiring treatment as pathology. It may be more accurate to identify the internalized form, or what others call "trait-shame" as the pathological or corrupted form of healthy, functional shame. A larger population size may provide more insight into this aspect of internalized shame; more research is needed in this area.

Counseling Practice and Gender Implications

In his work with process addiction in men regarding sexual and relationship behaviors, Carnes identified an addiction cycle "fueled" by dysregulation of shame and guilt emotions.[43] He went on to identify the perfect environment for addiction as the presence of secrets and contradictions. Carnes proposed the intervention for toxic shame and recovery from process addictive behavior was to treat shame and guilt with "integrity" and "acknowledgement."[44] Brown has authored a large amount of research with regard to shame, mainly associated with women.[45]

he identifies the perfect environment for shame with similar terms to Carnes's environment for addiction: secrecy, silence, and judgment. Brown, however, identifies "empathy" as "the antidote to shame."[46] She emphasizes that this antidote does not result in "shame resistance" where one never again feels the emotion, but rather "shame resilience," as the ability to process and apply shame effectively. Brown defined empathy as the feeling of "being connected and not alone," which she proposes is achieved

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[43]Butler and Seedall, "Attachment Relationship," 157-58; Erikson, *Insight and Freedom*, 9; Levert, "Comparison of Christian and Non-Christian Males," 149; and Price, "Re-Building Shattered Families," 168.

[44]Carnes, *Facing the Shadow*, 157-58.

[45]Brown, *Men, Women & Worthiness*, Session 2.2.

[46]Ibid.

through four skills: the ability to take another's perspective, to be nonjudgmental, to understand what the other person is feeling, and to communicate that understanding.[47]

Differences in treatment require definitions of shame, and the pathological variant of internalized shame that allow for accurate intervention. The current study indicated a significant difference is present, females scored significantly higher than males, this question cannot be allowed to go unanswered. Additional research is needed to identify and define the differences with regard to male and female experience, expression, and response differences to both shame and internalized shame to allow for differences in treatment as suggested by Carnes and Brown to be even more effective.

Implications for Ministry

Several authors have defined shame as a negative emotion and something to be eradicated.[48] However, not all researchers agree with this perspective: "Unintentional publicity and mild reprimand were shown to generally enhance both moral emotion and intentions to apologize without increasing hostility."[49] Research by Combs, *et al.*, demonstrated that it was the severe use of shame that resulted in wrongdoers believing they had been treated unfairly, and rather than contrition, they exhibited acts of anger and vengeance.[50] The repeated and severe use of shame as punishment as described by

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[47]Ibid.

[48]Ibid., Session 1.9; and Sweezy, "Teenager's Confession," 179.

[49]Ibid.

[50]Macaskill, "Differentiating Dispositional Self-Forgiveness," 30; Combs, Campbell, Jackson, and Smith, "Exploring the Consequences," 128; Gausel and Leach, "Concern for Self-Image and Social Image," 474; and Wolf, Cohen, Panter, and Insko, "Shame Proneness and Guilt Proneness," 360.

Combs is thought to establish internalized or toxic-shame.[51] The difficulty lies in how effectively to apply confrontation that may result in shame toward correction (2 Tim 3:16; Titus 2:8) without condemnation and internalization of shame from judgment (Matt 7:3ff). Several critical implications for ministry exist regarding the results of this study.

The majority of participants in this study were Christian believers, having made a profession of faith. All were suffering from at least one Axis-I diagnosed disorder that had escalated to a severity that led them to interrupt their work and home lives to attend treatment all day, Monday through Friday, some fighting the urge to commit suicide. Symptoms of the diagnoses received included overwhelming fears to the point of being admitted to an emergency room, intrusive thoughts interrupting the patient's ability to process external input, or visions and sounds that were not present.[52] While some writers have suggested that no place exists for despair or self-condemnation in a faith relationship with God, one cannot guarantee the despair or self-condemnation evident in internalized shame will not happen.[53] In some cases even Scripture is abused to justify crimes perpetrated against patients.[54] If the sufferer is directed to "just stop" when he or she is powerless to do so, or believe he or she will be disobeying God in the effort, shame

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[51]Mark 9:42; Luke 11:46, 17:1-2; Acts 15:10; 2 Pet 2:1; Beck and Demarest, *Human Person*, 250, 282; Cozolino, *Neuroscience*, 86; Gausel and Leach, "Concern for Self-Image and Social Image," 468-78; Johnson, *Foundations for Soul Care*, 14, 310; Pinel, *Biopsychology*, 450; Siegel, "Emotion as Integration," 166; Thompson, *Anatomy of the Soul*, 134; Tracy and Robins, "Self in Self-Conscious Emotions," 3; Policar, "Shadow of the American Dream," 20; and Vikan, *et al.*, "Test of Shame," 196-202.

[52]American Psychiatric Association, *DSM-IV-TR.* Symptoms described are requirement observations for some of the diagnoses present in the study population.

[53]Boa, *Augustine to Freud*, 187; and Witmer, *Romans*, 469.

[54]Beck and Demarest, *Human Person*, 250; and Johnson, *Foundations for Soul Care*, 14, 311.

and guilt will likely be the resultant emotions.[55] If the same admonitions are repeated in an attempt to help the subject, without first treating the internalized shame, the likely result would be an exacerbation of the pathology rather than healing.[56]

Areas for Additional Research

The ISS instrument appeared to be a viable instrument to measure internalized shame, however data and factor analysis results indicated it could be either expanded or focused for increased resolution. The PCA factors indicated possible internalized shame characteristics, in a clinical environment, that are not yet fully quantified by the ISS. Additional research is indicated on the possible definition of multiple aspects of internalized shame. Additional research is also needed to refine definition of internalized shame in terms of male and female linguistic expression.[57] One of the possibilities regarding the items of the ISS could be to use specific male and female expressions used to describe the experience.

Research is warranted with larger populations to explore internalized shame correlations to number of observed co-morbid Axis-I diagnoses, both to confirm the correlation, and to explore whether shame acts as a causal influence or resultant

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[55]Levert, "Comparison of Christian and Non-Christian Males," 149; Butler and Seedall, "Attachment Relationship," 295; and Carnes, *Facing the Shadow*, 157-58.

[56]Heb 12:13; Butler and Seedall, "Attachment Relationship," 295; and Carnes, *Facing the Shadow*, 157-58; Patrick Carnes, *Contrary to Love: Helping the Sexual Addict* (Center City, MN: Hazelden, 1989), 24; Levert, "Comparison of Christian and Non-Christian Males," 149; Naqvi, Shiv, and Bechara, "Role of Emotion in Decision Making," 261; Price, "Re-Building Shattered Families," 199; Steffens and Rennie, "Traumatic Nature of Disclosure," 272; and Rudy, *Neurobiology*, 159.

[57]Cozolino, *Neuroscience*, 2006, 86; Gausel and Leach, "Concern for Self-Image and Social Image," 473; Guiller and Durndell, "I Totally Agree With You," 369; Kalat and Shiota, *Emotion*, 226; Lanvers, "Gender in Discourse Behaviour," 481-93; Pinel, *Biopsychology*, 450; Thompson, *Anatomy of the Soul*, 134; Trevarthen, "Functions of Emotion in Infancy," 61; and Tracy and Robins, "Self in Self-Conscious Emotions," 11.

indicator.[58] Further investigation appears necessary to clarify the relationship between ISS scores and MMPI-2 scales like the F-, L-, and K-scales or Pd5, DEP3, and NEGE scales. Understanding correlations like the positive and negative relationships of F-, and K-scales with ISS scores may help to clarify either characteristics of internalized shame, characteristics of the ISS instrument, or both.

Outcome differences between the internalized shame scale and MMPI-2 scales open the question as to whether long-term guilt continues to exist as indicated by significant differences in the self-alienation scale, but as indicated by lack of significant differences in ISS scores, is either masked by shame, or the guilt events themselves become a source of shame. Additional research is necessary to explore whether the Self-Alienation (Pd5), Self-Deprecating (DEP3), and Negative Emotionality (NEGE) MMPI-2 scales actually operate as valid measures for guilt, and how guilt-and-shame expressions differ in a clinical population, if at all.

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[58]Agerstrom, Bjorklund, and Carlsson, "Emotions in Time," 184; Erikson, "Identity and the Life Cycle," 66; Kalat and Shiota, *Emotion*, 234; Roberts, *Spiritual Emotions*, 100; Tracy and Robins, "Self in Self-Conscious Emotions," 10; and Vikan, *et al.*, "Test of Shame," 196.

CHAPTER 6

THEOLOGICAL IMPLICATIONS

Introduction

When this research was initiated, it was believed that the Word of God identifies the emotions of guilt and shame with some clarity, and that much of the confusion of secular research could have been the result of the avoidance of the clarity of Scripture (Rom 1:25). Further, the belief was that scriptural terms describing objective shame and guilt events were applicable and paralleled subjective experiences observed in internalized shame.[1] However, as a result of the thematic biblical perspective selected for this study and the follow-up analysis in the current research, four main diversions from this line of thought have been suggested.

First, in its internalized form, the design structure of shame did not function as expected, but rather was more expansive and severe than anticipated. Second, although MMPI-2 defined defensiveness patterns were not present, evidence of "faking-good" validity scores were observed with a large positive correlation to internalized shame levels, suggesting scriptural descriptions of shame responses may indicate more

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[1]Gen 3:10, 4:6, 4:8; Cankaya, "Anger as a Mediator," 936; Gausel and Leach, "Concern for Self-Image and Social Image," 473; Pinto-Gouveia and Matos, "Shame Memories," 282; Kalat and Shiota, *Emotion*, 226; Pinel, *Biopsychology*, 126; Thompson, *Anatomy of the Soul*, 37; and Trevarthen, "Functions of Emotion in Infancy," 11. Propensity to hide (Gen 3:10), look at the ground (4:6), and display rage toward others (4:8), have all been identified by Cankaya as defensive behaviors to toxic or internalized shame. He defines anger as the emotion normally present in response to one's perception that he or she is being suppressed, attacked, threatened, deprived, or limited.

complexity than originally considered. Third, significant yet inconclusive differences in internalized shame scores between men and women were present in the study. Finally, distinct guilt measures in the presence of ubiquitous shame expressions suggested differences between the two emotions and the possibility that, once internalized shame is addressed, normal guilt and shame functioning may still be possible.

Two general reconsiderations of theological perspective from this study are the themes of shame as a foundational emotion, which should not be applied lightly because of the depth of the effects; and internalized shame as an independent pathology, requiring direct intervention before proceeding with the treatment of functional guilt and shame. Additional research is needed to verify that treatment identified for shame, empathy similar to that illustrated in Zechariah 3:3-4, continues to be effective for internalized shame allowing for integrity and acknowledgment interventions for state-shame and guilt to be effective.

These reconsiderations and reconciliations require additional research and inquiry into how to differentiate between internalized shame and pride in order to identify when direct confrontation is appropriate, and when that confrontation is likely to cause deeper wounding and tighter binding to sin. The great hope is that, even in the presence of elusive corruption effects, a God-established path to freedom and restored relationship with Him remains through the death and resurrection of Jesus Christ (John 3:16). The verse that captured the essence of this research topic has been Luke 4:18-19, in which Jesus Christ announced his ministry: "The Spirit of the Lord is upon Me, Because He anointed Me to preach the Gospel to the poor. He has sent Me to proclaim release to the captives, and recovery of sight to the blind, to set free those who are oppressed, to proclaim the favorable year of the Lord." While the null hypothesis was retained in each

element of the study, much was learned as the findings illuminated surprising insights into guilt and shame.

Biblical and Systematic Perspectives

Viewed within a theological framework of man as functionally designed by God, the concept of internalized shame represents a corruption process of the functional shame given by God. While the pathology of internalized shame can be distinguished from a systematic topical perspective, the corruption of shame represents a pathology occurring within a process described in Scripture. Dempster suggests that, while a systematic perspective is important, the perspective is less appropriate in the examination of themes that run across "the biblical literary topography," in that connections and interactions between themes are not as clear as they are when the process is taken as a complete narrative.[2] A biblical-theology review perspective has been selected for the current study, because the topic is associated with the corruption of an emotion, established in Genesis (Gen 1:25 and 3:7), and according to Dempster, resolved in the New Testament soteriological concepts of justification and sanctification.[3]

First Observation: Shame Just After Foundational Structure of Human Design

The presence of significantly high ISS scores with no variance between Axis-I disorder groups was surprising. The original hypotheses were based on the possibility that internalized shame could be distinguishable from guilt and that guilt would likely align with anxiety disorders, while internalized shame would operate similarly to

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[2]Dempster, *Dominion and Dynasty*, 21,

[3]Ibid., 234.

functional shame and align with depression disorders. Outcomes suggested that, as a dysfunctional or corrupted form of shame, internalized shame was experienced across all the mental-health dysfunctions identified in the population. The global nature of internalized shame experiences across dysfunction indicates it as a priority in treatment prior to confrontation or other treatment interventions.

Scriptural premise for the priority of shame treatment has been the prominence the Bible gives to the topic of shame. Although inferences can be made from previous verses regarding emotions of loneliness (Gen 2:20) and joy (Gen 2:23), shame's absence was the first emotion to be identified specifically (Gen 1:25). In Gen 3:7-10, the first response of the man and the woman after eating the forbidden fruit was to hide "their nakedness."[4] The consequence of their sin was the introduction of suffering and pain in human existence (Gen 3:16-19). The dichotomy illustrated in the transition from Gen 2:23 to 3:10 suggested a functional descriptor for the purpose of shame and guilt as an indicator regarding some aspect of a person's current relationship to God or sin and the resultant consequences of pain and suffering.[5]

The first hypothesis in this study was created out of a desire to explore the effects of the shame indicator when corrupted, as in when the emotion is internalized. The inquiry was whether shame in the internalized state continued to indicate a path toward healing or would become a roadblock to physical and spiritual healing. The study focused on whether internalized shame could be used to distinguish types of suffering

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[4]Gen 3:10, and Ross, *Genesis*, 31. Shame, in that Gen 2:25 states "they were not ashamed," is a state no longer present in Gen 3:10.

[5]Of the 104 records, only six indicated ISS scores in the normal range, 27 percent scored in extremely high range, 25 percent in the very high range, 25 percent in the high range, and 17 percent in the extremely low range.

represented by Axis-I disorder diagnoses, and what the relationship was, if any, that it would have to avoidance or defensiveness. The lack of significant differences in measured internalized shame levels between diagnoses groups suggested that, in the corrupted state, the experience of shame was exhibiting different results than hypothesized.

Reconsideration of Theological Literature for the First Observation

Hodge identifies shame and guilt as direct results of sin, the consequential behaviors of which include the desire to hide from God.[6] His view coincides with Berkhof's descriptions of original guilt and original pollution.[7] In the current study, shame has been physiologically associated with self-disgust, which would represent an appropriate response to a state that is spiritually polluted.[8] The anticipated response to recognition of a polluted state would be to seek out cleansing in a spiritual sense, sanctification (Psalm 51). In the corrupted state of internalized shame, research results indicate that emotion may operate toward opposite consequences and require unique treatment.

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[6]Hodge, *Systematic Theology*, 123.

[7]Berkhof, *Systematic Theology*, 233; and Hodge, *Systematic Theology*, 129. As a result of sin, Hodge suggests that Adam and Eve had a sense of degradation and pollution associated with shame, and a dread of displeasure from God associated with guilt as a fear of punishment. Berkhof described Original Guilt as a Federalist view of original sin based on a Covenant of Works theory suggesting that when Adam sinned, as representative of the human race, the entire nation of the human race sinned. On the other hand, Original Pollution is defined as corruption that has infected human nature as a result of the fall of Adam and is inherited by the entire human race.

[8]Ehrsson, Holmes, and Passingham, "Touching a Rubber Hand," 10564-73; Kalat and Shiota, *Emotion*, 47; Mataix-Cols, *et al.*, "Individual Differences," 3050; and Newberg, *et al.*, "Neurophychological Correlates," 92.

In the corrupted state as internalized shame, research outcomes suggest the distinction between behavioral guilt and essence-based shame are somehow blurred or confused. Given results indicating strong internalized shame presence, with a nonsignificant difference between types of suffering, the outcomes suggest that while shame remains in its corrupted state as internalized shame, the emotion may no longer serve as an aid in pointing the subject to Christ, but instead functions as an overall symptom roadblock requiring treatment as an individual pathology. This indication appears to align with Johnson's conceptualization: "believers who have been spiritually abused or raised in an environment that focuses on sin without the gospel of grace may have difficulty reading the Bible without it activating perfectionism or excessive shame and guilt."[9]

Suggested Reconciliation for the First Observation

The absence of specific alignment to Axis-I disorder groups, the presence of high ISS scores, and follow up analysis indicating a possible correlation of internalized shame with co-morbidity of Axis-I diagnoses, combine to suggest that shame, and specifically internalized shame, may be a more serious issue than originally considered. Observed data indicated a correlation of internalized shame across all Axis-I diagnoses, and higher ISS scores positively correlated with the number of Axis-I diagnoses for an individual. Unlike guilt, these results suggest that shame damage may occur at a deeper level, with wider ranging effects across both level and type of suffering.

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[9]Beck and Demarest, *Human Person*, 250; and Johnson, *Foundations for Soul Care*, 14, 311.

This adjustment indicates the need for a deeper respect for the placement for the emotion in Genesis and the seriousness of God's response to Cain's "downcast countenance" shame expression with "sin is crouching at the door; and its desire is for you, but you must master it" (Gen 4:6-7). Given the suggested effects, a greater care is called for when working with internalized shame in others in accordance with Gal 6:1, "Brethren, even if anyone is caught in any trespass, you who are spiritual, restore such a one in a spirit of gentleness; each one looking to yourself, so that you too will not be tempted" (Gal 6:1). Great care must be taken to help those in pain without pushing them further into the jaws of sin, because even the minister is at risk.

Second Observation: Absence of MMPI Defensive Patterns, Presence of High and Low ISS Responses

The results of this study showed very few "defensive" or "faking good" MMPI-2 patterns, and a significant number of scores, which were extremely high and very low, evident in a tri-nodal distribution of the ISS dependent variable. In concert with the absence of MMPI-2 defensiveness scores, high ISS scores indicated no significant differentiation of shame by presence or absence of identified defensiveness patterns. High ISS scores indicated a strong presence of internalized shame. The Self-Alienation (Pd_5) MMPI-2 content subscale thought to be associated with guilt revealed a large correlation with very low internalized shame scores. These results represented several dilemmas to the theological foundations of this study in that they both support and detract from schemata previously held.

Shame has been described as a physiologically powerful emotion (Num 12:14; Ezra 9:7; Ps 6), resulting in fear and anger as secondary expressions (Gen 3:8; 4:8), or

behavioral expressions of avoidance, internalization, and withdrawal (Gen 3:10).[10] Within the context of this scriptural framework, and in the current study population where emotional dysregulation was common, peaks within internalized shame scores were understandable, and patterns of defensiveness in MMPI-2 scores were anticipated. To have one pattern occur and not the other was intriguing.

In certain circumstances, extreme responses and defensive patterns could be identified as resistance, which in the past may have indicated confrontation as an appropriate intervention. However, given outcomes of past studies and this current study, such a confrontation would likely result in entrenchment rather than healing of the internalized shame.[11] The occurrence of internalized shame within a Christian population initiated questions regarding Schaeffer, Garrett, McIntosh, and Rima's conceptualizations of a Christian's vulnerability to sin.

Scripture identifies shame as useful in confrontation and correction across individual, social, and spiritual spectrums (2 Tim 3:16; Titus 2:8). Additionally, Scripture contains directives to exercise great care to confront "in a spirit of gentleness; each one looking to yourself, so that you too will not be tempted" (Gal 6:1; Eph 6:4; Heb 12:12-17), without condemnation (Matt 7:3ff), constantly keeping the purpose of the confrontation in mind: "If your brother sins, go and show him his fault in private, if he listens to you, you have won your brother" (Matt 18:15).[12] The impact on those

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[10]BibleMaster.com, *Greek Lexicon*, Internet; and Thayer and Smith, "*Entrepo*," Internet; de Hooge, Zeelenberg, and Breugelmans, "Restore and Protect Motivations," 111; Delitzsch, *Biblical Psychology*, 15-19; and Stuart, "Shame," Internet.

[11]Combs, Campbell, Jackson, and Smith, "Exploring the Consequences," 128.

[12]Gal 6:1, "restore him in a spirit of gentleness . . . so that you will not be tempted"; Matt 7:3ff; 2 Cor 2:5-9; and Heb 12:12-17.

condemned by severe shame from authority figures outside and inside the church was considered, as was an exploration of the conversation on boundaries between empathy and justice represented by Johnson and McMinn. Additional exploration into the behaviors associated with internalized shame is warranted, including how to identify them and how to respond to others as loving siblings in Christ.

Reconsideration of Theological Literature of the Second Observation

Initially, the lack of defensiveness scores appeared not to support Schaeffer's position that the expected dysfunctional response to the pain of shame would likely be a dichotomy of either rebellion or resignation.[13] However the tri-modal ISS score distribution that included extremely high and very low scores renewed support of the position. Additionally, the extreme high and low responses supported Ross's descriptions of relationship corruptions from sin, representing a shift in man's positional relationship to God, others, and himself into one of enmity, anger, and wrath.[14] This position was difficult to resolve with the fact that the majority of clinic participants of the current study identified themselves as Christian. However, resolution of this apparent dilemma may reside in previous recommendations to resolve the internalized shame first, then move to functional shame and guilt resolution.

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[13]Dan 4:28ff; Judg 4:8ff; 6:11ff; Bradshaw, *Healing the Shame*, 26; and Schaeffer, *True Spirituality*, 44. Nebuchadnezzar, Debora and Barak, and Gideon represent examples of the superhuman/ subhuman dichotomy. An inaccurate understanding of one's value as too high denies the need for God (Matt 19:24), and the inaccurate understanding of one's position as too low or too bad for God to redeem is inaccurate (John 5:5 and Mark 5:4ff); thus, they believe their "badness" is beyond God's ability to save.

[14]Eph 2:1ff; Grudem, *Systematic Theology*, 658ff; Jones, *Counsel of Heaven*, 33; Ross, *Genesis*, 31; and Schaeffer, *True Spirituality*, 94.

What was not clear initially was Schaeffer's suggestion that, without God, the resulting identity struggle is futile, because in sin, humans have no understanding of their position relative to their creator, a state that results in a consistent exposure to shame in a dynasty context.[15] Schaeffer's position did not seem consistent with functional or state-shame, because in a functional state, the emotion dissipates after the function is realized and the input stimulus is resolved. However, from the perspective of internalized shame as pathology that locks an experience of shame with the person long-term, Schaeffer's point appeared more consistent.[16] The pathology perspective of internalized shame as representative of a form of shame dysregulation aligns with the extreme high and low score data and scriptural accounts of dysfunctional responses to God's Truth that include attack, withdrawal, and confusion.

An additional problem occurred during interaction with this topic, namely that internalized shame, by definition, represents the sin of demeaning messages from some authority figure given to a disciple, until the disciple personally internalizes and repeats the messages. While the self-defeating thoughts and behaviors could represent the effects of what Schaeffer called repetition of "old-self" identity behaviors, a logical construct indicates the possibility that this population demographic could also have been aligned with Paul's Galatians 1:6ff discourse regarding believers being led astray by false teachers.[17]

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[15]Bradshaw, *Healing the Shame*, 26; Dodson, "Accountability Group," 49; McMinn, *Sin and Grace*, 122; Schaeffer, *True Spirituality*, 44, and 88; and Scott, *Naked and Not Ashamed*, 50.

[16]Schaeffer, *True Spirituality*, 44, and 88.

[17]Gen 3:10; and Ross, *Genesis*, 31. In this case, shame represents an indicator of boundary integrity when boundaries are established in accordance with Gal 6:2 and 5ff. From this perspective, boundaries represent a line by which one can discern whether to say "yes" or "no" to requests on their God-given resources (e.g. time, money, talent, commitment, and obligation).

The possibility of Christian authority figures acting in sin while believing they are within scriptural guidelines is supported in Scripture and leadership texts. Schaeffer characterized the corruption of man's relationship with himself as an inability to perceive oneself realistically (1 Cor 13:12). Blackaby suggests spiritual leaders are especially vulnerable to blindness pitfalls.[18] An example of extreme shame response would be to suggest that pastors, parents, or teachers become perfect. This extreme expression attempts to hide what McIntosh and Rima referred to as the "Dark Side of Leadership."[19] Internalized shame can be a learned behavior, taught by others, especially those in authority or those highly respected.[20] It is incumbent on those entrusted with leadership to examine themselves carefully.[21]

If internalized shame were the result of what Scripture identifies as false teachers, the most distinct illustration of the pathology would be represented by model patients who would imprison themselves in their own beliefs of powerlessness and lack of value, not out of a lack of faith in God, but specifically the result of accepting critical input from those placed in authority over them outside or inside the church.[22] These model internalized shame patients would have likely suffered physical, mental,

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[18]Henry Blackaby and Richard Blackaby, *Spiritual Leadership: Moving People on to God's Agenda* (Nashville: Broadman & Holman Publishers, 2001), 230.

[19]McIntosh and Rima, *Overcoming the Dark Side*, 22.

[20]Bradshaw, *Healing the Shame*, 109; Erikson, "Identity and the Life Cycle," 66; Fadiman and Frager, *Personality & Personal Growth*, 222; Tracy and Robins, "Self in Self-Conscious Emotions," 6; Gausel and Leach, "Concern for Self-Image and Social Image," 473; and Cankaya, "Anger as a Mediator," 936.

[21]Blackaby and Blackaby, *Spiritual Leadership*, 230.

[22]Paul directed believers continually to live out their new positions before God, remaining vigilant of the peril of false teachers even within the church itself. When only part of the Gospel is given and Romans 3:10-20 is used as critical input to a person without the addition of Romans 5:1ff and Ephesians 2:5, the message becomes false teaching.

emotional, or spiritual abuse, in some cases especially heinous because of the use of Scripture to justify the crimes perpetrated against them.[23]

These model patients would not normally align with Garrett's category of unbelief or distrust of God.[24] Rather, these model patients would represent followers of Christ, urgently seeking to know how to connect and relate to God in the midst of intrusive thoughts or images far beyond simple worry, flooding their minds, interrupting their abilities to think, or causing them to see things that were not present. From the perspective of sin, these patients would be suffering from what several theologians have distinguished as evil, possibly from the sin of others, and not necessarily from the consequences of their own choices.[25]

A final inquiry was the result of the positions of Johnson and McMinn that seemingly were conflicting. The corrupted internalized shame self-concept represents one's belief that he or she is "clothed in shame" (Ps 40:15) and not only broken, but unfixable even by God. According to Johnson, this self-concept results in defensive behaviors of fear and avoidance coupled with rebellion and anger, rather than acceptance, repentance, and contrition.[26] The extreme high and very low scores of the research appear to support Johnson's perspective. However, Dodson and McMinn's point remains valid,

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[23]Beck and Demarest, *Human Person*, 250; and Johnson, *Foundations for Soul Care*, 14, 311.

[24]Garrett, *Systematic Theology*, 535.

[25]Ibid., 556; Berkhof, *Systematic Theology*, 226; Grudem, *Systematic Theology*, 492; and Hodge, *Systematic Theology*, 129.

[26]Mark 9:42; Luke 11:46, 17:1-2; Acts 15:10; and 2 Pet 2:1; and Johnson, *Foundations for Soul Care*, 310.

that if one focuses on grace without sin, the subject does not have a chance to confront narcissism.[27]

The tension between Johnson and McMinn's proposals has been difficult to reconcile; however, some insight was provided in shifting the focus of the debate from functional shame to its corruption, internalized shame, as a unique spiritual pathogen. Dodson and McMinn's point appeared to be aligned with functional shame and guilt, and was supported by guilt scale data in the current study as likely to be effective. Johnson's position appeared more aligned with an internalized shame as individual pathology perspective, in which the pathogen would be addressed prior to addressing normal shame and guilt functions such that normal processing would be restored before confrontation. Working from the perspective of internalized shame as a corruption or abnormal shame, addressing internalized shame before normal shame and guilt would align with data in the current study showing internalized shame across all diagnoses.[28] Confrontation with internalized shame intact would likely result in an aggressive or passive response intended to defend against judgment, leaving the guilt intact. Fortunately, whether the source of corruption is personal sin, sin of others, or evil events beyond one's control, establishing treatment of internalized shame as prerequisite to other possibly more confrontational interventions still represents a viable reconciliation option.

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[27]Dodson, "Accountability Group," 48-52; and McMinn, *Sin and Grace*, 122.

[28]Internalized shame is distinguished here from "normal," "external," or "internal" shame. Internalized shame represents the habituation of negative self-talk messages heard during development, whereas internal shame could represent an internal recognition of a healthy, "normal," shame event.

Suggested Reconciliation for the Second Observation

A healthy functioning shame process would motivate the person toward, and be resolved through, development of an accurate positional and behavioral identity and relationship with self, society, and God.[29] Chapter five of Paul's letter to the Galatians encourages restoration behavior. However, simple application of Galatians 5 with the population of the current study was seen as difficult, in that Paul was addressing adults who had received the Gospel as adults, whereas 60 percent of the participants in the current study reported their first experiences with toxic shame of repeated social punishment of rejection and separation before age ten.

The suggested reconciliation is based in Paul's admonition to apply the gentle caution described in Galatians 6. Beck and Demarest proposed a healing approach to internalized shame, in keeping with Galatians 6:1 as a grace perspective focused on helping the person understand they are valued, loved, and accepted in God's grace through Christ in one's relational position as an adopted family member (Rom 8:15; 1 John 3:1). In other words, to align with this Galatians 6 perspective would require addressing the internalization of the shame first, taking a position of *paraklete*, and brother or sister in Christ.[30] Once restoration of functional shame is achieved, then confrontation of guilt and cleansing of shame can occur in an effective manner. The essence of this approach would be captured in the idea that before speaking into the

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[29]Gen 3:10; Beck and Demarest, *Human Person*, 227; Hunt and King, *Mind of Christ*, 66; Lowery, *1 Corinthians*, 509; Ross, *Genesis*, 31; and Stiebert, *Construction of Shame*, 48. Beck and Demarest propose that shame therefore represents a signal provided by the Creator, to help the individual perceive the boundaries of his or her position and essence before God, and level of purity within those boundaries (e.g. identity, essence, relational position, or role).

[30]Beck and Demarest, *Human Person*, 250.

justice or sanctification of the lives of others, addressed in the next observation section, one must first approach them as siblings, in love.

Third Observation: Male and Female Responses Distinct, Yet Similar

Study results consistently revealed significantly higher internalized shame scores for women than men, an anticipated difference because previous research had shown similar outcomes. Biblical manhood and womanhood have been described as distinct, while at the same time, equal in value to God.[31] Johnson described biological and neurological differences in the context of gender-based ontological equality.[32] Rekers has discussed the psychological foundations of masculinity and femininity from cultural and developmental perspectives, which parallel secular research, indicating developmental and language differences between male and female developmental experiences.[33] Psychological research has suggested that males have been more likely to be diagnosed with substance-abuse disorders than are females, and vice versa in anxiety

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[31]John Piper and Wayne Grudem, "Charity, Clarity, and Hope: The Controversy and the Cause of Christ," in *Recovering Biblical Manhood & Womanhood: A Response to Evangelical Feminism*, ed. John Piper and Wayne Grudem (Wheaton, IL: Crossway Books, 2006), 407.

[32]Gregg Johnson, "Biology: The Biological Basis for Gender-Specific Behavior," in *Recovering Biblical Manhood & Womanhood: A Response to Evangelical Feminism*, ed. John Piper and Wayne Grudem (Wheaton, IL: Crossway Books, 2006), 293. Johnson's position is consistent with additional developmental and linguistic research regarding gender "nurture" in addition to "nature" differences.

[33]George Alan Rekers, "Psychology: Psychological Foundations for Rearing Masculine Boys and Feminine Girls," in *Recovering Biblical Manhood & Womanhood: A Response to Evangelical Feminism*, ed. John Piper and Wayne Grudem (Wheaton, IL: Crossway Books, 2006), 294; Hussey and Katz, "Perception of the Use of Metaphore," 204; Allender, "Sexual Problems in Marriage," m10:30; Reeder, "Exploring Male-Female Communication," 117; Arthur, Johnson, and Young, "Gender Differences and Color," 828; Guiller and Durndell, "I Totally Agree With You," 369; Lanvers, "Gender in Discourse Behaviour," 492; and Parks and Robertson, "Attitudes Toward Women," 234.

and depression disorders, suggesting the possibility that shame might also be experienced differently between men and women in different diagnostic groups.[34]

The researcher in the current study did not anticipate the "same and yet distinct" quality between participant males and females to occur as uniformly across Axis-I disorder groups as it did. The outcomes of the current study suggest several possibilities regarding male and female internalized shame expression in participants of the current study: gender differences between internalized shame expressions may be consistent regardless of diagnostic differences, escalated experiences of internalized shame may mask gender expression differences between Axis-I disorders, or male and female differences between Axis-I disorder groups were not apparent because of the population size.

Reconsideration of Theological Literature for the Third Observation

Allender suggests when God judged Adam and Eve, he judged them both similarly, yet distinctly in terms of their sexual gender.[35] The curse on the woman represented the dynasty axis and resulted in a break in human relationships with self, each other, and God (Gen 2:25; 3:10). Allender's concept of God's curse on the woman as predicting pain in peer and general relationships aligns with this dynasty concept.[36]

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[34]David H. Barlow and M. Mark Durand, *Abnormal Psychology: An Integrative Approach*, 4th ed. (Belmont, CA: Wadsworth Publishing Co., 2005), 222, 234; Cook, *Internalized Shame Scale*, 6; Patrick J. Carnes, *Recovery Start: Book 2—The 90-Day Prep*, vol. 2, 3 vols. (Carefree, AZ: Gentle Path Press, 2008), 23; and Graham, *MMPI-2*, 163.

[35]Allender, "Sexual Problems in Marriage," m7:25.

[36]Gen 3:16-19; Allender, "Sexual Problems in Marriage," m9.35, 10.00; Ortlund, "Male-Female Equality and Male Headship," 109; and Ross, *Genesis*, 32.

The curse on the man represented dominion axis consequences and was represented by futility and hardship in human capabilities toward achievement of goals.[37] Allender's suggestion that God's curse on the man resulted in an atrophy of ability to subdue the environment aligns with Dempster's dominion concept.[38] Allender expands his concept to suggest a woman would bear her pain in terms of relationship (emptiness/ affiliation), while men would be expected to experience pain in relationship to accomplishment (futility).[39]

Cook proposed that inability to achieve would be associated with anxiety issues and guilt, while issues of relatedness and desirability would likely be associated with depression.[40] Given Allender and Piper's theological perspective, one might expect to see a clear distinction between male and female experiences of shame where a masculine experience would be associated with achievement and possibly guilt, and a feminine experience with worth, desirability, and possibly shame. Instead, observed results revealed females with higher internalized shame scores than males, and the scores for women remained higher whether the diagnosis was associated with depression or anxiety.

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[37]Dempster, *Dominion and Dynasty*, 49; Neyrey, *Honor and Shame*, 3; and Stiebert, *Construction of Shame*, 50.

[38]Allender, *Feeding Your Enemy*, Internet.

[39]Gen 3:16-19; Allender, "Sexual Problems in Marriage," m9.35, 10.00; Ortlund, "Male-Female Equality and Male Headship," 109, and Ross, *Genesis*, 32. For the man "futility," because in anything he does "death will be its end."

[40]Cook, *Internalized Shame Scale*, 6.

Suggested Reconciliation for the Third Observation

If differences did exist in the ways men and women experienced internalized shame between anxiety, substance abuse, and depression dysfunctions, they were either not observable, masked, or not present in this clinical population of one hundred participants. One other possibility is that when shame is corrupted and internalized, men and women experience it similarly, except that women either reported or experienced it more intensely.

From this perspective, the lack of significant difference observed in internalized shame score patterns between men and women could indicate an effect of corruption on shame that might obscure differences between men and women, or guilt and shame for that matter, into simple survival responses in which the painful experience of the corrupted state of internalized shame makes the distinction less relevant to the person experiencing the pathology, and thus would interfere with individualized healing. More research on this topic is needed to understand what these differences in male and female internalized shame scores really mean.

Fourth Observation: Shame and Guilt Differences

In post-analysis, significant differences between Axis-I diagnostic group differences were observed in MMPI-2 scales purportedly related to guilt, showing substance abuse scores highest in the Self-Alienation (Pd_5) subscale. This outcome appeared to challenge the position taken earlier in this study that explored the possibility of both shame and guilt as the same emotion. If MMPI-2 scales are valid measures of guilt, and internalized shame scale scores are precise with regard to internalized shame,

the data did not appear to support a position regarding guilt and internalized shame functioning in the same way or as a single emotional expression.

Self-Alienation scores revealed significantly different scores between Axis-I diagnosis groups, while internalized shame scale scores did not. Scores on the MMPI-2 scales associated with guilt revealed significant differences between diagnostic groups that were originally anticipated for shame. These observations, suggesting a possible difference between experiences of guilt and shame, present parallels to sin and corruption themes in Scripture, as well as Dempster's position that the resolution of the OT Dominion and Dynasty themes are represented in the NT concepts of justification and sanctification.[41]

Reconsideration of Theological Literature for the Fourth Observation

At the beginning of this research, it seemed that application of themes described by Berkhof, Hodge, and Grudem regarded a distinction between shame and guilt as distinct emotions with distinct purposes. This position was based on the theological constructs of shame as a signal to the presence of spiritual pollutedness, resulting in an initial desire to cover oneself, and guilt as a signal for awareness of trespass and fear of punishment.[42] Guilt was presumed to be experienced in the dominion axis, functioning to motivate a behavior of restitution for trespass of judicial or divine

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[41]Dempster, *Dominion and Dynasty*, 178-180, 234.

[42]Jas 1:8; Berkhof, *Systematic Theology*, 226; Hodge, *Systematic Theology*, 129; Grudem, *Systematic Theology*, 492; Johnson, *Foundations for Soul Care*, 24; and Stiebert, *Construction of Shame*, 49. This motivational purity represents both spiritual purity and identity as described in the NT term "double-minded" (Jas 1:8). Johnson describes a distinction in Scripture between guilt as associated with a person's actions (Rom 5:18-19), and shame as associated with a person's position, purity, essence, and value (Luke 9:26), as does Stiebert.

law. Shame was presumed to be experienced in the dynasty axis functioning to motivate behavior toward spiritual relationship restoration and purity.[43] This guilt/shame distinction parallels Berkhof and Garrett's concepts of depravity versus impotence in that pollution associated with depravity would represent an offense to relationship, and impotence a direct roadblock to ability.[44]

The position of the current study was modified based on the writings of Stiebert suggesting that the distinction between guilt and shame in the OT could represent the same shame experience, and Thompson who suggested that both emotions were a form of guilt.[45] This second position appeared to be supported by initial results indicating similar shame responses across Axis-I disorders.[46]

When self-alienation scores revealed significant differences between disorder groups, outcomes were observed to be similar to those initially hypothesized and not realized for internalized shame. Differences between observations of internalized shame and Self-Alienation (Pd_5) scores resulted in a return to the original hypothesis of this study: that guilt and shame expressions may be mutually distinct. Future research is warranted as to whether the corrupted state of shame, internalized or trait-shame, makes the distinction between shame and guilt more difficult to see or, as suggested earlier, less relevant to the person experiencing the pathology.

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[43]Gen 3:10; Beck and Demarest, *Human Person*, 227; Hunt and King, *Mind of Christ*, 66; Lowery, *1 Corinthians*, 509; Ross, *Genesis*, 31; and Stiebert, *Construction of Shame*, 48.

[44]Dempster, *Dominion and Dynasty*, 49.

[45]Stiebert, *Construction of Shame*, 50; and Thomson, *Heart of Man*, 21-22.

[46]Dempster, *Dominion and Dynasty*, 49. The emotion is experienced as guilt when associated with dominion issues of behavior, accomplishment, or the ability to subdue or rule one's environment.

At the end of this study, the concept of guilt and shame had realigned with that of Johnson's association of guilt with a person's actions (Rom 5:18-19), and shame with a person's essence or, in other words, purity, value, and relational position (John 1:12).[47] Additionally, this proposition of guilt and shame as separate emotions better aligns with Dempster's proposal regarding resolution of dominion and dynasty as NT sanctification and justification.[48]

Suggested Reconciliation for the Fourth Observation

As suggested in the previous observation, indications are that God may address the expressions of shame and guilt uniquely, with sanctification and justification respectively.[49] As stated earlier, Dempster has suggested that dynasty and dominion themes find resolution in the NT themes of justification and sanctification work of Jesus Christ.[50] Both Webster and Ferguson described the sanctification process in terms of purification (Rom 6:12-13; Eph 4:22-24; Jas 4:8), whereas justification happens once, but for all sins past and future.[51]

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[47]Cook, *Internalized Shame Scale*, 20; Garrett, *Systematic Theology*, 539; Grudem, *Systematic Theology*, 494-95; Johnson, *Foundations for Soul Care*, 24, and 320; Schaeffer, *True Spirituality*, 25; and Wilson, *God So Loved the World*, 21. Cook, *Internalized Shame Scale*, 21, suggested "shame is experienced as guilt when positive affect is attenuated by virtue of moral normative sanctions experienced as conflicting with what is exciting or enjoyable."

[48]Dempster, *Dominion and Dynasty*, 234.

[49]Rev 3:18; Beck and Demarest, *Human Person*, 250; Dodson, "Accountability Group," 48-52; Johnson, *Foundations for Soul Care*, 25; and McMinn, *Sin and Grace*, 122.

[50]Dempster, *Dominion and Dynasty*, 234.

[51]Gen 3:10; Beck and Demarest, *Human Person*, 227; Ferguson, *Holy Spirit*, 103; Hunt and King, *Mind of Christ*, 66; Lowery, *1 Corinthians*, 509; Ross, *Genesis*, 31; Stiebert, *Construction of Shame*, 48; and Webster, *Holy Scripture*, 86.

From this position of dominion and dynasty resolved in the sanctification and justification available in relationship with Christ, dominion is resolved as humans are empowered to subdue their existence and justified of their past through the Spirit (Rom 3:24-28; John 15:5; Phil 4:13).[52] Dynasty position is restored before God, as one is declared pure and intimately related to Him (John 1:12-13; Rom 8:12-17).[53] The suggested reconciliation is manifest in disciples trained to recognize a desire to hide as the signal to move toward contrition, repentance, and restoration of boundaries before the Creator (Gen 4:6-7). Additionally, training must include steps for how such a restoration is to be established; possibilities include integrity and empathy skills as proposed by Carnes and Brown.[54] A focus of intentional integrity would maintain alignment with the power of the Holy Spirit, and actions out of integrity with one's stated beliefs would result in transgression and the activation of guilt.[55] The previously identified distinction could thus be drawn between what is lawful as indicated by guilt, and what is profitable in relational and positional alignment (purity) as indicated by shame.

Conclusion and Summary

The original prospect of this research was based on a modicum of hubris. The belief was that, because of the perceived clarity of distinction between when shame was present and not present, the emotion similarly could also be clearly observed in human nature. Several insights have occurred during the process of this exploration. First, while

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[52]Ibid., 120.

[53]Grudem, *Systematic Theology*, 326.

[54]Ibid.

[55]Gen 3:10; Beck and Demarest, *Human Person*, 227; Hunt and King, *Mind of Christ*, 66; Lowery, *1 Corinthians*, 509; Ross, *Genesis*, 31; and Stiebert, *Construction of Shame*, 48.

shame may be described in simple terms, implications, experience, and effects are complex. Aquinas accurately observed, "Because God is infinitely simple, He can only appear to the finite mind as though He were infinitely complex."[56] If one believes the creations reflect the creator, and Proverbs 25:2 affirms, "It is the glory of God to conceal a matter, and the glory of kings to search out a matter," it would follow that concepts such as shame, while identified in simple terms in Scripture, will not be as simple to define or observe empirically, especially in a fallen world corrupted by sin.

Second, further reflection has reinforced the idea that the experience of shame itself is not always pathological and can act in service to God's will for healing and subsequent discipleship growth. However, shame may be mentioned so early in Scripture, because it is so basic to human nature, and as such needs to be interacted with great caution in that while great healing is possible, so also is great damage. Third, internalized shame appears to represent a corruption of shame, not a form of functionality, and as such requires focused treatment as a spiritual pathogen. Fourth, a scriptural perspective on current research suggests that some combination of Carnes's integrity and acknowledgment intervention with Brown's empathy intervention may provide important input to a balanced theological intervention inclusive of justification and sanctification concepts, perhaps to confront the guilty with truth and comfort the shamed with love. Finally, when internalized shame is present, it represents a therapeutic priority. In other words, treat the pathogen first, then deal with the shame and guilt.

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[56]Thomas Aquinas, "Summa Theologica, First Part, Question 3 'Of the Simplicity of God,'" *Christian Classics Ethereal Library*, Calvin College, 1274 [on-line]; accessed March 4, 2010; available at 2010 www.ccel.org/a/aquinas/summa/FP/FP003.html#FPQ3OUTP1; Internet; and Wikipedia, *Divine Simplicity*, Wikimedia Foundation (January 29, 2010) [on-line]; accessed March 4, 2010; available at http://en. wikipedia.org/wiki/Divine_simplicity; Internet.

A distinction made by ministry providers between guilt, shame, and internalized shame as individual events requiring unique treatment, opens an avenue to those suffering from internalized shame toward the freedom of becoming new creations in Christ. Addressing internalized shame behavior as pathology, with empathy, opens the possibility of the essence of the person beneath being loved and accepted just as they are as a prerequisite to treatment of presenting sin. This resolution aligns with Allender's description of shame as the "gift of exposure," and a "severe mercy" that allows humans to look deep inside to see what rules their hearts from a perspective of love rather than confrontation.[57] Additionally, this view perceives the emotions as soteriological motivators. Guilt is then useful to the Holy Spirit to bring a believer to repentance, while shame is useful to achieve what James refers to as purification of heart through humility and singlemindedness toward God (Jas 4:8). Imagery in both Zechariah 3:1 and Ephesians 5:26 illustrates a similar release from condemnation and process of cleansing, and a type of response by God of grace toward healthy shame and mercy toward healthy guilt.[58]

Whether internalized shame is an epiphenomenal indicator of pathology, or a causal defense mechanism to protect one's conceptualizations of themselves, others, and God as malicious, the effects become even more difficult to dismantle in a clinical setting. Outcomes of this study indicate internalized shame, as a corruption of shame, operates differently than functional shame or guilt. The hope of this researcher is to

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[57]Allender, *Feeding Your Enemy*, 20; Hunt and King, *Mind of Christ*, 66; Schaeffer, *True Spirituality*, 33; and Stiebert, *Construction of Shame*, 35.

[58]Johnson, *Foundations for Soul Care*, 25; and Rev 3:18. Buy "white garments so that you may clothe yourself, and that the shame of your nakedness may not be revealed."

illuminate a path that breaks through the complex and insidious embattlements surrounding the prisoner's heart and soul (John 1:1ff, Luke 4:18, Rom 6:17-20). To open possibilities of healing available through Jesus Christ, as the Word through which all creation was made, and the Holy Spirit, armed with the love of the Father.

APPENDIX 1

ITEMS OF CONSIDERATION FOR APPROVAL BY THE PH.D. COMMITTEE CONCERNING THE PROTECTION OF HUMAN SUBJECTS

1. Title of Study: A Study of the Relationship Between Trait-Shame and Clinical Mental Health

2. Researcher: Luigi Leos

3. Estimated beginning date of study: July 1, 2012

4. Estimated duration of the study: 6-to-12 calendar months

5. The subjects of this study will be patients, eighteen and older, receiving treatment at Meier Clinic Day Program in Texas and Illinois during the calendar year of 2012. They will be male and female of any race. Subjects will complete a twenty-question instrument designed to measure level of internalized shame as part of usual intake process at the beginning of treatment. No treatment will be administered to subjects. The number of subjects will be 150, thirty per diagnostic group (mood, anxiety, substance dependence, psychosis, and dissociation primary diagnosis). All patient records of those who sign an informed consent to be included in the study will be included. Name and other individual identification information will not be collected, and records will be tracked using the clinic-assigned unique record-identifier. Subjects will be aware that they are participating in a research study and that participation is voluntary. Completion of the instrument will require approximately ten minutes and will be done via provided scoring sheets. Subjects will be instructed to complete the instrument in accordance with the instructions provided for the other personality tests within forty-eight hours of their arrival times. No physical exertion is necessary for this study.

6. Information gathered will be kept confidential. Except for the clinic record number, no information that could be used to identify patients individually will be collected. If the information became public, little risk of recognition, embarrassment, or shame would exist, because clinic record-number associations to client identity are kept confidential. No additional foreseen risks or dangers exist to the subjects.

7. Except for the record number, no identifying information will exist in the database itself. Completed ISS standard answer forms will be attached to the client treatment file and subsequently stored and protected at each facility in accordance with Federal HIPAA law and Texas Administrative Code, Title 22, part 21, chapter 465.22.

8. All subjects will be eighteen years of age or older; therefore, no parental consent will be necessary for participation. Patients completing the ISS instrument will be given a consent form (see Appendix 2) that explains the nature of the study, a statement informing them that involvement is voluntary, and that their signature is required for inclusion of their information into the study. While the ISS instrument may be administered without completion of the consent form as part of IOP treatment, only those records that include a signed consent form will be included in the research.

9. In summary, all subjects will be required to sign or agree to a consent form in order to participate in the study. Participation is voluntary; therefore, while all may complete the instrument, their data will only be included if they authorize its use. Because all subjects will be adults, no need exists to obtain parental consent.

Signature of Researcher: ______________________________ Date: ________________

Signature of Chairperson: ______________________________ Date: ________________

Action of Ph.D. Committee: ____________________________ Date: ________________

APPENDIX 2

HUMAN SUBJECTS' RESEARCH
CONSENT FORM

You are being requested to participate in a short study to explore the relationship between feelings of shame and mental health diagnosis. The purpose of this study is to improve the quality of faith-based treatment in the clinical setting. This area of psychological research is important, and you can make an important contribution. Your identity will be protected and kept confidential in accordance with federal law and your name will not be used in any way. The data collected will be limited to Axis-I diagnoses, ISS score, age, gender, city and state of residence, highest education level, race or nationality, scores from MMPI testing, and clinic location and record identification numbers.

Directions: Please read and sign the attached release of confidentiality acknowledgement. Your name will not be collected as part of the data, no contact information will be collected, and your identity will remain anonymous.

Confidentiality of Information Acknowledgement

I, ________________________, understand that any information disclosed in this research study is confidential and protected by Federal Law. Federal Regulation (42 CFT Part 2) prohibits the release of any disclosure of such information without the written consent of the person to whom the information pertains. I further understand that I may withdraw from participating in the study at any time without explanation or penalty.

I agree to the terms set forth in this document:

____
Participant's Signature Date

APPENDIX 3

LETTER FOR PERMISSION TO PERFORM RESEARCH AT MEIER CLINICS IN RICHARDSON, TEXAS AND WHEATON, ILLINOIS

Nancy Brown
President, Meier Clinics
Wheaton, Illinois

Paul Meier, M.D.
Medical Director, Meier Clinics
Richardson, Texas

Dear Ms. Brown & Dr. Meier:

My name is Luigi Leos, and I am a Ph.D. resident student at Southwestern Baptist Theological Seminary in Fort Worth, Texas. I respectfully request permission to conduct a research study on the relationship between internalized shame and clinical mental health diagnosis. My intention is to establish empirical support for possible future development of a Christian psychology-based intervention on the impact of internalized or toxic shame on patients suffering from symptoms of DSM-IV-TR Axis-I disorders.

My hope is to include a thirty-question internalized shame scale as part of the normal intake process of the Day Program's psychological testing already conducted at those locations at no cost to Meier Clinics. Additionally, I would like to request addition of an informed consent form to be presented to clients during their Day Program intake. This would provide clients an opportunity to agree or decline permission to access their record information in accordance with Meier Clinics Client Rights Statement #13. I would provide on-site training for test and admissions coordinators in administration of the instrument, and for treatment teams in use of the Internalized Shame Scale (ISS) instrument in their treatment of patients at no cost to Meier Clinics. I plan to purchase all necessary ISS forms in the hope that the instrument could be beneficial to treatment and included in patient records for future reference, as well as useful for research purposes.

For your review, I have attached copies of the informed consent forms and the ISS instrument that patients would be requested to complete. The research would require access to ISS, MMPI-2 scores, and psychiatrist Axis-I diagnosis in treatment records of participants who consent to inclusion in the study. In order to maintain compliance with

HIPAA law, Federal Regulation (42 CFT Part 2), and Texas Administrative Code (Title 22, part 21, chapter 465.22), name, address, and other individually identifying information will NOT be used. The data to be collected would be limited to clinic location, clinic record number, Axis-I diagnoses, ISS score, age, gender, city and state of residence, highest education level, race or nationality, scores from MMPI-2 testing, and answers to three questions regarding their recollected age of first shame memory.

If you have any questions regarding this research, please contact the researcher directly or the guidance committee chair listed below.

Researcher: Luigi Leos
Address: 2099 N. Collins Blvd, Suite 100
Richardson, TX 75080
Phone: 214-477-1625
E-mail: Luigi.Leos@earthlink.net

Chairperson: Dr. Dana Wicker
Email: Dana@dbu.edu

Thank you for your consideration!

Your Servant in Christ,

Luigi Leos
LPC, LMFT, NCC

APPENDIX 4

PERMISSION TO USE THE ISS

Multi-Health Systems Incorporated
P.O. Box 950
North Tonawanda, New York 14120-0950
Email: customerservice@mhs.com

Greetings,

My name is Luigi Leos. I am a Ph.D. resident student at Southwestern Baptist Theological Seminary in Fort Worth, Texas. I respectfully request permission to reproduce the questions of the Internalized Shame Scale (ISS) in a proposal for my dissertation, and in the final dissertation.

I further request permission to use the ISS instrument QuikScore forms already purchased in a research study of internalized shame and Axis-I diagnosis in a clinical psychiatric setting.

Thank you for your consideration,

Luigi Leos, LPC, LMFT, NCC
Carrollton, Texas

From: Khira Ray <khira.ray@MHS.com>
To: luigi.leos@earthlink.net
Subject: RE: Order Confirmation 629589
Date: Mar 20, 2012 10:24 AM
Attachments: 0- Permissions & Translations Interactive Form Final Version.xls

Hi Luigi,

You must first gain permission to make copies of the QuikScore forms by filling out the attached application. With the purchase of the materials and meeting the purchaser requirements, you may go ahead and use the ISS in your research.

You may only include 6 items from the ISS in your research. Please indicate which items you wish to include in the applications well.

Regards,

Khira Ray|
Translations & Documentation Specialist
Tel:1-800-456-3003
416-492-2627
Fax: 1-888-540-4484
416-492-3343

From: luigi.leos@earthlink.net [mailto:luigi.leos@earthlink.net]
Sent: Tuesday, March 20, 2012 11:10 AM
To: Khira Ray
Subject: Re: Order Confirmation 629589

Khira Ray,

I plan to use these tests and will require an additional 250 QuickScore forms in a dissertation research study. Because I am not a first-time purchaser of b-designated materials, what do I need to do to gain permission to use the test in the research experiment, and copy the answer sheet (or some example questions) into the research proposal and dissertation appendices?

Thank you for your assistance in this matter.

Luigi Leos, MAMFC, LPC, LMFT, NCC

-----Original Message-----
From: Khira Ray
Sent: Jul 21, 2011 8:48 AM
To: luigi.leos@earthlink.net
Subject: Order Confirmation 629589

Thank you for your recent MHS order. Please retain the following order confirmation details for your records.
Order Number: 629589
Inventory Id: ISS040 Inventory Description: ISS Complete Kit
Quantity Ordered: 1 Unit Price: $ 131.00 Extended Price: $131.00
Your order will be shipped by UPS US Ground.
The shipping and handling cost of $15.00 has been added to your invoice, along with any applicable taxes.

Your invoice or receipt will be sent to you by standard mail service to the billing address provided.
For your reference, your MHS Customer ID is 177109.
Please reference this Customer ID number when placing future orders. If you have any questions or require further information, please contact our Client Services department at customerservice@mhs.com, or visit our website for complete contact information including hours of operation.
Thank you,
MHS Client Services

WWW.MHS.COM

APPENDIX 5

INTERNALIZED SHAME SCALE (ISS) EXAMPLE QUESTIONS[1]

Below is a list of statements describing feelings or experiences that you may have. Read each statement carefully and circle the number to the right of each item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below. Try to be as honest as you can when responding. Please answer all of the items.

Never	Seldom	Sometimes	Often	Almost Always
0	1	2	3	4

	Never	Seldom	Sometimes	Often	Almost Always
1. I feel like I am never quite good enough.	0	1	2	3	4
2. I feel somehow left out.	0	1	2	3	4
3. I think that people look down on me.	0	1	2	3	4
4. All in all, I am inclined to feel *that* I am a success.	0	1	2	3	4
5. I scold myself and put myself down.	0	1	2	3	4
6. I feel insecure about other's opinions of me.	0	1	2	3	4

---

[1]Multi-Health Systems, "MHS Student Research Discount Application Guidelines," Psychological Assessments & Services (North Tonawanda, NY: Multi-Health Systems, 2012), 3. Copywright and Responsible Use of Scored Data per MHS: MHS Inc. retains all rights to our published assessments. Although MHS staff may provide assistance in the interpretation of the results, we do not share the scoring keys of our assessments with researchers. For information related to test construction, reliability and validity, please refer to the technical manual. MHS does not grant permission under any circumstances for full versions of our instruments to be included as a part of a dissertation, in the appendices, or included in any document derived from the use of our instrument in your study or for any other purpose. Misuse to this end is a violation of MHS's copyright. Full versions are available on a temporary basis for review-board approval purposes only under the requirement that they be destroyed shortly thereafter. You may include up to six items from the assessment for illustrative purposes with the appropriate permissions. See Part B of the application to apply for permission. The instrument(s) used in the project cannot be copied or reproduced, in whole or in part, or distributed to individuals outside of the designated research team for any reason. The instrument(s) used in the project cannot be translated, modified, or used to develop another psychometric assessment tool without the expressed permission of MHS, please contact us before applying should you need to make this request.

APPENDIX 6

ADMISSIONS COORDINATOR INSTRUCTIONS FOR ADMINISTRATION OF THE ISS INSTRUMENT[1]

This research project will span six months and requires the administration of three forms: Research Consent Form, ISS test results, and the Historical Data Collection Form. Once the forms are completed, all three are to be placed in the patient's chart/record in the same location as their other psychiatric tests.

RESEARCH CONSENT FORM

The Research Consent Form is to be completed during the intake process when other administrative and patient consent forms are signed. Assure the patient that their participation is voluntary, and they are not required to sign the research consent form.

HISTORICAL DATA COLLECTION FORM

Please place a copy of the blank historical data collection form in the patient's chart with the psychosocial assessment forms for completion by the therapist during the intake session.

ISS TEST: General Information/Logistics

You will be provided a set of fifteen tests and one electronic copy of the ISS test on a jump drive. For your initial fifteen intakes, the ISS is to be administered first, before the other tests.

For each patient intake after the first fifteen, and for the remainder of the six months of the study, the order in which they take the ISS test in relation to the other assessments does not matter. For these patient intakes, print out a copy of the ISS test using the file on the jump-drive provided.

---

[1]Cook, *Internalized Shame Scale*, 6.

Administer the ISS to all patients, whether they sign the consent form or not. Data for those who do not sign the form will not be used in the research; however, the test results will be available to the therapist should they wish to use them.

ISS TEST: Administration

The ISS test is to be administered during patient completion of other required psychiatric testing. DO NOT MENTION OR SINGLE OUT the ISS instrument from other tests as specifically measuring shame.

Before Administering the Test:

Enter the patient number in the name field to ensure confidentiality

This test is administered under the following guidelines assumed to be the same as the other testing performed at intake:

- There are no wrong answers.
- There is no time limit.
- Answers will be kept confidential.
- Complete the assessment in a single sitting.
- Base responses on current feelings, what you have most often experienced over the past few weeks.
- Circle only one answer for each item. If you have trouble selecting one of two choices, pick one. You will have an opportunity to discuss it further with your therapist when you meet with him or her.
- Answer all questions; please do not leave blanks.
- Do not score the form; the therapist will do the scoring.

During Testing:

Administer the Test Page only. Scoring will be done either by the therapist or the researcher. The patient may use the same pencil used for the other tests administered. If the patient has any questions regarding answering the test, ask them to do the best they can based on their present-day experiences.

When Testing is Complete:

Before filing the ISS test in the patient's record, ensure that all questions have been answered/filled in. Ask participants to complete any blank entries.
Place the completed ISS test in the patient's chart with the other psychiatric tests.

APPENDIX 7

THERAPIST INSTRUCTIONS FOR SCORING AND USE OF THE ISS INSTRUMENT[1]

This research project requires the completion of two forms: scoring the ISS test results, and asking the questions listed on the Historical Data Collection Form. Once completed, all three forms are to remain in the patient's record in the same location as the other psychiatric tests completed by the patient.

Scoring the ISS Assessment

The patient will have completed the test page. Instructions for scoring are included on the scoring page. Briefly, the ISS consists of two scales: Self-Esteem scale (questions 4, 9, 14, 18, 21, and 28), and an Internalized Shame scale (all remaining questions).

To score the test, simply add the response column values for the six self-esteem questions (score range 0-24), and the column values for the remaining twenty-four internalized shame questions (score range 0-96).

The ISS test is not specifically a measure of shame, but rather how often a person ruminates on shame messages. The test can be used to inform treatment in at least two ways: overall score indications and specific question responses. Use of the specific question responses in treatment is self-explanatory.

Overall Score

Scores between 45 and 59 have been associated with anxiety, scores above 60 have been associated with depression, and scores considered normal range from 35 to 44. It has been suggested that scores below 34 may indicate forms of defensiveness and attempts to conceal internal thought processes.

If the internalized shame score is above 50, the self-esteem score is expected to be below 18. If this is not the case, a discrepancy may be indicated as in the possibility of the subject attempting to conceal their internal thought process.

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[1]Ibid.

Historical Data Collection Form

The purpose of the form is to collect, to their best recollection, the developmental stage/age at which the patient first remembers receiving devaluing/worthlessness/shame messages.

It is not necessary to be exact, but it is requested that an estimated age (not age range) be provided.

If the earliest event is in adolescence or young adulthood, assess whether the recalled event is similar to others in early development. If not, use the age provided.

If an age range is provided, use the earliest age. If the patient suggests the messages have been with them as long as they can remember, or since birth, enter < 3 yrs. on the form and ask for an earliest recalled event, along with the age of that event.

If the patient has no recollection, as in cases of severe childhood trauma, please note "no recollection."

APPENDIX 8

HISTORICAL DATA COLLECTION FORM

(This form is to be completed by the patient during initial intake.)

Please answer the following questions to the best of your ability, as best as you can recall.

1. What was your approximate age at the time of your earliest memory of feeling shamed? ______________

2. What was your approximate age at the time of your most painful or traumatic memory of feeling shamed (if the same event as above, write "same as above")? ______________

3. What was your approximate age at your first memory of painful shame, if any, associated with your current condition? ______________

APPENDIX 9

MMPI-2 STANDARD SCALE ABBREVIATIONS[1]

Basic Scales

?: Cannot Say Scale, Patient Level Of Cooperation
L: Validity, Overly Virtuous Answers
F: Validity, Psychological Distress
K: Validity, Openness To Emotional Expression
Hs: Hypochondriasis
D: Depression
Hy: Hysteria
Pd: Psychopathic Deviate
Mf: Masculinity-Femininity
Pa: Paranoia
Pt: Psychasthenia
Sc: Schizophrenia
Ma: Mania
Si: Social Introversion-Extroversion
MAC-R: Mac Andrew Alcoholism Scale

Content Scale Abbreviations

Anx: Anxiety
Frs: Fears
Obs: Obsessiveness
Dep: Depression
Hea: Health Concerns
Biz: Bizarre Mentation
Ang: Anger
Cyn: Cynicism
Asp: Antisocial Practices
Tpa: Type A Personality Traits
Lse: Low Self-Esteem

---

[1]Ibid.

Sod: Social Discomfort
Fam: Family Problems
Wrk: Negative Work Attitudes
Trtn: Negative Treatment Indicators

Supplementary Score Abbreviations

Es: Ego Strength
Do: Dominance
Re: Social Responsibility
O-H: Over-Controlled Hostility
PK: PTSD (Keane)
PS: PTSD (Schlenger)
TRIN: True Response Inconsistency
VRIN: Variable Response Inconsistency

(Depression Subscales)

D1: Subjective Depression
D2: Psychomotor Retardation
D3: Physical Malfunctioning
D4: Mental Dullness
D5: Brooding

Hysteria Subscales

Hy1: Denial of Social Anxiety
Hy2: Need for Affection
Hy3: Lassitude-Malaise
Hy4: Somatic Complaints
Hy5: Inhibition of Aggression

Psychopathic Deviate Subscales
(Harris-Lingoes)

Pd1: Familial Discord
Pd2: Authority Problems
Pd3: Social Imperturbability
Pd4: Social Alienation
Pd5: Self-alienation

Paranoia Subscales

Pa1: Persecutory Ideas
Pa2: Poignancy
Pa3: Naiveté

Schizophrenia Subscales

Sc1: Social Alienation
Sc2: Emotional Alienation
Sc3: Lack of Ego Mastery, Cognitive
Sc4: Lack of Ego Mastery, Conative
Sc5: Lack of Ego Mastery, Def. Inhib.
Sc6: Bizarre Sensory Experiences

Hypomania Subscales

Ma1: Amorality
Ma2: Psychomotor Acceleration
Ma3: Imperturbability
Ma4: Ego Inflation

Social Introversion Subscales (Ben-Porath, Hostetler, Butcher, & Graham)

Si1: Shyness/Self-consciousness
Si2: Social Avoidance
Si3: Alienation, Self and Others

APPENDIX 10

TRANSFORMED ISS SCORE DISTRIBUTION

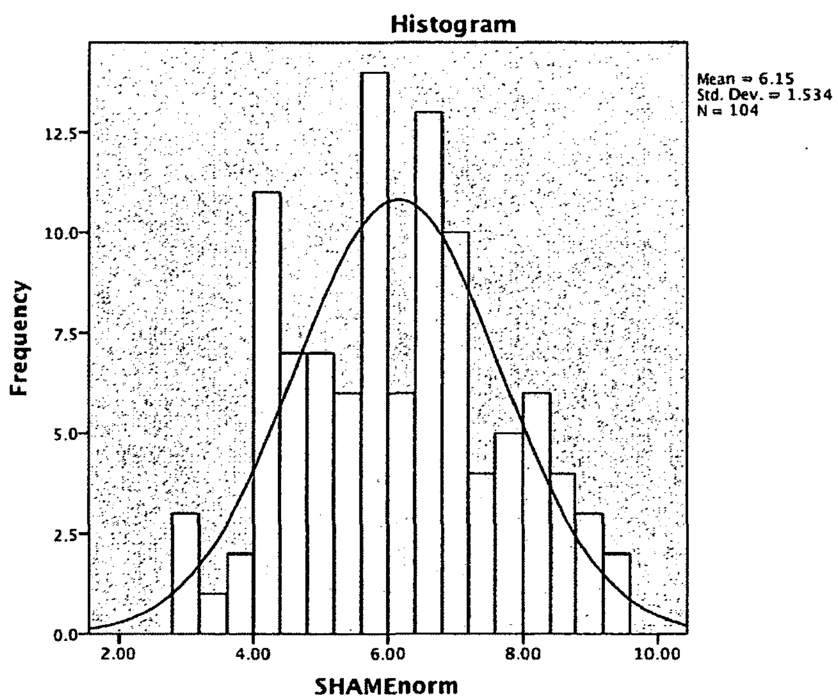

Figure 4. ISS score distribution.

APPENDIX 11

ISS PRINCIPLE COMPONENTS ANALYSIS
ADDITIONAL INFORMATION

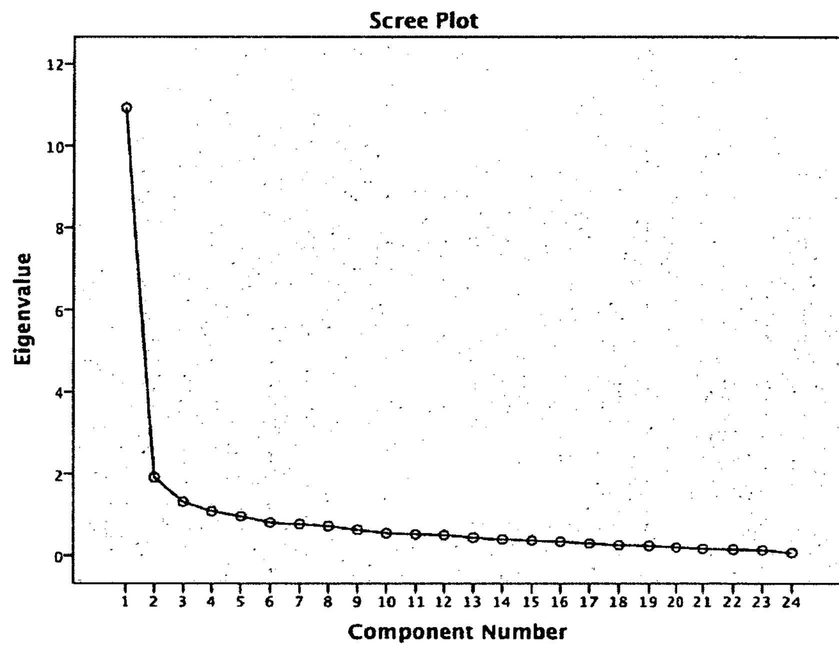

Figure 5. Scree plot of ISS item PCA.

Table 26: PCA unrotated loadings.

Item #	Component				
	1	2	3	4	5
I12	.794	-.125	-.155	.013	-.260
I10	.769	-.143	.156	-.096	-.010
I8	.763	-.182	-.099	.166	-.218
I27	.762	.395	.242	-.082	.048
I25	.744	.175	-.384	.038	.030
I6	.720	-.345	.004	-.013	.371
I19	.717	-.208	-.181	.258	.233
I1	.716	-.293	.324	.001	-.006
I7	.707	-.221	.255	.087	.106
I26	.701	.441	.160	-.077	.146
I20	.696	.076	-.137	.215	.209
I11	.688	-.030	.176	.010	-.372
I2	.673	-.086	-.052	-.444	-.155
I3	.653	-.119	-.071	-.473	.133
I24	.650	.205	-.388	-.035	-.130
I23	.647	.234	-.205	-.334	.083
I15	.640	-.140	.022	-.069	-.510
I13	.633	-.196	-.164	.247	.134
I17	.616	-.116	-.200	.368	-.128
I5	.606	-.337	.259	.198	.056
I29	.593	.521	.395	.121	.114
I16	.557	-.285	.178	-.292	.180
I22	.531	.409	-.403	.000	.121
I30	.528	.586	.300	.209	-.137

Extraction Method: Principal Component Analysis.
a. 5 components extracted.

Table 27: Component correlation matrix for PCA with Oblimin rotation of five-factor solution of ISS items.

Component	1	2	3	4	5
1	1.000	.391	-.177	-.403	-.493
2	.391	1.000	-.261	-.320	-.404
3	-.177	-.261	1.000	.116	.185
4	-.403	-.320	.116	1.000	.358
5	-.493	-.404	.185	.358	1.000

Extraction Method: Principal Component Analysis.
Rotation Method: Oblimin with Kaiser Normalization.

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VITA

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Luigi is a native of Texas and resides in Carrollton. He is the son of Elizabeth Carlo, RN. He is married to Mary Huguet Leos, a native of southern Louisiana, daughter of Joyce Huguet and the late Day J. Huguet Sr. Luigi is the father of one son, Antonio Luigi Leos, one daughter Allyson Leos Harris, and the grandfather to three grandsons.

After a six-year career in the United States Navy Submarine Service, and a twenty-year career in the Information Technology industry, Luigi answered the call to a ministry in counseling. He received his Master of Arts in Marriage and Family Counseling and Master of Arts in Christian Education from Southwestern Baptist Theological Seminary in 2007. He completed practicum at Millwood Psychiatric Hospital in Arlington, Texas, and an internship at the intensive outpatient treatment program at the Meier Clinics in Richardson, Texas. Luigi has spent the last six years on staff with Meier Clinics providing outpatient treatment for patients with clinical disorders and marriage and family therapy. Luigi is a Licensed Professional Counselor in the state of Texas and a Licensed Marriage and Family Therapist in the state of Texas.

Luigi holds a Bachelor of Arts of Vocational Education degree from Southern Illinois University and a Master of Arts in Management and Organizational Behavior from the University of Phoenix. He is a member of the American Association of Christian Counselors and is certified by the National Board of Certified Counselors.

Luigi enjoys spending time with his family, submarine movies, riding Harley-Davidson motorcycles, and martial arts.