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SHAME AND COMPULSIVE BEHAVIOURS

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A Dissertation Submitted to the Faculty of Arts, University of the Witwatersrand, Johannesburg in partial fulfilment of the requirements for the degree of Master of Arts (Clinical Psychology)

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ABSTRACT

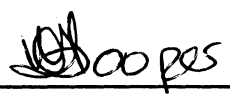
The area of shame, in psychology, has become increasingly popular in recent years. Despite a great richness of theoretical literature, there is, unfortunately, a dearth of actual research on shame. This study has sought to empirically investigate the relationship between shame and three compulsive behaviours, namely, alcohol dependence, drug dependence and disordered eating. Relations between shame and alcohol dependence, and shame and drug dependence have already been established in the research literature. This study sought to validate these relationships and to extend the research in the area to establish a link between shame and disordered eating. Cook's Internalised Shame Scale was used to assimilate shame, whilst Millon's Clinical Multiaxial Inventory was used to assess drug and alcohol dependence. Disordered eating was assessed by using the Eating Attitudes Test. Pearson's Product Moment Correlations were computed, and regression analyses were conducted. It was found that shame was significantly correlated with alcohol dependence, drug dependence and disordered eating, and that shame predicted 33% of the variation in alcohol dependent behaviour, 36% of the variation in drug dependent behaviour, and 30% of the variation in disordered eating.

Within the methodology used it was not possible to establish causality. However, it was possible to contextualise these results within the literature, and suggest possible explanations.

From within the literature on shame it was suggested that shame is linked to alcohol abuse and drug abuse as well as to disordered eating, and that the relationship is one of circular causality. Shame is consequent on these behaviours but these behaviours also attempt to reduce shame and are intended to be self soothing, and containing of the uncomfortable feelings attached to an inadequate sense of self. Limitations of the study, and suggestions for future research were examined.

DECLARATION

I declare that this dissertation is my own, unaided work. It is being submitted for the Degree of Master of Arts (Clinical Psychology) at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other University.



27 day of December, 1996.

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CHAPTER 1: INTRODUCTION AND RATIONALE FOR THE STUDY.

"Shame is an emotion insufficiently studied ..."

(Erikson, 1951, p.226).

In view of the above comment Erikson would have been gratified that shame, as a pervasive affect, rather than as a transient state moment, has in recent years been extensively examined in psychology. Previously, following Freud's precedent, guilt had been seen as the more important affect and was studied using a variety of methodologies and from a number of theoretical positions. However, in the last few years shame has become a popular area of study. Unfortunately, however, shame still tends to be discussed, at some distance, as an interesting idea and is seldom exposed to the rigours of empirical research, or the untidiness of therapeutic examination. In addition, although the current theoretical formulations of shame yield rich and evocative implications, there is still a lack of coherent theoretical integration in the area.

Although a more comprehensive definition of shame will follow in the literature review, it is useful to briefly define the term at this point, and separate shame from guilt. Shame inevitably invokes a failed self, whilst guilt is of action. More simply, one feels guilty when one acts in a transgressive way, whilst one

is ashamed because one is transgressive (Nathanson,1987).

Erikson's work on shame was largely prototypical, and he was successful in saying in a few pages what most theorists have taken far longer to explain. This is not, simplistically, to deny the power, or fascination of the work that has subsequently emerged in the development of a theory on shame, but to comment on the clarity and provocative simplicity of Erikson's formulation.

What Erikson, in an extension of Freud's ideas suggests, is that the developmental process of identity formation is enacted in the physical arena. This idea is of central importance to this study in that the understanding is that shame develops and is manipulated in the physiological cycle of control and release with particular reference to bodily excretions. Within this formulation, the anal phase is an enactment of separation, of developing a separately controlled physical body and ultimately a boundaried, autonomous psychological self. If this process is blocked by a power struggle for control over the child's body and identity, Erikson suggests that the result is one of shame about self and doubt in one's abilities.

In the consequent repetition of this struggle for separation and autonomy in the individual's life, the underlying shame and doubt

will, within Erikson's formulation, result in a compulsive holding on, an explosive letting go, or a cycle of the two. There will be an underlying rage, a need to hide away the self, and a vulnerability to the primitively and physiologically felt pain of being ashamed.

Subsequent writers have developed these themes and have discussed a developmental timetable for shame (Miller, 1989; Nathanson, 1987; Tomkins, 1962; Wurmser, 1990), the relation of shame to identity and healthy narcissism (Block Lewis, 1987; Lynd, 1958; Nathanson, 1987; Wurmser, 1990) the underlying rage that accompanies a sense of shame (Block Lewis, 1987; Scheff, 1989; Wurmser, 1987; Yorke, 1990), the secretive, hidden nature of shameful people's lives, the rigidity and compulsivity and implied interaction of shame with the conscience or superego (Kaufman, 1981; Lynd, 1958; Miller, 1989), and the relationship of shame to a lack of genuine flexible interpersonal boundaries.

The writers that have examined shame invariably say that they have come to an examination of this area as a result of perceived inadequacies in the clinical arena. In other words most writers on shame have found that this primitive emotion is often at the core of the therapy experience, and at the heart of certain pathologies but is insufficiently discussed. They suggest that guilt about what we do is easier to examine and account for than shame about who we are. Consequently further new themes have

emerged in the literature such as shame and the therapy process, shame and appropriate behaviour in culture, and shame in relation to drug and alcohol dependence, eating disorders and other compulsive behaviours. This last theme is one that has emerged in the last decade, largely as a result of the work by people such as Potter-Efron (1987), Kaufman (1981) and Cook (1986).

Compulsive behaviours are generally defined in the literature as those behaviours that occur repetitively, and effectively against the conscious will or desire of the individual concerned. They are usually recognised by the individual as destructive, or contrary to societal norms and values, and yet the individual feels compelled to repeat the behaviour again and again. It is not, for the purposes of this study, strictly accurate to define these behaviours as addictive, in that addiction implies a physical need for the behaviour. The use of the term compulsive suggests that the underlying need to repeat the behaviour is psychological and questions the psychological reasons for the original acquisition, and the subsequent maintenance of a behaviour or cycle which is potentially destructive. Behaviours which have been described as compulsive include alcohol and drug abuse, eating disorders, compulsive gambling or compulsive spending, to name a few. The behaviours which this study examines are alcohol dependence, drug dependence and compulsive eating habits.

In the psychological literature on drug and alcohol dependence and compulsive eating habits there are several themes linking these behaviours to shame, both directly and indirectly. At one level there is the obvious link of shame with being dependent on a substance, and all the consequent shameful behaviours that occur, such as being drunk, or losing one's job, or, in the eating disorders, there is the shame of binging, or of vomiting and of having one's life dominated by food. But this shame is as a result of the enactment of behaviours which are not sanctioned by society and most writers restrict their comments to the shame that results directly from these behaviours. At another level however, shame is beginning to be seen as in some way being at the heart of a compulsive behaviour cycle. Many writers comment that at the heart of the compulsive behaviours lies an inadequate sense of self or a tussle for real autonomous control over the individual's body or life which precedes the compulsive behaviour and is not only consequent upon it.

In the theoretical literature on shame there is an established link between shame and drug dependence as well as between shame and alcoholism. In relation to alcoholism and shame it has been suggested that shame is transmitted in families, particularly families where there is a secret such as abuse, and that behaviours such as alcohol dependence are likely to develop as a way of coping with the secret (Fossum and Mason, 1986; Potter-Efron, 1989; Imber-Black, 1992). The relationship between shame

and alcohol dependence, and by implication, the relationship between shame and drug dependence has been empirically investigated, but the relation between shame and eating disorders has not been investigated. This latter relation has been suggested by the literature, but not empirically established. Furthermore, within the theory, despite the now extensive literature linking shame to narcissism, and the development of self (Block Lewis, 1971; Lynd, 1958; Nathanson, 1987, Miller 1990), the impaired development of a sense of self has not been linked with the eating disorders although it has been with alcoholism and drug dependence.

The aim of this study was, therefore, to assess the relationship between shame and compulsive eating habits. In order to compare the results of this study with others in the literature the relationship between shame and alcohol and drug dependence was re-examined. Shame was measured using Cook's Internalised Shame Scale. Drug and alcohol dependence were measured using Scales 7 and T respectively of the Millon Clinical Multiaxial Inventory. Compulsive eating habits were measured using the Eating Attitudes Test. The interrelationships between these variables were calculated using Pearson's product moment correlations.

CHAPTER TWO: ORIGINS OF THE NOTIONS OF SHAME: AN EXPLORATION OF DEFINITIONS.

> "Why is shame surfacing now? The recent acceleration of addictive, abusive and eating disorders has shifted the focus of attention. These are syndromes in which shame plays a central role, and the new and growing focus on these particular disorders has moved shame into the spotlight."
>
> (Kaufman, 1989. p.4)

2.1. A CHRONOLOGICAL DEVELOPMENT OF THE LITERATURE ON SHAME.

A knowledge of shame would seem to have been part of our cultural heritage from the very earliest of times. This may account for an exploration of shame within the discipline of anthropology, long before psychology, as a discipline, began to examine the idea. The earliest references to shame are those in religious texts, such as the Bible, with, for instance, allusions to the power of shameful exposure in the Psalms and the reference to Noah's sons respecting his shame and avoiding the sight of his exposed genitals. There are further references in the Talmud where the Talmud tractate Shabbath says "Jerusalem was destroyed because its people had no shame." (in Wurmser, 1987). Implicit

in the biblical texts of the Creation is a relationship between shame and knowledge, and shame and sexuality. The orthodox Jewish conception of hell includes an awareness of a time when the individual examines his life in the presence of other people and is shamed by the misdeeds or waste in his life.

There is a Greek myth told by Protagorus on the origins of shame. It holds that Zeus, fearing the destruction of the human race who lacked "the art of politics", sent his messenger, Hermes to earth with two gifts, Aidos and Dike. Aidos is a sense of shame incorporating a concern for the good opinion of others. It is the shame that is felt in the public betrayal of a mutual ideal, such as a soldier betraying his companions. Dike, in this case, means the respect for the rights of others, and implies a sense of justice. With shame and justice (or respect), man[1] was considered by the gods to be in a position to live amicably with one another. (Pines,1990).

In the *Laws,* Plato speaks of two kinds of fear, the fear of something evil happening, and the fear of shame (Aidos). He goes on to say, "And isn't it further so, that this fear saves us in many important ways..." (in Wurmser, 1987, p.66).

Within English literature there are many references to shame,

---

[1] Please Note: The male generic pronoun will be used throughout this dissertation.

amongst them Shakespeare's *King Lear*, Tolkien's *Lord of the Rings*, and Tolstoy's *War and Peace* (Wurmser, 1987). The exceedingly painful nature of shame was described in a letter written by Keats in 1818: " The most unhappy hours in our life are those in which we recollect times past to our own blushing. If we are immortal that must be Hell" (in Hultberg, 1988. p.115).

Shame, within culture, is seen as a social regulator, and this idea becomes central to psychological conceptions of shame. Jacoby (1994) comments on the essentially social nature of shame by saying, "Shame resides on the borderline between self and other.". The notion of shame as defined by culture will be further developed later in this review.

Both `shame' and `guilt' as words derive from Old English roots, but shame appears in some form in all Germanic languages. The Indo-European base of the word shame is `isikam' or `skem', meaning to hide or cover up, to envelop, and at times it also carries the meaning of `wound'. The old English root of guilt carries the dual meaning of guilt and debt (Banmen, 1988; Lynd, 1958; Pines, 1990).

There are multiple connotations attached to the word `shame' in English. These include, primarily, the sense of shame as a private experience, and as a public communication (Buss, 1980). French, German and Greek have separate words for the separate

communication of the public and private nature of shame. For instance, the French word `pudeur' communicates the modesty surrounding sexuality, and the word `honte' the public conception of a shameful act (Banmen, 1988; Lynd, 1958; Pines, 1990; Wurmser, 1987.).

What follows is a chronological development of the literature on shame in psychology. This review in no way claims to be comprehensive. The literature in psychology is both prolific and broad ranging, and it has consequently been necessary to incorporate a selection of key theorists.

Within psychology, the earliest mention of shame appears to be in the work of Freud who rarely uses the term. However, in his brief comments on shame, this father of psychology begins to delineate separate thematic strands which are later developed in the body of psychological theory in this area. In his *Interpretation of Dreams* he mentions shame in connection with embarrassment in frequent dreams about being naked. Apart from that Freud discusses shame almost exclusively in connection with disgust, and considers shame and guilt as an expression of resistance against the drives, especially the sexual drive (Hultberg, 1988).

The following passage is characteristic of Freud's conception of

shame:

> During the period of life which may be called the period of `sexual latency' - i.e. from the completion of the fifth year to the manifestation of puberty (round the eleventh year) - reaction formations, or counter forces, such as shame, disgust, and morality are created in the mind. They are actually at the expense of the excitations proceeding from the erotogenic, and they rise like dams to oppose the latter activity of the sexual instincts. (Freud, 1908, p.171.).

The themes of morality and conscience, the pre-oedipal development of shame in the formation of superego, and the cultural implications of shame are ones which are developed and expanded on by later theorists in the area. Freud, however, considered guilt to be the more significant affect of the two, thus setting a precedent . To this day, shame does not have a separate heading in the psychological abstracts, but is subsumed under a heading on guilt.

It would seem that the prototypical psychological understanding of shame lies in Erik Erikson's developmental theory. In *Childhood and Society* (1977) he defines the resolution of the second developmental stage, which corresponds with Freud's Anal phase, as the resolution of a crisis between Autonomy and Shame

and Doubt. Erikson defines shame as the awareness of absolute exposure, a metaphorical, and perhaps literal, nakedness. Interestingly, Erikson speaks of `a sense of' shame, and says,

> ... such senses pervade surface and depth, consciousness and unconscious. They are, then, at the same time, ways of experiencing accessible to introspection; ways of behaving observable by others; and unconscious inner states determinable by test and analysis.
>
> (p.226).

In that shame is associated with the Anal phase, it is associated with a physical cycle of control and release. Erikson suggests that excessive shaming results in a cycle of too much control and too much release. He implicates, at a later stage, the development of an overzealous conscience, or Superego, as a result of overwhelming shame. Furthermore he says, "Too much shaming does not lead to a genuine propriety but to a secret determination to try to get away with things, unseen - if indeed, it does not result in defiant shamelessness." (p.227). This begins to imply a connection between shame and compulsive behaviour cycles, involving hidden acts such as secret drinking, eating and drug abuse.

Erikson is the first psychological theorist to specifically and separately delineate shame, and in his writing in the area he

successfully points to those ideas which have subsequently been developed in the literature as central to an understanding of shame. His work is a prototypical cameo of all that follows in the area particularly because he sees shame as being bound up with identity or the development of self. Almost all of the subsequent literature on shame, no matter from what source, implicates the notion of a flawed sense of self and the inadequate formation of a healthy narcissism, and this idea is further developed at a later point in this literature review.

The first writer to elaborate on Erikson's ideas and to address shame as a separate entity is Helen Lynd, in *On Shame and the Search for Identity* (1958). Lynd uses Erikson's conception of ego-psychology as a springboard, and speaks of shame as central to the development of personal identity. According to Lynd, Erikson's concept of identity occurs within a dialogue between the individual and society. She comments that "... some sort of correspondence between the inner and outer world is indispensable for a sense of identity " (p.204) and consequently,

> ... it is almost impossible for an individual to develop a sure sense of himself unless he can find aspects of his social situation with which he can clearly identify. (p.215).

Lynd questions the rationale behind guilt being studied more often than shame, and delineates a shame and guilt axis in each

individual. The guilt axis incorporates a sense of wrongdoing, and responsibility, or accountability for one's actions. She suggests, rather interestingly, that this conception of guilt used to be about a categorical polarisation of good and bad, but that in modern times, metaphorical terms such as `maturity' and `productivity' are used instead.

The shame axis is seen to centre around the development of a self, of who you are, and the development of one's individual narcissism. In this area, she suggests that narcissism can either be a healthy self love which leads to a healthy self concept, or pathological narcissism which reflects an inadequate sense of self.

Lynd's work is progressive in that she draws a strong relationship between the individual and society, suggesting that healthy individuals result in healthy societies, and that healthy societies give birth to healthy individuals. Her closing comment, if somewhat idealistic, is interesting for her time:

> Pride in the sense of self-respect transcends shame, but it is fully consonant with humility. Only the man with true pride in his capacities as a human being can have a significant humility; only the truly humble in apprehending the immensity of the universe and the world beyond himself can have a significant pride - a sense of his own identity. (Lynd, 1958; p.258).

The next significant theorist to address shame was Sylvan Tomkins. His work, *Affect, Imagery, and Consciousness: Vol. 1 and 2.* (1962 & 1963), holds that affect is physiologically based, innate, and can be observed very early in the infants life, through observing facial expression. As a result he believes that the objective study of affect is possible, in that by distinguishing the various facial expressions registering affect the researcher can firstly pin-point the initial emergence of the affect, and secondly trace and register the development of the specific affect. Tomkins designates nine innate affects, comprising both positive and negative affect. Each affect, in symmetry with affect being innate, serves a role in the individual's functioning. The positive affects are, firstly, interest or excitement, observed by the eyebrows being down and the stare tracking an object; secondly, enjoyment or joy, observed by the smiling response; thirdly, surprise or startle, with eyebrows raised and eyes blinking (Tomkins, 1962).

The negative affects are firstly, distress or anguish, observed from the crying response; secondly, fear or terror, in which the eyes may be frozen open in a fixed stare, or moving away from the feared object to the side, the skin pale, sweating and trembling, and the hair erect; thirdly, shame or humiliation, with eyes and head lowered; fourthly, `dissmell', with the upper lip raised; fifthly, disgust, with the lower lip lowered and protruded; sixthly, and finally, anger or rage, with a frown, clenched jaw,

and red face (Tomkins, 1963).

Tomkins holds that shame as an affect base in the individual is innate in its basic form, but develops in the following way. He holds that when the infant looks into the mother's face and the mother's eyes return the gaze the relationship between infant and mother is affirmed. But, if the infant attempts to attract the mother's gaze and the mother does not respond, then the infant lowers its eyes in `defeat' or shame. If the infant is repeatedly unsuccessful in engaging the mother's gaze, then a pervasive affective base of shame can be established. Tomkins sees shame as a way of negotiating sundered relationships (in Nathanson, 1987).

The above is an almost punishing summary of Tomkins' work which is meticulously detailed, and offers some interesting and useful ways of assimilating affect and psychological development. Tomkins has enjoyed more recognition in recent years than when his work first emerged, particularly through Nathanson's most recent writing in which Nathanson represents Tomkins as a seminal theorist in the study of affect (Nathanson, 1992).

After Tomkins' work in the 1960's there were no key theorists in the area of shame until Block Lewis' (1971) work on the relationship between shame, guilt and pathology. She draws on previous work in the area, and on Kohut's work on narcissistic

personalities, to establish shame within a psychoanalytic framework as inextricably linked to a concept of self, to narcissism, and to relationships with others. Block Lewis suggests that in shame, hatred is turned against the self, and says that shame underlies the borderline and narcissistic personalities. Her work is central in delineating a link between shame and narcissistic rage and she espouses a shame-rage cycle in which the outcome is pathological. She says:

> Humiliated fury needs to be understood and therefore interpreted as a `feeling-trap'. On the one hand it is a `subjective' reaction; it is `only' about the self ... It is simultaneously evoking a rage reaction both at the self for being humiliated and at the other, who has been experienced as betraying, disapproving or scornful. Humiliated fury is inevitably directed against the offending other, and retaliatory impulses are evoked to `turn the tables' on the other. (Block Lewis, 1987; p.102.)

Block Lewis, at a conceptual level, integrates her work with that of the cognitive behavioral theorists, by invoking such theorists as Seligman (1981), in a discussion of attributional styles and depression. Block Lewis suggests that attributional style is about the attribution of blame, and that blame attributions are closely related to the concept of shame. Interestingly, however, she is emphatic that it is necessary to fully assimilate the

subjective nature of shame in a phenomenological methodology (1987). Thus her awareness of theoretical metaphors from partisan approaches within psychology yields a rich conceptual integration. As with many other writers in the field, she indicates that her research in the area of shame arose out of an awareness of a gap in her clinical knowledge in her dealings with patients (ibid).

In the 1980's interest in the area of shame increased. This section will incorporate the work of selected writers in the 1980' and 1990's.

The first general source of information concerning shame arises from psychoanalytic thought. Shame has always been perceived as lying within the province of psychoanalytic theory, largely, it would seem, because conceptions of shame are bound up with formulations of infantile psychic development. Thus shame is imbricated into the literature on the development of conscience or superego.

Interestingly, however, many theorists amalgamate their psychodynamic position with theoretical work from within other areas in psychology, such as that of cognitive-behaviour sim. Although this theoretical amalgamation can be problematic because of the vastly different assumptions underpinning the paradigms from which these approaches are derived, nevertheless these

attempts at integration are useful. Before considering these integrations however, the work of psychoanalysts such as Kaufman (1980 & 1989), Wurmser (1981), Nathanson (1987), Pines (1990) and Miller (1990) will be considered.

Kaufman conceives of shame as integral to interpersonal relationships. Shame originates inter-personally in significant relationships, where, he says, it sunders "interpersonal bridges", resulting in a shattering of trust in which one's expectations are exposed as wrong. He suggests that shame becomes internalised through the development of `shame-binds' in the three motivational systems of affects, drives and needs. These `shame-binds' occur when the child expresses a particular affect which is followed by a parental response inducing guilt. From Kaufman's perspective, the experience that has traditionally been labelled guilt is really internalised blame and contempt. He indicates that the critical phenomenological differentiation is not between shame and guilt but between shame as affect and internalised shame.

Wurmser (1981), in line with previous themes, delineates shame in relationship to narcissism and narcissistic rage. Interestingly, he is one of many writers in this area who devotes considerable thought to the role of shame in the therapy experience. He suggests that shame constrains the therapy encounter in a fundamental way, mediating what is included in

therapy, what is kept out of therapy, and that furthermore the use of shame provides the therapist with a powerful weapon, which, if unacknowledged can be wielded with devastating results.

Nathanson (1987 & 1992) draws heavily on Tomkins' work to delineate a very early timetable for the emergence and development of shame. Thus he holds shame as innate, and central to the development of individual boundaries in interpersonal relationships. He draws on Tomkins' discussion of the gaze to delineate the mechanisms by which shame develops in the individual, and how a pervasive shame base could be assimilated. Nathanson goes on to explicate the role of shame in various psychical constructs such as sexuality and the relationship of shame to guilt, from which he delineates specific clinical applications. Although, very often his theoretical concepts are fundamentally different to traditional psychoanalytic precepts, he draws heavily on the psychodynamic explanation to communicate his thoughts in this area, holding once again, that a full theoretical understanding of internal infantile psychic development in essential to a cohesive body of psychological theory.

Susan Miller (1989) provides, firstly, from within a strict psychoanalytic base, an explication of shame and its role in the development of conscience. She also speaks of assimilating the shame experience via phenomenological methods to, in some way

acknowledge the subjectivity of the shame experience. In *The Shame Experience* (1985) Miller is meticulous about delineating the many experiential connotations of the shame experience, and translating this experiential detail back into theoretical formulations. One of her useful contributions is the discussion of the interplay between shame and feeling states such as sexual excitement, and aggression.

In this discussion Miller comments that a feeling state can be regarded as " a statement by the self about the self." (p.124), and generally the selection of feeling states arises out of individual defences. For instance, should the individual move from shame to anger, this is partly because an aggression or rage underlies the shame experience, but, she posits, it is also largely because anger may be more easily negotiable than shame, for the individual concerned. Miller's work will be examined later in this literature review in more detail in relation to the question of a developmental timetable for shame, the development of conscience in the individual, and the development of healthy narcissism.

A second major source of recent theory on shame is in the literature of compulsive behaviours, such as alcoholism, eating disorders, compulsive spending, or compulsive gambling. Clinicians have developed an entire area of theory around the shame concept based largely on their therapy with individuals

manifesting compulsive behaviours. Amongst these theorists are Fossum and Mason (1986), Potter-Efron (1989), Cook (1982 & 1991) and Middelton Moz (1990).

What this group of writers generally postulate, is that shame, as a result of its origins in the anal phase, if experienced in excessive amounts, expresses itself in a cycle of control and release, which cycle repeats itself in the notorious control and release cycle of the compulsive behaviours.

Fossum and Mason (1986), speak of shame based family systems, and suggest that shame is transmitted from generation to generation, regulating the families concerned via the unspoken shameful elements of their interactions. These two writers suggest that in those families in which specific pathologies such as incest or alcoholism are manifested, the underlying shame produces various pathologies such as the compulsive behaviours. Within this formulation shifting the compulsive behaviour requires the recognition of the underlying shame base and breaking the shame-cycle.

McFarland and Baker-Baumann (1990) discuss the relationship between shame and the eating disorders. They suggest an interplay between the compulsive shame cycle previously delineated, and cultural elements concerning body image and eating habits as one of the primary bases of the eating disorders. Other writers such

as Scheff (1989) attempt to delineate the role of eating disorders as a shame metaphor.

There has been a considerable amount of work done in the area of alcohol abuse and shame by people such as Potter-Efron (1989) and Cook (1982 & 1991). Cook devised an Internalised Shame Scale in response to his work in the area of alcohol and drug abuse, through the use of which, Cook and Potter-Efron established a significant relationship between internalised (in contrast to momentary) shame and alcoholism. This instrument has been used to assess shame in this study and will be further discussed in the methodology chapter.

What follows first however is a discussion on the definition of shame for the purposes of this study.

2.2. TOWARDS A DEFINITION OF SHAME.

The following represent dictionary definitions of shame which, although somewhat pedantic, are included to show the many strands that are incorporated in definitions of shame. As was mentioned in the introduction to this literature review, an accurate definition of shame is difficult because the one word implies so much and this is clear in the dictionary definitions below.

shame: n. the humiliating feeling of having appeared to disadvantage in one's own eyes, or those of others, as by shortcoming, offence, or unseemly exposure, or a like feeling on behalf of anything one associates with oneself: susceptibility to such feeling: fear or scorn of incurring disgrace or dishonour: modesty : bashfulness : disgrace : ignominy : disgraceful wrong : cause or source of disgrace : a thing to be ashamed of : those parts of the body that it is felt to be immodest to expose. v. to make ashamed : to cover with reproach : to disgrace : to put to shame by greater excellence : to drive or compel by shame.

(Webster's Dictionary, 1971)

shame n. 1. Feeling of humiliation excited by consciousness of (esp. one's own) guilt or shortcoming, of having made oneself or been made ridiculous, of having offended against propriety, modesty, or decency, (flushed with shame ; begin with shame to take the lowest room). 2. Restraint imposed by desire to avoid such humiliation (cannot do it for very shame; has no sense of shame, is quite dead to or lost to shame); for -! (appeal to person not to

disregard or reproof for disregarding, this restraint or desire). 3. State of disgrace or regret or ignominy or discredit (shame on you!; put person to -, disgrace him esp by exhibiting one's superior qualities etc. ; person or a thing that brings disgrace etc. (is a shame to his parents; would think shame to do it; is a sin and a shame) What a -!, (1)that is disgraceful!, (2) how unlucky!.

shame v. 1.Be ashamed, refuse from shame to (he shamed not to say). 2. Bring shame on, be ashamed to make ashamed; put to shame by outdoing (a sanctity which shames our religions); force by shame into or out of doing, conduct, etc.

(**Oxford English Dictionary**, 1976)

The above definitions notwithstanding, and in line with the literature reviewed, shame, for the purposes of this study, is defined as a particular and specific affect which not only occurs transiently in state moments, but has an underlying affective base acquired over time in a series of shameful moments or events. Thus this definition encompasses both the idea of shame as a transient state and shame as a trait. This is important in relation to compulsive behaviours because, by definition,

compulsive behaviours result in shameful moments, but it will also later be argued that compulsive behaviours are rooted in shame as a trait. This assumption underpins the Cook shame scale which was used in this study. The Cook scale, like the present author, conceives of shame as a particular affect and does not conceive of it as an affect that can be subsumed under general negativity.

This assumption is in contrast to that made by Watson and Clarke (1984) who suggest that affects such as depression, anxiety, and by, implication, shame, can be amalgamated as a tendency to experience negative affectivity. It is however in line with the view of Yorke (1990) who asserts that, "Shame differs from `negative affects' other than guilt in that it is a major regulator not only of social conduct and personal relationships but even at times of thinking itself." (p.1).

Thus it would appear that there is sufficient justification in the general literature on shame for the adoption by this study of the aforementioned definition. Before concluding this section however, it might be useful to include some descriptions of the shame experience derived from the literature in an attempt to communicate some sense of what shame `feels like'.

According to Lynd (1958),

> Blushing manifests the exposure, the unexpectedness,

> the involuntary nature of shame. One's feeling is involuntarily exposed openly in one's face; one is uncovered. With blushing comes the impulse to `cover one's face', `bury one's face', `sink into the ground. (p.33).

Yorke (1990), goes on to say,

> Shameful experiences are not easily forgotten and when recalled the affect itself may be strongly re-experienced. It carries with it a strong sense of exposure...of nakedness. (p.1).

He speaks of the role of an observer whether actual or internalised, the sense of being watched as a central component of the shame experience.

Kaufman (1980), along with Tomkins (1987), speaks of blushing and averting ones eyes, and Pines (1990), speaks of the sense of inferiority and inadequacy that accompanies shame. But it is Erikson, who, once again offers an apposite summary when he says,

> Shame supposes that one is completely exposed and conscious of being looked at: in one word self-conscious. One is visible and not ready to be visible; which is why we dream of shame in a situation in which we are stared at in a condition of incomplete dress,

> in night attire, `with one's pants down'. Shame is early expressed in an impulse to bury one's face, or to sink, right then and there, into the ground. (p.227).

Having provided these descriptions, this section ends however, with a restatement of the definition of shame which it intends to accept. Thus, shame is defined as a particular and specific affect which not only occurs transiently in state moments, but has an underlying affective base acquired over time in a series of shameful moments or events.

Having argued for the acceptance of the above definition of shame, the following chapter will explore the relationship between shame and guilt and a variety of other themes which are frequently highlighted in the literature on shame.

CHAPTER THREE: A SELECTIVE EXPLORATION OF COMMON THEMES IN THE SHAME LITERATURE.

The current literature on shame is voluminous. In the following chapters therefore the author will confine herself to themes which seem to have some relevance to the association between shame and compulsive behaviours, this topic being the focus of this study.

As compulsive behaviours are usually transgressive of social norms and generate both a sense of shame and guilt, this chapter will begin with an exploration of the relationship between shame and guilt.

3.1. Shame and Guilt.

Traditionally the theory of shame is linked with that of guilt, and the separation of one from the other is quite difficult. As was mentioned previously shame is still listed in the psychological abstracts under the heading of guilt. This linking of the two affects is not just a theoretical one, there is a closely linked interaction between them in psychological

processes. As Hultberg comments,

> Shame and Guilt feelings thus tend to be confused in our culture, and a thorough analysis of both is often required to distinguish between the two emotions. (1990, p.115).

Within psychoanalytic theory, shame is seen as being absorbed by guilt during the emergence of the Superego in the resolution of Oedipus. This formulation arises out of Freudian psychoanalytic theory and is seen by many as providing an inadequate explanation of shame (Miller,1989; Nathanson, 1987). The debate on the emergence of shame will be developed more fully under the relevant theme, but suffice to say at this juncture that shame is regarded as a primitive affect, and guilt as the more sophisticated affect, attention to which in the therapeutic context is not only easier, because it is developmentally more accessible, but ultimately more valuable. Indeed some theorists, notably Block Lewis (1971), see shame as merely a more primitive form of guilt.

This study sees shame as separate from guilt, and surmises that a fuller understanding of the role of shame in the psyche will provide valuable material in and of itself. As Lynd (1958) comments,

> Nothing comparable (to guilt) covers lack of beauty or grace, errors of taste and congruence, weakness and certain kinds of failure, feelings of meanness or envy, rejection of the gift of oneself - situations that are experienced as exposure of deeply personal inadequacy. (p.64).

The literature covers endless formulations on the similarities and differences between shame and guilt, which it is useful to explore briefly. In addition, the interplay between these two affects will be commented on at regular intervals in the remainder of this literature review, in an attempt to distinguish between the two affects with a view to delineating their possible relationship.

It is generally agreed that guilt carries the implication of responsibility, whilst shame carries a sense of inadequacy of self. More simply, guilt is as a result of something `I have done', whilst shame is as a result of `who I am'. Thus Pines (1990) comments that shame cannot be repaired, or reparation made for it, whilst guilt can, and Nathanson (1987) states that guilt implies action, whilst shame implies that some quality of the self is brought into question, and goes on to say, "Guilt limits action, while shame limits narcissism." (p.5).

Block Lewis (1981) states that the core tendency of the human

being is to seek social contact, and that both shame and guilt are affects that mediate social interaction. According to Friesen (1979), shame is a failure experience and a rational experience, and as such grows out of a loss of self control, and is accompanied by a loss of self-esteem. The self is seen as lacking, and more specifically as lacking in social terms (in Banmen, 1988). In this sense it is similar to guilt which is generated by a sense of having acted in a socially transgressive manner.

Thus, it is suggested that the most important link between shame and guilt is that both affects constrain the cultural, and the individual within the cultural.

3.2. A Developmental Timetable for Shame.

It is impossible, however, to conceive of shame in a relationship to such concepts as culture and conscience without being able to place this affect within a developmental timetable. There are however many different views as to exactly when shame is first experienced.

One of these is outlined by Kaufman (1989) when he suggests that shame is accessible throughout the life cycle, that there is no

one time when shame is developed, but that it is a response to shameful events at any time in the individual's life.

The second theory on the development of shame is that outlined initially by Tompkins (1962) which suggests that shame is an innate affect as evidenced by early facial expressions such as blushing and lowering of the eyes. This theory forms a basic part of Nathanson's work, and can be integrated with Kaufman's position in that a constant potential for shame implies an innate capacity for the affect.

In a similar vein, arguing for the innateness of shame, but also implicating a belief in its emergence slightly later in the first year of life Broucek (1982) argues that "... so-called stranger anxiety in the first year of life is probably as much shame-shyness as anxiety."

In yet another view concerning the development of shame, a number of psychoanalytic theorists ally the development of shame with the anal phase, and postulate that it emerges roughly between one and a half and three years.(Erikson, 1951; Miller, 1989; Wurmser, 1990). This view represents the more traditional developmental theories on shame and places the genesis of shame between the fifteenth and twentieth months of life (Wurmser, 1990).

All the above mentioned theorists consider shame to be pre-oedipal, and to be subsumed by guilt in the post-oedipal emergence of superego. Miller (1989) specifically outlines a theory of conscience within this timetable where she suggests that the experience of shame is so painful, in that it is the experience of a flawed self, that guilt, which is an experience of regret for something one has done, not something one is, arises and takes the place of shame.

While the above mentioned authors focused on the time frame for the emergence of guilt, other writers in the field have focused on the mechanisms through which shame develops.

The early object relations theorists, basing their work on that of Melanie Klein, stressed the role of the primary other in the early shame experience. The suggestion is that the `bad-me' is based in shame, and Alonso and Rutan (1988), hold that the imagined loss of the object in the paranoid-schizoid position demonstrates to the infant his basic unloveableness (in Gorsuch, 1990).

There is, as yet, no conclusive evidence for any of these positions. Yorke (1990), comments that, "Extensive observations in our mother-toddler group, where the children's ages range from 16 to 27 months, have failed to identify unequivocally the earliest roots of shame. It was difficult to know whether a

particular piece of behaviour was source, expression or result of shame. "

Of course, a similar situation pertains when, as in this study, one examines the links between shame and compulsive behaviours in later life.

Despite the difficulties involved in pinpointing the time at which shame develops, there is consensus in the literature that it is an emotion which is embedded in the social. Thus there is agreement that shame is sustained through experiences of being shamed, and that these experiences occur early on in a social context. Thus Demos (1983) for example, postulates that the mediating factor in the development of shame is the sudden un-relatedness accompanying the sundering of the infant-mother communication dyad. This has its roots in specific deficits in the caretakers capacity to transform negative affects in the child, and produces an experience of incompetence in the context of which the child attempts to form a safe linkage for the unbound image of his own badness and dangerousness attached to these affects. The resultant ideo-affective complex is what Klein (1957) termed `bad-me' which intensifies the feeling of shame implicit in the original sundering of the communication dyad (Nathanson, 1987).

Thus shame arises in and is sustained by difficulties in the

social world which have profound implications for the child's ability to bind, regulate and deal with negative affect. It is this difficulty in the self soothing and the mobilisation of ritualistic, secret behaviours in the face of interpersonal failure that is implicated in the link between shame and the compulsive behaviours, which are the focus of this study. This link will, however, be fully explored at a later point. What follows now is an exploration of the more traditional link between shame and conscience.

3.3. Shame and Conscience.

> While shame keeps its watch, virtue is not wholly extinguished in the heart.
>
> Edmunde Burke.
>
> "Reflections on the Revolution in France."

The clearest theoretical explanation of the relationship between shame and the development of Superego or conscience is that outlined by Susan Miller (1989), in her article *Shame in the Formation of Conscience.* This was briefly indicated in the previous section but is elaborated upon here. In developing her

formulation Miller (1989) indicates that the way in which shame interacts with the development of superego occurs as follows. In the experience of shame, the self is experienced as painfully inadequate, and as a defence against this the young infant learns a conception of `I should', the transgression of which results in guilt. In the process of learning these shoulds the child learns what to do to avoid the painful shaming experience. Through this process, the internalisation of parental norms occurs, and finally the superego develops. Once the superego has developed, guilt develops, but unlike shame which is associated with a weak failed sense of self, guilt is located in a stronger sense of self which feels responsible for its own transgressions. In the move from shame to guilt the child also moves from a sense of being controlled by the parents to a sense of self control.

Thus Miller states that the very young child feels that his body, mind, and fate are controlled by the parents, and not by the self. He is ashamed of this inadequacy and because of this strives for self control. In the process, however, the child often begins to overvalue self-control and the child's recognition that self-manipulation was initially instituted to show `I can' (and therefore not feel powerless or ashamed) is lost to the feeling `I must' (or otherwise will be in the wrong and guilty). (p.234).

Thus Miller outlines clearly the link between shame and guilt and implicates shame in the development of conscience, which incorporates societies prohibitions and exhortations. It is this link between shame and societal expectations, expectations which are often culture specific, which is explored in the following section.

3.4. Shame and Culture.

At several previous junctures in this literature review, the importance of a relationship between the development of shame and specific cultural practices has been suggested. This view is however, perhaps best summarised by Pines (1990), who comments that,

> "Emotions are self-concerning, partly physical responses that are at the same time, aspects of moral and ideological attitudes. Emotions are both feelings and cognitive structures, linking person, action and sociological milieu." (p.2).

Implicit in this quote is the view that emotions are shaped by culture, idealogies and attitudes, but that such idealogies and attitudes are themselves perpetuated through the manipulation of affect.

This idea is further elaborated upon in the work of Lacan (1970) and Mitchell (1971) both of whom in their separate discussions of the Freudian explanation, speak of the transmission of culture in the negotiation of Oedipus. The implication is that in the interface between the development of the individual psyche and the family, a process of cultural transmission is enacted. This cultural transmission however, is dependent on the successful manipulation or regulation of affect within the individual, by the family and within society.

If, as has been stated at many stages in this review, shame is a powerful constraint, then it stands to reason that the places where the constraint occurs are the places where the individual and culture interact.

Thus Pines (1990) both affirms and legitimates this manipulation and regulation in the following quote,

> "... it is clear that both shame and guilt are powerful regulators of society's norms. We are all at risk from the actions of shameless persons who do not recognise the boundaries of these norms. Shamelessness is unlike gentleness ... To be shameless is to have power, to manipulate others." (Pines, 1990, p.4).

He once again underlies the importance of self regulation through shame for example when he suggests that there are areas that it

is appropriate to be modest about, or that need to be strongly modified by shame. In arguing for the importance of self regulation through shame, Pines (1990) not only stresses the importance of such regulation for the smooth functioning of society, but also for the development of a self which has some sense of its own separateness and privacy. Pines thus links the sense of shame to the issue of modesty and privacy, which he calls the external face of shame. In examining Western society he suggests two areas in relation to which privacy is crucial, namely sexuality and therapy.

In both of these areas Pines suggests that shame protects one's integrity, and warns if our sense of self is being exploited or invaded. In this sense shame speaks to damage inflicted upon the self by others, while guilt refers to damage inflicted upon others by the self. However, clearly the self can inflict damage on itself.

This self damage however, occurs in the realm of the social, even when this occurs only at the level of the imaginary, a fact that was stressed by the social anthropologist Ruth Benedict in her ground breaking work on shame and guilt in different cultures.

Benedict (1977) originally studied Japanese culture, and distinguished between shame and guilt cultures. In a shame culture, according to Benedict, the highest goal is not, as it

is in a guilt culture, a clear conscience, but a good reputation amongst people. Identification, and not submission is then the most important factor in the process of socialisation. In a shame culture there are no firm concepts of good and evil in the metaphysical sense of the words, instead there are absolute ideas of honour and disgrace, renown and contemptibility, respect and ridicule. In such societies ridicule is often the most extreme punishment which can be inflicted on an individual (Benedict, 1977).

However, as most modern anthropologists point out, it is impossible in practise, to make a clear distinction between shame and guilt cultures, and Benedict's theories have often been disputed. It has been suggested that Western-European culture seems to have developed from a guilt culture to a shame culture, and is now perhaps, a mixture of the two (in Hultberg, 1990).

Nevertheless the work done by Benedict seems to endorse Pine's ideas concerning the nature of shame as both a public and a private affect. It also endorses the notion that shame not only serves to control behaviour, but that given that shame cultures prescribe certain behaviours to reinstate good relations when these are sundered, this work affirms the notion that behaviour can also regulate shame, which is a central tenet of this dissertation, and is central to the context of therapy with those individuals for whom shame is the central dynamic.

3.5. Shame Within the Therapy Relationship.

> ... if shame is the emotion experienced when we are uncovered, then the very act of analytic exploration must produce shame...
>
> (Nathanson, 1987, p.64).

According to Yorke (1990), the clinical difference between shame and guilt is that guilt brings material into analysis, and shame keeps it out. What became particularly interesting in the compilation of this literature review was the way in which so many writers saw shame as integral to the therapy experience because the therapy encounter involves a disrobing of the self. Thus shame, to a large extent, defines the way in which the patient manages the encounter. To continue the metaphor, shame encompasses those parts that should remain hidden, and fashions the way in which the patient reveals himself (Lynd, 1958; Wurmser, 1987).

An area that has come to be seen as particularly important is the role of the therapist's shame. Firstly, Alonso and Rutan (1988), hold the training of the therapist to be an inherently exposing, shameful process, with the process of supervision exposing the trainee, in an often painful way. Equally, it is suggested that,

very often, the therapist in the countertransference responds with shame, which, if not acknowledged, can exacerbate the client's shame, in a potentially devastating way (Goldberg, 1990; Kopf, 1976; Pines, 1990).

Lynd (1958), devotes considerable attention to the power held by the therapist over the client. The following, rather lengthy injunction powerfully outlines the responsibility of the therapist to a vulnerable patient, who, according to Lynd, would be so largely due to the inherently shaming nature of the therapy. She suggests that this is because psychoanalytic therapy stands in a special relation to the search for identity:

> It would be impossible to explore the meaning of shame and of identity without special reference to psychoanalysis. ... No profession has ever occupied a position or assumed a responsibility entirely comparable to that of psychoanalysis. The psychoanalyst has been compared to a surgeon. But because of the kind of intimate relation he has and encourages with his patient, his own character and his personal values enter into his therapeutic methods in a way and to an extent that is not true for any surgeon. He has been compared to a priest. But the priest by the nature of his assumption does not do the kind of detailed probing over a period of years that the analyst does; and to many persons who attend

> psychoanalysis today, to speak with the voice of Science is more than to speak with the voice of God. This particular combination of intimacy and impersonal authority is, I think, without precedent. It gives to the analyst enormous power. The persons who come to him are vulnerable, and the process of analysis tends, at least in its initial stages, to increase their vulnerability. Both because of the methods they use and the content of their therapy, there is probably no group of persons today - with the exceptions of priests and some practitioners of `mental healing'- in a position to exercise as much power over persons with whom they come into professional contact as psychoanalysts.
>
> (Lynd, 1958, p.195/196).

According to Banmen (1988), an awareness of shame as a major force in the therapeutic encounter offers indications for treatment. He recommends acknowledgement of the power of shame for the patient, and working from a shame based identity to an identity that is self affirming. Hultberg (1990) says that shame bases are often a result of attacks on the individual's privacy, and consequently suggests that a respect for the individual's privacy should be inherent to the therapy process. In stressing the importance of a respect for privacy in therapy for the

development of an identity that is self affirming, Hultberg (1990) affirms the views of the self psychologists who delineate the circumstances which facilitate the development of a healthy sense of self and those which impede it.

He also implicitly acknowledges the intrinsic shamefulness of certain secrets, yet secrets in therapy are very often the heart of the therapy encounter. Perhaps, equally, it is the secrets in society that define its essence. Thus privacy and shame serve the same boundary defining functions in terms of what lies inside and outside of social acceptability, as they do in defining the boundaries of the self, the shifting nature of these boundaries notwithstanding. It is to the role of shame in the development of the self, that attention is now turned.

3.6. Shame and the Development of Self or Narcissism.

The relationship between shame and the formation of self, or identity, or narcissism, in the sense of investment in the self, (the term selected depends in part on the theoretical grounding of the specific writer), has already been shown in this literature review to be one of the central theoretical themes in any discussion of shame. This relationship, particularly relevant to the link between shame and the compulsive behaviours, is

postulated to exist in this study, as certain compulsive behaviours such as self-mutilation and even personality disorders have been postulated to serve as defences against shame. In this regard, the work of Block Lewis, who sees borderline personality organisation as a defense against shame is worth mentioning, as is the work of most self psychologists including (Kohut, 1971) who implicate shame in the development of narcissistic personality disorders. However, given the breadth of literature in this regard, the present review will mention only the work of Erikson for its historical importance, and the work of Kohut, who remains the most central and frequently cited of the self psychologists.

If, as has been stated earlier, Erikson can be said to be the first theorist to give separate and specific attention to shame, it must be noted that his discussion of shame occurred within a specific developmental theory that was part of his general theory defining the quest for identity in individuals. Thus one of the earliest discussions of shame took place in the context of a theory dealing with the formation of identity.

This trend has continued in the work of the self psychologists, most especially Kohut. Kohut (1971), focusing on the antithesis of the need for privacy, speaks of the child's need for exhibitionism and the need for this grandiosity to be empathetically affirmed by the gleam "in the mother's eye". Kohut

speaks of the importance of the mother's initial appreciation of the child's exhibitionism, and the equal importance of later natural, but gradual, empathetic failures in establishing the child's sense of a separate self, and sense of an ability to regulate and soothe personal affective states. Failure to acknowledge the child's initial need for exhibitionism through for example shaming him, and empathetic failures which are too intense for the child to tolerate, interfere with the child's original sense of merger with the mother, and a sense of trust in her ability to assist the regulation of inner states. Both the sudden sense of separateness from the mother, and the feeling that affective states will be overwhelming lead to a fragmentation of the self and an overwhelming sense of shame. Thus shame both initiates and is generated by an experience which sunders interpersonal contact, but most importantly for this study, by an experience which deprives the child of help in self soothing, and in regulating negative affect. It is this deprivation in the area of self soothing which the present author believes underpins the development of compulsive behaviours such as substance abuse and eating disorders. These are behaviours which the author believes the subject initiates to self soothe and to shore up a fragmented sense of self, and to deal with an overwhelming sense of shame. They are, however, behaviours which by their very nature generate shame, and thus in the longer term serve to elicit the very experience they are intended to ameliorate, thus giving them their compulsive nature.While it is

of course, not possible, other than through longitudinal studies, to establish causal links between shame and compulsive behaviours, it is the intention of this study to at least investigate whether an association between shame and certain compulsive behaviours can be established. In doing so the author intends to firstly to reinvestigate the relationship between shame and alcohol abuse and shame and drug abuse. This link has already been established in the literature to but this study will attempt to ascertain whether the link will still be significant in a non clinical population. Secondly,she intends to investigate the relationship between shame and the eating disorders to ascertain whether the link between shame and the compulsive behaviours extends beyond that already established with alcohol and drug abuse. This will again be assessed in a non clinical population. Before outlining the methodology of the study however, the literature pertaining to the links between shame and compulsive behaviours is outlined in Chapter Four.

CHAPTER FOUR: THE COMPULSIVE BEHAVIOURS.

4.1. Introduction to and Definition of the Compulsive Behaviours.

> Compulsion: Compelling or being compelled; irresistible urge; ...
>
> (Oxford Dictionary, 1984)

> Compulsion (Psychiatry): An inner drive that causes a person to perform actions often of a trivial and repetitive nature against his will.
>
> (Collins Dictionary, 1971)

Compulsive behaviours are defined in the psychological literature as those behaviours that occur repetitively, and, effectively against the conscious will or desire of the person concerned. They are usually recognised by the individual as damaging to their lives, or in some way contrary to societal values, and yet the individual feels compelled to enact these behaviours. These behaviours are central to a variety of pathologies ranging from substance dependence, to such pathologies as compulsive gambling

and spending, to the eating disorders. The behaviours measured in this study were alcohol and drug dependence, and the eating disorders, incorporating repetitive overeating, bulimia nervosa and anorexia nervosa, all of which have a compulsive quality.

Within the literature alternative terms such as addictive behaviour and dependent behaviour are also commonly used (Levin, 1987; Miller and Heather, 1986). It must be noted, however, that these alternative terms indicate a primary physiological base, whereas the term `compulsive behaviour' points to a recognition of psychological bases. This is not to suggest that the two do not interact, but rather that the term addictive behaviour has primarily been used by medical practitioners (Rankin, 1986).

Returning then to the notion of `compulsive behaviour', it would seem there is an increasing cognisance that certain behaviours have a common element in their enactment which can be effectively designated as compulsivity. As Rankin (ibid) comments,

> The fact that more cues frequently and more intensively exert their effect on behaviour is an important definition, not only of severe dependence, but also of compulsiveness. This raises the whole issue of the relationship between dependence and compulsion and focuses attention on the individual's inability to exert control, the development of the stereotypical behaviour, and the loss of flexibility

> in response. This raises further questions about dependence and compulsion. Clearly they are not the same phenomenon, but do actually share similar consequences, notably a loss of flexibility in behaviour. (p. 364)

Thus it has been recognised that individuals who enact one compulsive behaviour, may also enact other behaviours in a compulsive way. Williamson (1990) comments that those individuals who are alcoholics may also eat compulsively, or indulge in spending sprees and it is the contention of this study that shame is a central emotion underpinning all these compulsive behaviours.

4.2. Alcohol Dependence and Shame.

This is the area which has been most successfully researched within a quantitative empirical methodology. Both Cook (1988 & 1992) and Potter-Efron (1992) have established a clear link between alcohol dependence and shame by using Cook's internalised shame scale. Clinically this area has also been extensively explored by theorists such as Kaufman (1992), Nichols (1991), Jacoby (1994) and many others.

From within the literature on alcohol dependence, there is an

increasing awareness of the psychological bases of this disorder. Previously it was considered to be a primarily physical addiction with primarily physical treatment or solutions being indicated. However, in more recent years those in the field are suggesting psychological solutions to this condition.

For instance, Forrest (1983) suggests that "The interpersonal nature of alcoholism has been less than adequately appreciated and understood by clinicians and psychotherapists. ... Invariably the alcoholic is interpersonally conflicted." (p vii). And further, " The alcoholic sustains devastating narcissistic injury within the realm of mother-infant-significant-other relationships." (p.7).

This position dovetails with one of the significant hypotheses in this literature review, that shame and the development of a sense of self are inextricably linked. If the two positions are amalgamated, it may be that both the trait of shame and an inadequate sense of self are implicated in the development of alcohol dependence.

Nan van den Bergh (1993) states further that, "Addiction comes from an internalised sense of powerlessness that shows itself by an obsession with anaesthetic behaviours which are really destructive." (p.6). She then goes on to contextualise this powerlessness within a feminist perspective.

It is interesting to note that alcoholism was primarily considered, in the past, to be a male pathology. This is no longer necessarily the case. There is frequent discussion in more recent times on the increasing instance of female alcohol dependence (ibid).

In closing this section it is necessary to comment that much of the literature linking shame and alcohol dependence discusses the way in which families, by insisting on the alcoholism being kept secret, propagate a cycle of shame, which is then in itself linked to a number of compulsive behaviours including alcohol and drug dependence, sexual acting out, compulsive gambling and spending among others.

4.3 Drug Dependence and Shame.

The link between drug dependence and shame has also been well established in the theoretical literature as a clinical actuality by, once again, people such as Potter-Efron (1992) and Kaufman (1992). However, although it is not always discussed separately, it is almost always implicated as an addictive behaviour with similar dynamics to those of alcohol dependence.

Following from this recognition, drug dependence, like alcohol dependence is seen as being both inherently shameful and, further

as arising out of shame. Thus circular causality is implicated. Thus it would seem that substance dependence implies an inadequate sense of self, an interpersonal transmission of shame and addictive behaviour and an unhealthy relationship with secrecy.

From within the psychological literature on drug dependence Imber-Black (1993) comments that drugs are readily available for numbing and releasing the pain of buried secrets. Papp (1993) further comments that, "In most cases the treatment of addiction is the treatment of secrecy and denial." (p.150). These ideas once again dovetail with the literature on shame.

4.4 Compulsive Eating Habits and Shame.

It would seem that in this area the relationships between shame and secrecy, shame and culture and shame and the self intersect, and therefore all of these ideas will be discussed briefly in this subsection.

Eating disorders have traditionally been considered a womens' pathology, and explanations have tried to account for this in various ways. Gill Edwards in *Fed Up and Hungry* (....), speaks of women in relation to gender role expectations of being a good daughter wife and mother, and suggests that women can only

achieve control, autonomy or selfhood in indirect ways such as in relation to food. She refers to Szasz and says,

> Addiction, obesity and starvation are political problems, not psychiatric; each condenses and expresses a contest between the individual and some other person in his environment over the control of the individual's body. (p.67).

Other writers in this area have commented on the pressures exerted on women by the media to have a particular type of body, whilst at the same time placing women in charge of the shopping for and preparation of food. The preparation and presentation of food becomes one of the acceptable ways through which a women defines self. In these kinds of ways the eating disorders have come to be seen as an expression of women in culture. Gill Edwards (ibid) explains by saying "It is only one of a range of solutions found by women to the problem of living in a society which promotes an abundance of food but applauds a scarcity of flesh." (p. 182.)

The eating disorders have simultaneously been recognised as middle class diseases, or `diseases of wealth' (Bruch, 1988; Dally and Gomez, 1990; Dana & Lawrence, 1990). It has been commented that in order to use starvation psychologically, or abuse food in any way, one has to, by definition have access to enough food. According to the Encyclopedia of Obesity and Eating

disorders, these disorders are differentiated from starving by the actual access to food of those who suffer from these disorders. This encyclopedia traces the eating disorders through history, and the occurrence is always in societies of abundance (1994).

However, while these disorders may only occur in societies of abundance, writers, such as Bruch (1988) and Edwards (1987) return again and again to the fragile or damaged sense of self that underpins the eating disorders. One of Bruch's basic premises is that eating disordered individuals have a basic sense of not being adequate or good enough in the eyes of their mother primarily. She suggests that they are expected constantly to present themselves perfectly and to always be likeable, and that they are not allowed to express separateness or autonomy. This would link with the literature on shame in that shame is seen as central to the formation of an autonomous self, and a healthy narcissism. In fact it would suggest, theoretically at least, the possibility that shame may be causally implicated in the eating disorders. However, once established, shame is also implicated in the maintenance of the eating disorders given the secrecy and shame involved in rituals underlying these disorders. It is interesting to note at this point that many research studies indicate that women have higher scores on shame scales than do men (Imber-black, 1993).

Having said this however, perhaps the view put forward by Gill Edwards (1987) most adequately summarises the current author's view concerning the eating disorders in general,

> A consensus is gradually forming as to what anorexia, and the eating disorders in general are really about - at least at the level of the individual, and perhaps her family. To summarise many views these disorders may now be understood to be a desperate way of coping with the problems involved in becoming a self-respecting, autonomous person. (p.62)

4.5 Conclusion.

> Along with our awareness of abuse came our appreciation of shame as an engine that drives secrecy, forcing our stories underground and banishing our traumas to dissociated obscurity. Shame and secrecy may destroy lives in one generation and pass like an invisible cursed heirloom to the next, creating traditions of deception and evasion that no longer have a discernible origin.
>
> (Imber-Black, 1993, p.viii)

This review of the literature in chapters two, three and four, has examined the literature on shame and, to a lesser extent the theory on various compulsive behaviours, and attempted to justify a linking of these variables. The particular emphasis of this review has been that shame is bound up with the development of a sense of self in an interpersonal context. It has been suggested that one way of dealing with a damaged formation of self is the development of a particular behaviour cycle as a way of redefining or renegotiating a more complete or fuller sense of self. However, once this particular behaviour is used for self soothing or shoring up the self, especially if the behaviour is shameful and kept secret, the potential for it to become compulsive increases exponentially as it then comes to generate the very sense of deficiency in the self that it intends to correct.

That the use of alcohol and drugs in a compulsive manner is linked to shame has already been established in the literature. The intention in this study then, is to reinvestigate this relationship in a non clinical sample, and to further ascertain whether this link may be extended to compulsive eating habits. As the study is a correlational one, no causal inferences may be drawn from it. In any event, however, the theoretical literature indicates circular causality between shame and compulsive behaviours and the establishment of a significant association between the two variables will therefore in and of itself be

sufficient to support the postulates of the theoretical literature, which asserts that such a relationship does indeed exist.

CHAPTER FIVE: METHODOLOGY.

5.1. Aims of the Study.

As already indicated the aim of the study was to assess the relationship between shame and compulsive eating habits. In order to compare the results of this study with others in the literature the relationship between shame and alcohol and drug dependence was also assessed.

5.2. Research Design.

This was a non-experimental correlational study as no treatment was administered to the subjects at any time. Consequently, no causal relations could be inferred and only associations could be established.

5.3. Subjects.

The sample comprised 92 subjects from five industrial organisations within which the researcher had personal contact with departmental heads who agreed to hand out the

questionnaires. Subjects were approached by departmental heads, assured of confidentiality and further assured that participation was completely voluntary and in no way related to their work performance. Information to this effect was added to all the questionnaires. Questionnaires were returned in sealed envelopes. Some subjects posted their questionnaire back to the researcher. In all, 103 questionnaires were handed out but 11 were discarded on the basis of age and language. The profile of the subjects is presented in Table 5.1.

Table 5.1. Description of the Sample. (n = 92)

Variable	Category	Percent	Mean - Where Applicable	Standard Deviation
Age	18 - 24 25 - 40	19% 81%	28.13	5.31
Home Language	English Afrikaans African	83% 12% 5%		
Education	Bel. Matric Matric Degree Postgrad.	40% 26% 22% 12%		
Monthly Income (In Rand)	< 1000 1000-2999 3000-4999 5000-9999 > 10 000	1% 18% 39% 29% 13%	5300	3488
Length of Employment in Current Position	< 1 yr 1-3 yrs 3-5 yrs > 5 yrs	34% 29% 18% 19%		
Length of Employment in Previous Position	< 1 yr 1-3 yrs 3-5 yrs > 5 yrs	34% 33% 24% 17%		
Marital Status	Married Unmarried	57% 44%		
Sex	Male Female	41% 59%		

5.4. Instruments.

A questionnaire was compiled which included the following:

5.4.1. Measurement of Shame - Cook's Internalised Shame Scale.

This scale was formulated in 1988 by David Cook to measure the intensity of internalised shame within individuals. It was originally formulated in response to Cook's work with alcoholics and the families of alcoholics. Cook's instrument seeks to measure a level of pervasive internalised shame, not momentary shame or humiliation.

The scale consists of 35 items which have been tested on three separate populations for reliability and validity. Reliability indices for the samples were established by Cook, and they were 0,95; 0,93 and 0,95 respectively. Validity was established across four elements of Internalised shame (Cook, 1988).

In this study the mean was 33.6 out of a possible maximum total of 140 with a standard deviation of 22.02 and a range of 2 - 101, this standard deviation showing a heterogenous group on shame. The scores were moderately positively skewed (1.06) indicating that the majority of scores were relatively low with only a few relatively high scores. Expressed as a percentage, the rescaled mean was 24.00. The internal consistency reliability of the scale was high (KR-20 = 0.95), indicating the presence of a

unidimensional scale, ie. one which measures an underlying homogenous construct.

5.4.2. Measurement of Alcohol and Drug Dependence - Millon's Clinical Multiaxial Inventory (MCMI).

This inventory was designed as a diagnostic instrument in relation to DSM III R. It consists of 175 items arranged into 20 scales corresponding to DSM III-R diagnostic categories. This study has used the first edition of Millon's instrument, the second not being available at the onset of this study. Both versions are the result of extensive empirical enquiry and the MCMI-I which has been used for this study has yielded high validity and reliability scores on several studies (Mental Measurements Yearbook, 1992).

In this study Scale B measuring Alcohol Dependence and Scale T measuring Drug Dependence were used. Higher scorers on Scale B, the alcohol abuse scale, are considered by Millon to be at risk of a history of alcoholism, and to be living in constant relation to alcohol dependence. Higher scorers on Scale T, the drug abuse scale are equally considered to have a history of drug abuse, and to have problems restraining their impulses in relation to appropriate social limits.

In this study the mean for the drug dependence scale was 26.98 out of a possible maximum total of 89 with a standard deviation of 13.19 and a range of 6 - 74, indicating, once again a heterogenous group. The scores were moderately positively skewed (1.16) indicating that the majority of scores were relatively low with only a few relatively high scores. Expressed as a percentage, the rescaled mean was 30.31. The internal consistency reliability of the scale was high (KR-20 = 0.87), indicating, once again, the presence of a unidimensional scale.

In this study the mean for the alcohol dependence scale was 17.34 out of a possible maximum total of 64 with a standard deviation of 8.64 and a range of 5 - 46, indicating, yet again, a heterogenous group. The scores were moderately positively skewed (1.47) indicating that the majority of scores were relatively low with only a few relatively high scores. Expressed as a percentage, the rescaled mean was 27.09. The internal consistency reliability of the scale was high (KR-20 = 0.82), indicating the presence of a unidimensional scale.

5.4.3. The Measurement of Compulsive Eating Habits - The Eating Attitudes Test (EAT).

This scale is a 40 item measure of disordered eating attitudes devised by Garner and Garfinkel (1979). Although specifically designed as a diagnostic indicator of anorexia nervosa, it is a useful measure of compulsive eating habits including anorexia, bulimia and compulsive overeating. This scale has been shown to have significant internal reliability ($r = 0.94$; $p < 0.001$). Criterion validity for the instrument was also found to be significant ($r = 0.87$; $p < 0.001$) (Garner and Garfinkel, 1979).

In this study the mean for the EAT was 47.05 out of a possible maximum total of 130 with a standard deviation of 18.40 and a range of 6 - 130. The scores were moderately positively skewed (1.21) indicating that the majority of scores were relatively low with only a few relatively high scores. Expressed as a percentage, the rescaled mean was 29.41. The internal consistency reliability of the scale was high (KR-20 = 0.88), indicating the presence of a unidimensional scale.

5.4.4. Biographical Information.

In addition to the above, the questionnaire included questions

pertaining to age, home language, highest level of education attained, income, length of employment in current position, marital status, sex, whether the individual was currently in a long term relationship, and to what extent they considered career and relationship to be important priorities.

5.5. Statistical Analysis.

Pearson Product Moment Correlation Coefficients were used to investigate the interrelations of the biographical variables with the measures of compulsive behaviours. In addition, separate Stepwise Regression Analyses were computed using alcohol and drug dependence and compulsive eating as the dependent variables.

CHAPTER SIX: RESULTS.

In this chapter the results of this study are presented in three sections. In the first section a correlation matrix detailing the correlations between the main variables is presented, in the second section t-tests examining the differences between scores of males and females on the three measures of compulsive behaviour are presented, and in the third section the results of the stepwise regression analyses are presented.

6.1 Pearson's Product Moment Correlation Matrix.

The Pearson's Product Moment Correlation Matrix is presented in Table 6.1 for the biographical variables of age, education and income and the scores on the shame, EAT and alcohol and drug dependence scales.

Table 6.1

	Age	Educ.	Income	Shame	EAT	Drug Dep.	Alc. Dep
Age	1.00						
Educ.	-0.27	1.00					
Income	0.25 *	0.29	1.00				
Shame	-0.28 **	-0.12	-0.23 *	1.00			
EAT	0.20	0.05	-0.18	0.49 ***	1.00		
Drug Dep.	-0.17	-0.33 **	0.04	0.45 ***	0.14	1.00	
Alc. Dep.	-0.18	-0.31 **	-0.01	0.59 ***	0.21 *	0.86 ***	1.00

* $p < 0.05$

** $p < 0.01$

*** $p < 0.001$

From Table 6.1 it can be seen that:

- Shame is highly significantly correlated ($p < 0.001$) with alcohol dependence ($r = 0.59$), drug dependence ($r = 0.45$) and eating attitudes ($r = 0.49$). These relations are graphically represented in Figures 6.1, 6.2 and 6.3 in the form of scatter diagrams.

Fig. 6.1. Scatterplot Representation of the Correlation between Shame and Alcohol Dependence.

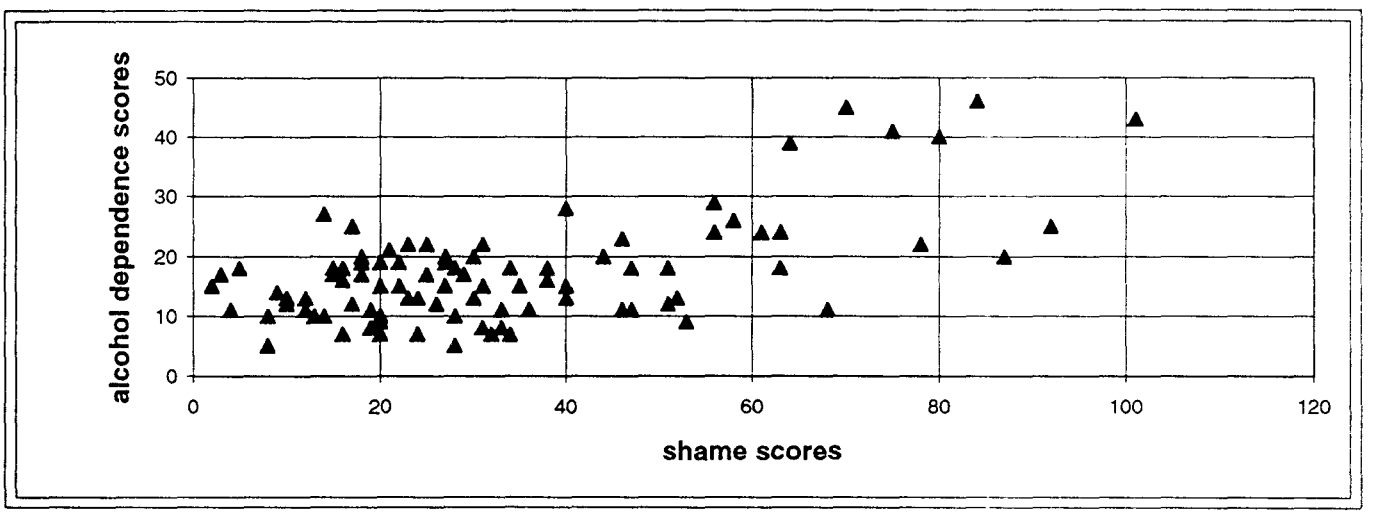


Fig. 6.2. Scatterplot Representation of the Correlation between Shame and Drug Dependence.

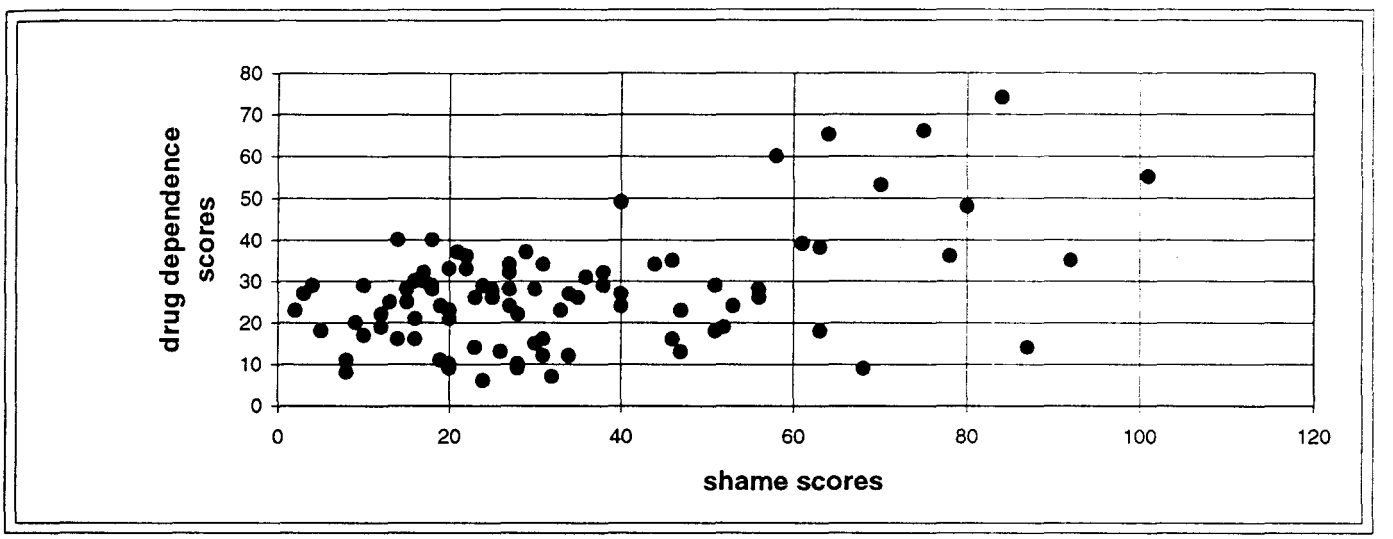
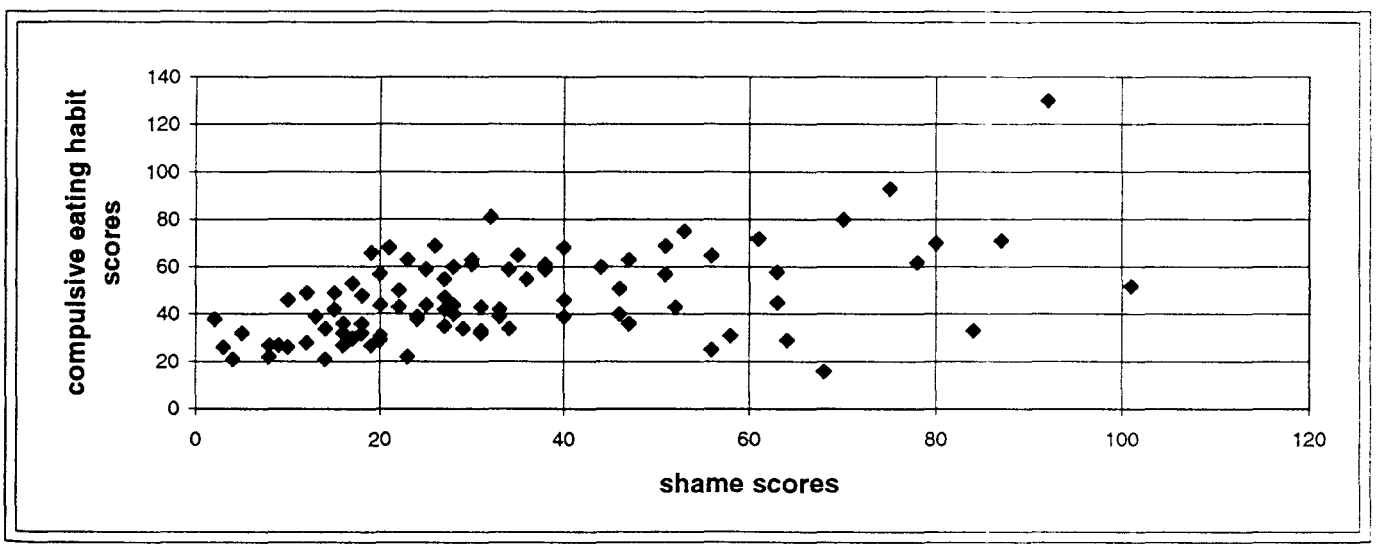


Fig. 6.3. Scatterplot Representation of the Correlation between Shame and Compulsive Eating Habits.



- Alcohol and drug dependence are highly significantly correlated ($r = 0.86$; $p < 0.001$). The correlation between compulsive eating habits and alcohol dependence, although significant ($r = 0.21$; $p < 0.05$) is substantially lower, accounting for less than 5% of the variance. Compulsive eating habits and drug dependence are not significantly correlated at all.

- There is a significant negative correlation between shame and age ($r = -0.28$; $p < 0.01$), and shame and income ($r = -0.23$; $p < 0.05$), suggesting a tendency for shame to decrease with increasing age and income.

- There is a significant correlation between age and income ($r = 0.25$; $p < 0.05$), and between educational level and income ($r = 0.29$; $p < 0.01$).

- Finally, there is a negative inverse correlation ($r = -0.33$; $p < 0.01$) between drug dependence and education and alcohol dependence and education ($r = -0.31$; $p < 0.01$).

6.2. T-test Procedures.

As sex is a nominal variable, it could not be correlated with the scales of shame and alcohol and drug dependence and compulsive eating. Consequently t-tests were computed to compare males and females on alcohol dependence, drug dependence and eating behaviour. The results of these are presented in Table 6.2.

Table 6.2.

Scale	**Mean**	**Mean**	**Std. Dev.**	**Std. Dev.**	**Range**	**Range**	**t-test statis -tic**
	M.	**F.**	**M.**	**F.**	**M.**	**F.**	
Alc. Dep.	18.82	16.50	9.13	8.20	5-46	5-45	1.27
Drug Dep.	30.24	25.07	14.56	11.59	9-74	7-66	1.89
EAT	42.22	50.54	14.39	20.26	21-75	16-130	2.29 *

* $p < 0.05$

** $p < 0.01$

*** $p < 0.001$

From the results in Table 6.2 it can be seen that males and

females differ significantly on compulsive eating habits ($t = 2.29$; $df = 90$; $p < 0.05$). Although males have higher scores on both alcohol and drug dependence, these differences are not significant.

6.3. Stepwise Regression Analyses.

Stepwise Regression Analyses were computed using alcohol and drug dependence and compulsive eating habits as the dependent variables.

6.3.1. Regression of Alcohol Dependence on Shame and Biographical Variables.

A series of stepwise regressions was computed for the prediction of alcohol dependence. The shame scale was a significant predictor, predicting 33% of the variation in alcohol dependent behaviour. When education was added in the second step of the regression, the total variance in alcohol dependent behaviour, explained jointly by shame scores and education level was 0.41 (see Table 6.3).

Table 6.3. Summary Results of Stepwise Regression Analyses of Alcohol Dependence on Shame Scales and Biographical Variables.

Variable Regressed	Possible Predictors	Significant Predictors	Partial R	Model R	F Value
Alcohol Dependence	Shame	Shame	0.33	0.33	36.85 ***
Alcohol Dependence	Education, income, sex, marital status	Education	0.08	0.41	-9.48 **

* $p < 0.05$

** $p < 0.01$

*** $p < 0.001$

6.3.2. Regression of Drug Dependence on Shame and Biographical Variables.

A series of stepwise regressions was computed for the prediction of drug dependence. The shame scale was a significant predictor, predicting 20% of the variation in drug dependent behaviour.

In the regression of drug dependent behaviour on the shame

measures and the biographical variables, 36% of the variation in drug dependence is explained jointly by scores on the shame scale, income earned and the highest educational qualification obtained. The results of this regression analysis are presented in Table 6.4

Table 6.4. Summary Results of Stepwise Regression Analyses of Drug Dependence on Shame Scales and Biographical Variables.

Variable Regressed	Possible Predictors	Significant Predictors	Partial R	Model R	F Value
Drug Dependence	Shame	Shame	0.20	0.20	19.04 ***
Drug Dependence	Education, income, sex, marital status	Education	0.10	0.30	- 10.24 **
Drug Dependence	Income, sex, marital status	Income	0.06	0.36	7.03 **

* $p < 0.05$

** $p < 0.01$

*** $p < 0.001$

6.3.3. Regression of Compulsive Eating Habits on Shame and Biographical Variables.

Once again stepwise regressions were computed for the prediction of compulsive eating habits (EAT). The shame scale was a significant predictor, predicting 30% of the variation in compulsive eating habits.

In the regression of the eating habits based on shame and the biographical variables 36% of the variation in compulsive eating habits is explained jointly by scores on the shame scale and the sex of the respondent. The results of this regression analysis are presented in Table 6.5.

Table 6.5. Summary Results of Stepwise Regression Analyses of Eating Habits on Shame Scales and Biographical Variables.

Variable Regressed	Possible Predictors	Significant Predictors	Partial R	Model R	F Value
EAT	Shame	Shame	0.30	0.30	31.03 ***
EAT	Education, income, sex, marital status	Sex	0.07	0.36	7.50 **

* $p < 0.05$

** $p < 0.01$

*** $p < 0.001$

CHAPTER SEVEN: DISCUSSION: IMPLICATIONS OF THIS STUDY.

This study has sought to further examine the psychological phenomenon of shame, particularly in relation to compulsive behaviours, including those of disordered eating and alcohol and drug dependence. With regard to alcohol and drug dependence the study investigated whether a significant relationship between these variables and shame could be demonstrated in a non clinical population. With regard to the eating disorders, the question was raised as to whether a link between shame and this particular type of compulsive behaviour would be found. The relation between shame and these three behaviours was investigated by using Pearson's Product Moment correlations, and regression analyses.

It was found, as has been detailed in chapter six, that shame was significantly correlated with all three of these behaviours. That shame is significantly correlated with alcohol and drug dependence serves to endorse and extend the existing research literature. That internalised shame is significantly correlated with disordered eating is a new contribution to the research on shame.

These findings were confirmed by the regression analyses in that shame was a significant predictor of the compulsive behaviours investigated in this study. Specifically, in this study, shame predicted 33% of the variation in alcohol dependent behaviour, 36% of the variation in drug dependent behaviour and 30% of the variation in disordered eating.

In attempting to grapple with the findings of the study, while it is clear that internalised shame is related to alcohol dependence, drug dependence and compulsive eating, the reasons for this are not clear. From the study itself it cannot be said in what way, or why these variables are related. However, if one interprets these results with reference to the literature on shame it becomes possible to make informed guesses in this regard.

From the literature, it is clear that shame follows the enactment of compulsive behaviours, and this in itself could account for the results. Certainly, writers such as Potter-Efron (1987) have written poignantly of the shame following the use of alcohol by those dependent on it, and of the shame following the compulsive use of drugs. So too has Bruch (1978) written of the shame-filled anguish of the eating disordered.

However, an equally plausible explanation of the results is that shame generates and precedes compulsive behaviours and that it

has the status of a trait rather than being a momentary affect attendant on a transgressive act. As already indicated in the literature review, the body of thinking which would implicate shame in the compulsive behaviours in this manner is written either by psychoanalysts, or, more latterly by self-psychologists. In this literature shame is conceptualised as being imbricated into the experience of an inadequate sense of self, either because the self is experienced as excessively bad, as in the Kleinian frame, or as out of control as would be suggested in Miller's frame, or, as being fragmented and overwhelmed by affect which cannot be regulated, as would be the case in Block Lewis' and Kohut's theoretical formulations.

All these theorists agree, however, that the individual would then have an overwhelming need to deal with the feelings concerning an inadequate sense of self and the shame attached to it. They may deal with these feelings by projection, as is postulated in the Kleinian framework, or, alternatively, by the enactment of behaviours which the individual feels would alter his negative affective internal state, and serve the function of self-soothing. These behaviours, however, including those studied by this project, are often not socially acceptable when engaged in, in excess, and thus by their very nature these behaviours begin to generate the very shame that they are intended to alleviate, lending these behaviours their compulsive quality.

In assessing the findings of this study, it has been seen that at least three different kinds of compulsive behaviour are significantly correlated with shame. It is important to remember that shame in this study was measured by a scale which treats shame as a trait rather than as a state, and this lends support, albeit indirect support, to the notions of the analysts and self psychologists outlined above. However, as already indicated, the findings may equally well be interpreted to indicate that shame follows compulsive behaviours rather than precedes them. The truth however, probably lies in the notion of circular causality, although even this claim cannot be made on the basis of this study.

However, what can be said in relation to this research is that the behaviours chosen for study, those of eating, drinking and drug abuse, would seem to have a face validity in regard to the notion of self soothing given their association in the literature with orality and dependence in general. In other words all three of these behaviours are clearly used as a comfort or escape by the individuals who enact them, and are represented in the literature as such.

The same cannot be said of other behaviours such as self mutilation and compulsive gambling, whose association with self soothing is not immediately apparent, and yet they too have been postulated in the literature to serve the function of self-

soothing. The relation of these behaviours to shame remains, however, to be empirically tested, and this would be an interesting study for the future.

Returning now to the present research, as already indicated, the primary results of this study confirm the link between alcohol and drug dependence in a non clinical sample, and extend the relationship between shame and compulsivity to a third class of behaviours. Beyond this, however, the study has also yielded some interesting secondary findings. For example, alcohol dependence and drug dependence were also found to be significantly correlated. Thus, in this study, subjects who were, or had been, dependent on alcohol tended to also be, or have been, dependent on drugs. Furthermore, while no causal inferences can be made in this study, shame was found to be significantly associated with lower levels of education, and both shame and lower levels of education were found to be associated with alcohol and drug dependence. This may reflect either that an enduring sense of shame, and lower levels of education precede alcohol and drug abuse, or that alcohol and drug abuse precede early school drop out, and that shame accompanies this. The association between shame and lower levels of education may also reflect that all the variables are related to a third overarching factor. However, it is of interest that, in this sample, while drug dependence and higher income levels were related, this was not the case with regard to alcohol abuse. This possibly indicates the higher cost

of drugs and the need for a higher income to support this habit.

The results pertaining to gender were interesting in that in examining the results of the regression analyses of compulsive eating habits on shame, higher levels of compulsive eating habits are predicted by higher levels of shame in women. In terms of the literature this result was to be expected, insofar as eating disorders occur primarily in women. That internalised shame in women is predictive, to a significant degree, of eating disorder is a valuable finding. The extent to which women and eating disorders are linked in the literature is to the point where gender is almost part of the definition of the eating disorders, and much of the literature in the area of eating disorders attempts to understand this relationship. The results of the present study may extend this understanding by linking the relation between gender and eating disorders through shame. In what ways, however, or why this link occurs can, once again, not be extrapolated from the results of this study. This topic could certainly be the basis for a separate study in its own right.

In conclusion, however, the central finding of this study remains, simply, that there are significant associations between shame and three different kinds of compulsive behaviours. This, of course, has implications for treatment in that for any therapy to be successful it would need to address the relationship between shame and compulsive behaviours in all its possibilities.

Specifically it would need to explore the option that shame may be both a consequence and a precursor of compulsive behaviours.

Before finally concluding this chapter however it is important to examine some of the broader limitations of this study and from this awareness to suggest future areas for investigation.

This study was exploratory, as is most of the research on shame. It sought, through a specific methodology to examine a clearly delimited research question, and is consequently bound by these parameters. In other words a quantitative measure of correlation between shame and three behaviours was investigated. As a result the variables are by definition reduced to numerical values (this will be further discussed at a later point in the chapter), and because they are compared by means of correlation no causality can be established. Thus it was said in the discussion that although they are certainly related, how or why this relation exists cannot be answered within the parameters of the methodology employed for this study.

As an exploratory study, however, the aim was merely to empirically establish a relation between shame and the selected behaviours. More specifically the aim was to establish a relation between shame and compulsive eating attitudes and shame and alcohol and drug dependence in a non clinical sample. This study was successful in attaining these aims. However, by insisting on

defining the variables numerically, a great deal of richness of the data was lost.

Thus, although Cook's scale, for example, is a valid, and reliable measure of shame, it reduces a powerful, subjective internal experience to a number, for purposes of comparison. Consequently, in the case of shame, this process causes a lot of the richness of the phenomenon to be lost. It is for this reason, that much of the research in the area is phenomenological.

Consequently, it would be valuable to examine the phenomenology of shame in relation to the specifics of the various eating disorders. Qualitative measures are extremely important for the accurate study of this area.

In relation to the measures of the compulsive behaviours, a limitation was the use of self report scales without collateral information. Further research could thus use more behavioral measures or include collateral information.

A further limitation of the study is that it was conducted in a relatively small sample with a fairly specific profile. The results therefore, cannot be easily generalised.

In conclusion then, it would seem that the merits of this study lie in the fact that it highlights many further questions in the

area that need to be answered by research. For instance, what is the exact nature of the relation between shame and the compulsive behaviours with special reference to causality? How does the established relationship between shame and compulsive behaviours need to be addressed therapeutically? How does shame interact with culture in the formation of self? Is the formation of self bound up with shame, or negative affect, or affect in general? If the development of the self and shame are interlinked, in what ways are gender identities formed by shame? All these questions require answers, but to investigate them would require a far more sophisticated methodology than was used in this study, and thus, at this point, this project must rest its case.

ERRATUM

Please note that there are a number of errors in the format of this reference list. Most notably, the use of the word `in' when referencing journal titles such as "in Contemporary Family Therapy Vol. 9...". In such cases the word `in' should not be included. The abbreviation of volume to vol. is also incorrect. Furthermore there are various spelling and case errors in this list of references.

REFERENCES

Alonso, A. and Rutan, J.S. (1988). Shame and Guilt in Psychotherapy Supervision. in Psychotherapy Vol 25: Winter 1988: pp. 576-580.

Bacal, H. (1990). Does An Object Relations Theory Exist in Self Psychology? in Psychoanalytic Enquiry, 10: 197-220.

Banmen, J. (1988) Guilt and Shame: Theories and Therapeutic Possibilities. in International Journal for the Advancement of Counselling. Vol. 11: 79-91. Kluwer Academic Publishers. Dordrecht - Netherlands.

Benedict, R. (1977). The Crysanthemum and the Sword. London. Routledge and Kegan Paul.

Block Lewis, H. (1971) Shame and Guilt in Neurosis. New York. International Universities Press inc.

Block Lewis, H. (1987) Shame and the Narcissistic Personality. in Nathanson, D.L. (ed) The Many Faces of Shame. New York. The Guilford Press.

Bratter, T.E. and Forrest, G.G. (ed.) (1985) Alcoholism and Substance Abuse: Strategies for Clinical Intervention. London. The Free Press: Collier MacMillan.

Bruch, H. (1978) The Golden Cage. Cambridge. Harvard University Press.

Bruch, H. (1988) Conversations with Anorexics. New York. Basic Books.

Buss, A. H. The Psychology of Aggression. U.S.A. John Wiley and Sons.

Buss, A.H. (1980) Self-Consciousness and Social Anxiety. San Francisco. W.H. Freeman and Company.

Cassell, D.K. and Larocca, F.E.F. (1994) Encyclopedia of Obesity and Eating Disorders. New York. Facts on File inc.

Craig, R,J. (ed.) (1993) The Millon Clinical Multiaxial Inventory. London. Lawrence Erlbaum and Associates.

Dally, P. and Gomez, J. (1990) Anorexia and Obesity: A Sense of Proportion. London. Faber and Faber.

Edwards, G. (1987) Fed Up and Hungry. London. The Women's Press.

Erikson, E. (1976). Memorandum on Youth in Readings in Adolescent Psychology. (1977-78 ed) New York. Harper and Row.

Erikson, E (1977). Childhood and Society. Paladin Books. London.

Forrest, G.G. (1983). Alcoholism, Narcissism, and Psychopathology. Springfield, Illinois. Charles C. Thomas Publisher.

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

Garner, D.M. and Garfinkel, P.E. The Eating Attitudes Test. in Psychological Medicine, 1979, 9, 273-279. Great Britain: Cambridge University Press.

Goldberg, A, (ed) (1980) Advances in Self Psychology. New York. International Universities Press.

Goldberg, C. (1990) The Role of Existential Shame in the Healing Endeavour in Psychotherapy Vol 27, No 4, pp. 591-599.

Goldberg, C (1991). Understanding Shame. Northvale. U.S.A. Jason

Aronson Inc.

Gorsuch, S.E. (1990) Shame and Acting Out in Psychotherapy in Psychotherapy. Vol 27, No 4, pp 585-590.

Hultberg, P. (1988) Shame - A Hidden Emotion. in the Journal of Analytical Psychology, Vol 33, pp 109-126. Hamburg.

Imber-Black, E. (ed.) (1993) Secrets in Families and Family Therapy. New York. W.W. Norton and Company.

Jacoby, M. (1994) Shame and the Origins of Self-Esteem. London. Routledge.

Karpel, M. (1980) Family Secrets in Family Process, 19: 245-306.

Kaufman, G. (1989) The Psychology of Shame. Theory and Treatment of Shame Based Syndromes. Springer Publishing Co. New York.

Kaufman, G. (1992). Shame: The Power of Caring. U.S.A. Schenkman Books.

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

Kopf, S. (1976) the Naked Therapist EDITS Publishers. San Diego.

Lansky, M. (1987) Shame and Domestic Violence. in Nathanson, D. (ed) The Many Faces of Shame. New York. The Guilford Press.

Lawrence, M. and Dana, M. (1990) Fighting Food: Coping With Eating Disorders. London: Faber and Faber.

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

Lichtenberg, J. (1983) Psychoanalysis and Infant Research. Hittsdale, New Jersey: The Analytic Press.

Lynd, H. (1958). On Shame and the Search for Identity. London. Routledge and Kegan Paul.

Mc Farland, B. and Baker-Baumann, T. (1990). Shame and Body Image. Culture and the Compulsive Eater. Florida. Health Communications Inc.

Middelton-Moz, J. (1990). Shame and Guilt. The Masters of Disguise. Florida. Health Communications Inc.

Miller, S. (1989). Shame as Impetus to the Creation of Conscience in International Journal of Psychoanalysis, Vol.70. pp. 231-243.

Miller, S. (1985). The Shame Experience. New Jersey. Lawrence

Erlbaum and Associates.

Miller, W.I. (1993) Humiliation. New York. Cornell University Press.

Nathanson, D.L. (1987). A Timetable for Shame in Nathanson, D.L. (ed) The Many Faces of Shame. New York. The Guilford Press.

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

Nichols, M.D. (1991) No Place to Hide. New York. Simon and Schuster.

Piers, G. and Singer, M.D. (1953). Shame and Guilt. Springfield, Illinois. Thomas.

Pines, M. (1990). The Universality of Shame: A Psychodynamic Approach. Paper from the Conference on Shame: Theoretical and Clinical Aspects. University College. London.

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

Sceff, T.J. (1989) Cognitive and Emotional Conflict in Anorexia: Reanalysis of a Classic Case. in Psychiatry Vol 52, May 1989,

pp.148-161.

Sidoli, M. (1988) Shame and the Shadow in The Journal of Analytical Psychology. Vol. 33. pp 127-142. London.

Tomkins, S.S. (1963). Affect, Imagery and Consciousness. Vol. 1: The Positive Affects. London. Tavistock Publications.

Tomkins, S.S. (1963). Affect, Imagery and Consciousness. Vol 2: The Negative Affects. London. Tavistock Publications.

Tomkins, S.S. (1987). Shame. in Nathanson, D (ed) The Many Faces of Shame. New york. The Guilford Press.

Van den Bergh, N. (ed) (1991). Feminist Perspectives on Addictions. New York. Springer Publishing Co.

Watts, F.N. MacLeod, A.K. and Morris, L. (1988). Associations Between Phenomenal and Objective Aspects of Concentration Problems in Depressed Patients in British Journal of Psychology. Vol.79. pp. 241-250.

Watson, D and Clarke, L.A. (1984), Negative Affectivity: The Disposition to Experience Aversive Emotional States. in Psychological Bulletin Vol.3. pp 564-490.

Wurmser, L (1981) The Mask of Shame. Baltimore: John Hopkins University Press.

Wurmser, L. (1987) Shame: The Veiled Companion of Narcissism. In Nathanson, D. (ed). The Many Faces of Shame. New Yorke. The Guilford Press.

Yorke, C. (1990) The Development and Function of the Sense of Shame. Paper from the Conference on Shame: Theoretical and Clinical Aspects. University College: London.

Zuk, G. and Zuk, C. (1987) Parental Blaming and Acquisition of Guilt: A Developmental Task of Childhood. in Contemporary Family Therapy Vol. 9, (4) Winter (1987). Human Sciences Press. pp 221-228.

SHAME AND COMPULSIVE BEHAVIOURS

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ABSTRACT

The area of shame, in psychology, has become increasingly popular in recent years. Despite a great richness of theoretical literature, there is, unfortunately, a dearth of actual research on shame. This study has sought to empirically investigate the relationship between shame and three compulsive behaviours, namely, alcohol dependence, drug dependence and disordered eating. Relations between shame and alcohol dependence, and shame and drug dependence have already been established in the research literature. This study sought to validate these relationships and to extend the research in the area to establish a link between shame and disordered eating. Cook's Internalised Shame Scale was used to assimilate shame, whilst Millon's Clinical Multiaxial Inventory was used to assess drug and alcohol dependence. Disordered eating was assessed by using the Eating Attitudes Test. Pearson's Product Moment Correlations were computed, and regression analyses were conducted. It was found that shame was significantly correlated with alcohol dependence, drug dependence and disordered eating, and that shame predicted 33% of the variation in alcohol dependent behaviour, 36% of the variation in drug dependent behaviour, and 30% of the variation in disordered eating.

Within the methodology used it was not possible to establish causality. However, it was possible to contextualise these results within the literature, and suggest possible explanations. From within the literature on shame it was suggested that shame is linked to alcohol dependence and drug dependence and disordered eating within a circular causality as an attempt at self soothing, and containing the uncomfortable feelings attached to an inadequate sense of self. Limitations of the study, and suggestions for future research were examined.