Shame in Child Maltreatment: Contributions and Caveats

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This special section is a collection of papers that investigates the role of shame in children with abuse histories. Relationships are found between abuse-specific shame or general shame proneness and a variety of outcomes. However, the relationships are not consistent. The utility of these findings will be enhanced by studies that use common measurement approaches and address similar outcomes, as well specific tests of intervention approaches that target shame.

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The articles in this special section on child maltreatment and shame are efforts to elucidate the role of shame as a contributor to child abuse consequences. As many of the authors mention, most of the research attention on emotions in child maltreatment—especially with reference to posttraumatic stress—has focused on fear as the negative emotion that produces psychological distress in the aftermath of trauma. More recently, researchers have begun to explore other negative emotions that might arise during or after abuse and that might factor into understanding outcomes. Shame has emerged as a leading candidate.

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Although shame is the specific target of the investigations, the primary contribution of these articles may be in confirming that strong negative emotional responses to abuse experiences beyond fear are important in explaining outcomes. For example, why does child sexual abuse produce such high rates of post-traumatic stress disorder (PTSD) when most situations do not involve fear-inducing events? While part of the explanation may lie in the perception of life threat as opposed to objective danger (a known predictor for PTSD), perhaps there is something about the nature of sexual trauma that is more likely to produce other intense negative emotions. Because shame and anger are associated with PTSD in adult samples experiencing a variety of traumas (Andrews, Brewin, Rose, & Kirk, 2000), more attention to these emotions in child research is warranted. In addition, of course, clinicians have long observed that strong negative emotional responses that are not fear related seem to be just as troubling for children who are traumatized.

Another general and important conclusion from these articles is that intense negative emotion about the experience itself (or while remembering it) and a tendency to respond to situations with negative emotionality matter. There is good evidence that preexisting psychiatric difficulties predict worse outcomes. It makes sense, then, that preexisting variations in susceptibility to respond with shame would be associated with heightened risk. Shame proneness and guilt proneness are examined in these articles; however, there might be other relevant styles of responding worth exploring as well.

Overall, these articles suggest that this line of inquiry has the capacity to move the field forward in important ways. Extending the study of emotions in children who are abused beyond fear and anxiety holds promise for learning more about vulnerability to severe consequences, differential pathways to the range of possible outcomes, and potential targets for therapeutic interventions. The articles show that
shame (whether abuse specific or general, and whether verbally or nonverbally expressed), as well as humiliation, has theoretically sound and empirically demonstrated relationships to outcomes in diverse groups of children who are abused. However, these relationships are neither straightforward nor entirely consistent. One possible reason for this is discussed in the following section.

**The Importance of Measurement and Definitions**

A lesson of these studies is that definitions and measurement make all the difference. As illustrated in the articles, shame can be defined in a variety of ways. Then, depending on how it is measured, shame produces different associations with outcomes. For example, results from these studies suggest that shame has and does not have direct relationships to harmful consequences. How a construct is measured has long been a thorny issue in child maltreatment, with defining neglect and emotional abuse being prime examples. Presumably the same can be said about other fields during their earlier stages of development. Thus, this line of research may be too new to allow firm conclusions regarding shame.

Several of the researchers make a point about the importance of distinguishing shame from guilt (or shame proneness and guilt proneness). While both are relatively common and are correlated with each other, guilt about actions taken or not taken is not the same as a more general negative sense of self. Making this distinction appears justified because guilt and shame, when measured separately, tend to produce different relationships to outcomes. However, just to complicate matters, while these authors tend to equate guilt with self-blame, in a previous effort Wolfe, Sas, and Wekerle (1994) assessed guilt and self-blame separately and found different relationships to PTSD in sexually abused children.

In terms of measuring shame, it can be quite simple. Feiring and Taska (this issue) are interested in abuse-specific shame and have used a measure that consists of four questions, two of which specifically mention being ashamed and two others that ask about wanting to go away and hide, or feeling dirty. They have demonstrated significant associations with posttraumatic stress in prior reports. In the article included in this section, Feiring and Taska also measure children’s responses to visual depictions designed to reflect shame. This measure is correlated with other measures of shame and predicts outcomes. It remains to be seen whether this addition has incremental value over simply asking shame-related questions directly.

The other investigators target “shame proneness,” a more general shame response that might be present in children who are nonabused as well as children who are abused. The methods include engaging respondents in a success and/or failure task (Bennett, Sullivan, & Lewis, this issue); presenting scenarios (Stuewig & McClosky, this issue); or having respondents recount abuse or other adverse events (Negrao et al., this issue). Shame and other emotions are measured by various schemes for coding facial, body, and/or emotional response alternatives. This use of different methods of measurement can lead to further complications because there may be discrepancies between verbal and nonverbal expressions of emotions. As demonstrated by Negrao et al., describing and revealing emotional states may not be coherent, and lack of coherence may have different relationships to outcomes than coherence. Furthermore, these researchers deconstructed elements of shame and anger to define humiliation that produced yet another set of relationships to outcomes.

The diverse measures of shame used in the articles in this special issue are associated with at least some outcomes in children who are abused, but in different ways. There are relationships between some forms of maltreatment and shame but not others; some relationships are direct while others are mediated; and shame is related directly or indirectly to some outcomes but not related at all to others. This raises questions about what exactly is being measured, or which measure is the real indicant of shame. Are all of the measures tapping the same construct but in slightly different ways? Or, as suggested by Negrao et al. does shame sometimes also overlap, at least in part, with other emotions such as humiliation?

Another question is whether there is something about the nature of shame that makes it important to measure it more obliquely than other emotions. Fear, anxiety, and depression, for example, are generally measured by a few or more direct questions. Although there are different instruments, when inspected they appear to be variations on the same kinds of items. On the other hand, perhaps if these emotions were measured less directly, it would lead to similar disjunctions in relationships to outcomes such as psychiatric diagnoses or delinquency.

The question then becomes, to what extent can such a line of inquiry enhance our understanding of the consequences of child maltreatment, or inform treatment with children who are maltreated? That is, according to these studies, it is theoretically possible for a child to have trauma-specific shame, general shame, humiliation, anger, and/or guilt and self-blame as separate emotional (or closely related cogni-
tive) states and for each to have a separate pathway to a particular outcome. These results suggest that parsing emotional responses very finely can lead to statistically significant relationships to maltreatment consequences. However, if the distinctions do not have the possibility for eventually informing intervention or treatment responses to children, they may ultimately be seen as little more than academic exercises. It is thus crucial that this line of research move toward strong tests of its clinical relevance.

Many questions remain to be answered. Because these articles use different measures and target different outcomes, direct comparisons are not possible. For example, only Feiring and Taska focus on abuse-specific shame and its relationship to PTSD, although Negrao et al. do measure shame while recalling abuse in one group of respondents and PTSD. The studies investigating other forms of trauma such as physical abuse and/or harsh parenting, neglect, and exposure to domestic violence only assess general shame. Furthermore, those investigations do not address PTSD but rather examine outcomes such as delinquency and depression. We need studies that assess trauma-specific shame for various traumas as well as general shame, including a variety of possible outcomes, to begin to create a more coherent picture of these associations.

Clinical Implications

Beyond increasing knowledge of abuse consequences, there is the question of the clinical meaning of findings from studies such as those in this Child Maltreatment special section. It is not necessary for research to always have practical implications; basic research is a building block to a more complete understanding of a phenomenon. For example, although it is informative to know that there may be discrepancies between verbally and nonverbally expressed manifestations of negative emotional states, how might a clinician translate this into practice? Certainly no one would recommend that practitioners begin coding facial expressions or body posture as part of clinical interventions. Clinicians might make more informal interpretations of nonverbal expressions without relying on a systematic procedure; however, doing so might be risky. For example, there is general agreement about nonverbal manifestations of fear or sadness, and it is common for clinicians to comment on discrepancies. With respect to shame, however, it is not yet clear what reflects shame in a child when the child is denying having the feelings versus what might be projection by the therapist.

Based on these studies, the clinical take-home message regarding assessment is that abuse-specific shame is (a) likely important to attend to in the clinical environment and (b) can be ascertained through direct questioning in much the same way that emotional states such as guilt and self-blame are typically ascertained already. In contrast, general shame proneness (or guilt proneness) seems a bit more elusive to establish clinically. It may be possible to ask parents about their children’s general responses to situations in a way that elucidates a style of responding that appears across situations (e.g., how does your child generally respond if she doesn’t do well in a particular situation?).

Deblinger and Runyon’s (this issue) treatment implications article makes the argument that trauma-specific cognitive behavioral therapy (CBT), an already proven intervention, can be theoretically applied to shame. The treatment components of teaching skills to manage negative emotions, correcting maladaptive attributions, helping children to develop the skills needed to talk about and put the experience into perspective, and enhancing parental support and responsiveness presumably could be effective for addressing shame and other abuse effects. This is a reasonable assertion; however, it remains to be tested. Certainly, the articles in this issue suggest that it is time to design and test treatments that target shame.

CONCLUSION

Overall, this collection of articles suggests many intriguing possibilities for relationships among abuse experiences, shame, and outcomes. Methodologically, they represent sophisticated approaches to examining hypotheses, often using innovative measurement strategies and longitudinal designs. These scientifically sound articles have advanced our knowledge of the impact of maltreatment on adjustment. For this line of research to mature and progress, it must now move toward resolving inconsistencies in measurement and definitions and must submit itself to strong tests of its clinical utility. I look forward to clinical trials through which the theory, research, and practice in this new area can be put to the test and look forward to learning from the results.

REFERENCES


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