Introducing Shame Resilience to Women Who Struggle with Complex Trauma and Substance Abuse

Kirsten R. Robertson

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INTRODUCING SHAME RESILIENCE TO WOMEN WHO STRUGGLE WITH COMPLEX
TRAUMA AND SUBSTANCE ABUSE

A Dissertation

Presented to the Faculty of
Antioch University Seattle
Seattle, WA

In Partial Fulfillment
of the Requirements of the Degree
Doctor of Psychology

By
Kirsten Robertson
March 2019
INTRODUCING SHAME RESILIENCE TO WOMEN WHO STRUGGLE WITH COMPLEX TRAUMA AND SUBSTANCE ABUSE

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DOCTOR OF PSYCHOLOGY

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ABSTRACT

INTRODUCING SHAME RESILIENCE TO WOMEN WHO STRUGGLE WITH COMPLEX TRAUMA AND SUBSTANCE ABUSE

Kirsten Robertson

Antioch University Seattle

Seattle, WA

The relationship between shame and trauma has been documented in research beginning as early as the 19th century. Not until the second half of the 20th century did extensive research clearly define both trauma and shame, with the addition of Posttraumatic Stress Disorder (PTSD) as an official diagnosis in the field of mental health. Many researchers and clinicians believe an additional diagnosis should be added to the list of trauma-related mental health diagnoses—one that includes repeated traumatic experiences during childhood. Despite the known relationship between shame and various traumatic experiences, direct shame interventions have yet to find a place in standard therapeutic trauma-specific protocols. By implementing a group therapy curriculum designed by Dr. Brené Brown, based on her Shame Resilience Theory (SRT), this study was designed to assess possible empirical support related to the need for, and benefits of, addressing shame directly in participants who suffer from internalized shame and who have experienced traumatic childhood trauma, which has led to complex PTSD.
Pre- and post-group measurements were quantitatively analyzed. The outcomes confirmed the initial hypotheses and resulted in significantly decreased internalized shame, a decline in trauma-related symptomology, with reason to pursue further clinical treatment for trauma-related issues.

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*Keywords:* complex PTSD, shame resilience, trauma, substance use, women
Dedication

This dissertation is dedicated to all those who have experienced complex trauma and struggle as adults to feel worthy of love and belonging. May you find peace, healing, and may you know deep down at your core that you ARE absolutely worthy.
Acknowledgements

This dissertation would not have been possible without a ton of help. I want to first thank The Ranch, a residential recovery center in Tennessee, for introducing me to Dr. Brené Brown’s work and first showing me how much I love to work with individuals who have experienced complex trauma and who struggle with substance abuse. I learned so much and will forever be grateful.

I would like to thank every teacher in college who helped me by writing a letter of recommendation and believing that one day I might be a good psychologist. This especially includes my mentor and committee member, Dr. Kathryn Sherrod. My life would not be the same without you.

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When reality took a turn, I could not have finished what I started without the help of Dr. Janet Adams-Westcott. Your flexibility and introductions made this possible. Thank you so much.

Women in Recovery in Tulsa, OK also gets a gigantic thank you for what the program stands for, the people it helps, and the change I saw. Thanks for showing me that programs like this exist. A special thank you to Mimi Tarrasch, Roxanne Hinther, and my co-facilitator
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CHAPTER I: INTRODUCTION

Experiencing traumatic events in childhood—such as physical, sexual, and emotional abuse or neglect—may lead to mental and physical illness in adulthood, which can affect the individual throughout a lifetime (Brier & Scott, 2006; Courtois & Ford, 2013; Felitti & Anda, 2000; Herman, 1992; Rizvi, Brown, Bohus & Linehan, 2011). These long-term effects increase the need for treatment to aid individuals in healing the damage created by past traumatic events, and in helping to improve quality of life. Research supporting the correlation between trauma and the tendency to internalize feelings of shame is well substantiated (Dearing & Tangney, 2011; Teyber, McClure, & Weathers, 2011). Subsequently, shame tends to create a lens of believing oneself to be bad or deeply flawed (Bockers et al., 2015; Chan, Hess, Whelton, & Yonge, 2005; Courtois & Ford, 2013; Harvey, Dorahy, & Vertue, 2011). Research also supports ways in which internalized shame exacerbates psychopathology and augments mental and physical illnesses. Perhaps the cruelest irony is shame often prevents individuals from seeking the very treatment they need, because they feel the need to hide, rather than seek support (Bennett, Sullivan, & Lewis, 2010; Bryan, Morrow, Etienne, & Ray-Sannerud, 2103; Dyer et al., 2009; Gaudet, Sowers, Nugent, & Boriskin, 2016; Held, Owens & Anderson, 2015; Platt & Freyd, 2011; Whiffen & MacIntosh, 2005).

Many effective trauma-focused therapies exist; however, most trauma-focused treatment protocols do not incorporate an aspect of directly addressing shame, or teach individuals skills to foster shame resilience (Beck et al., 2013; Dearing & Tangney, 2011; Gaudet et al., 2016; Holl et al., 2016; Talbot, Talbot, & Tu, 2004). Interventions that address shame directly may be a much-needed component to reinforce trauma-focused therapies. The current research aims to
empirically support the benefits of teaching trauma survivors psychoeducation about shame along with other tools they might need to become shame-resilient.

### Differentiating Between Complex PTSD and PTSD

Trauma is defined as an event that is “extremely upsetting and at least temporarily overwhels the individual’s internal resources” (Briere & Scott, 2006, p. 4). Traumatic events may include, but are not limited to, experiencing a natural disaster, war, child abuse, domestic violence, sexual assault, transportation accidents, fires, physical assault, and torture (Briere & Scott, 2006). Traumatic events can occur in many types of life situations and could be experienced only one time or multiple times before causing lasting negative effects on a person’s life, unless mitigated by intervention (van der Kolk, 2015). In some instances, a person who has experienced a single traumatic event, or even multiple traumatic events, can recover from that experience independently without lasting negative psychological impact. In other instances, the effects of traumatic events on a person’s life can be devastating (Bockers, Roepke, Michael, Renneberg, & Knaevelsrud, 2015; van der Kolk, 2015).

The Diagnostic and Statistical Manual, fifth edition (DSM-5), characterizes those negative symptoms that do not dissipate one month after experiencing a traumatic event as Post Traumatic Stress Disorder (PTSD). Although this diagnosis applies to many who struggle with the effects of trauma, some clinicians believe the DSM-5 should include an additional diagnosis for those who have experienced multiple traumatic events beginning in early life and who suffer slightly different symptoms compared to those of people who fall under the standard PTSD diagnosis (Briere & Scott, 2006; Dyer et al., 2009; Herman, 1992; Taycan & Yildirim, 2015; van der Kolk, 2015). This new diagnostic category, known as complex PTSD, was included in the
International Statistical Classification of Disease, eleventh edition (ICD-11), but has not yet been officially included in the DSM (Friedman, 2014).

**Barriers to the Treatment of Trauma**

A groundbreaking study on 17,000 adults revealed the long-term impact traumatic childhood events, or Adverse Childhood Experiences (ACEs), have on a person’s adult life (Felitti & Anda, 2000). The study found strong correlations between the number of ACEs experienced with major sequelae such as substance abuse, depression, chronic anxiety, suicidality, risky sexual behaviors, career issues, interpersonal relationship issues, biomedical diseases, and reduced life expectancy (Felitti & Anda, 2000). Even more impressive, it was found that after patients were offered a trauma-oriented questionnaire plus biopsychosocial information forms to be filled out prior to visiting a doctor’s office, there was a 35% decrease in repeat visits among those patients the following year (Felitti & Anda, 2000). The authors concluded that asking, listening, and allowing a patient to leave the doctor’s office with a feeling of being accepted after revealing past traumatic experiences provided a major intervention for this population (Felitti & Anda, 2000). Since adult negative life outcomes are often correlated with traumatic experiences, addressing these events therapeutically is imperative to helping victims of childhood trauma heal the emotional wounds the traumatic event has created (van der Hart, Nijenhuis, & Steele, 2006; van der Kolk, 2015).

**Shame**

If processing traumatic events associated with PTSD and complex PTSD can reduce some of the negative life effects induced by those events, then assessing which obstacles may
prevent individuals from disclosing and working through their traumatic experiences is essential. Brené Brown, Ph.D., a leading researcher on the topic of shame, has defined shame as “the intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging” (Brown, 2007, p. 5). Morrison (2011) describes shame as one of the most agonizing of human emotions, causing one to want to sink into the ground or disappear.

Among other consequences, shame tends to silence people or makes them reluctant to discuss or reveal the memories and ideas causing them to feel shameful (Morrison, 2011; Brown, 2007). Thus, individuals may feel reluctant to address the traumatic events around which they feel shame, perpetuating their negative self-image and adversely shifting the way they view themselves and function in life (Herman, 1992). This creates a negative feedback cycle that can result in many diagnostic illnesses. The wounds of unaddressed trauma can manifest in personality disorders, anxiety, depression, substance use, suicidality, and many other symptoms (Brier & Scott, 2006; Courtois & Ford, 2013; Herman, 1992; Rizvi, Brown, Bohus & Linehan, 2011).

Shame-proneness, also known as internalized shame, and defined as the tendency to experience shame across various types of situations, is exacerbated in adulthood when childhood experiences entail trauma, chaos, and disorder without consistent nurturing and caretaker responsiveness (Dearing & Tangney, 2011; Teyber, McClure, & Weathers, 2011). When children begin to internalize the belief that something is wrong with them without hearing evidence in the form of love or nurturing that the belief may not be true, negative consequences begin to manifest. Interestingly, research has also shown a relationship between shame-proneness and low self-esteem, suicidal ideation, borderline personality disorder (BPD),
depression, anxiety, eating disorder symptoms, PTSD, substance abuse, and a host of other intrapersonal and interpersonal problems (Dearing & Tangney, 2011; Rizvi et al., 2011).

Notice the similarity between the symptoms associated with unaddressed trauma and those associated with internalized shame. Shame, trauma, and the symptoms listed above are correlated and interact with each other. Some research clearly suggests that the shame following traumatic incidents, as much as the initial experience of the traumatic event, fuels the ensuing negative effects (Bennett, Sullivan, & Lewis, 2010; Bryan, Morrow, Etienne, & Ray-Sannerud, 2013; Dyer et al., 2009; Gaudet, Sowers, Nugent, & Boriskin, 2016; Held, Owens & Anderson, 2015; Platt & Freyd, 2011; Whiffen & MacIntosh, 2005). Directly addressing the shame component in the trifecta of shame, trauma, and negative symptomology should be a natural inclusion in treatment conceptualization.

The Need for Empirically Supported Shame Interventions

Although abundant research exists supporting the negative effects of shame on trauma survivors, there is also a documented need for effective interventions to address the relationship of shame to trauma (Beck et al., 2013; Dearing & Tangney, 2011; Gaudet et al., 2016; Holl et al., 2016; Talbot, Talbot, & Tu, 2004). Many current treatments, however, neglect to factor in the element of shame in addressing trauma-related symptomology. For example, in neither their article nor their book outlining preferred treatment for complex PTSD, do Briere and Scott include the idea of addressing shame directly (Briere & Scott, 2006; Briere & Scott, 2015). This omission attests to the fact that although correlations between shame and trauma are known, addressing shame directly has not yet become part of standard treatment protocols. Fortunately, recent research on the general effects of shame has helped clarify the benefits such an approach may offer.
Purpose of This Study

To acknowledge how shame functions as a barrier to treatment, in addition to acknowledging the need for effective shame interventions, this study was designed to introduce an intervention that directly addresses shame in a population that struggles with internalized shame to see if a reduction in negative symptomology occurs. With outcomes supporting the three asserted hypotheses listed below, the current research provides support for including interventions that teach shame resilience skills in conjunction with other trauma-focused interventions in populations that have a history of complex trauma.

Chosen Intervention

Brené Brown, Ph.D., has spent more than 13 years conducting research focused on understanding shame and the means by which a person who has internalized shame can learn to develop a different relationship with themselves, becoming what she refers to as “shame resilient” (Brown, 2007). Dr. Brown created a group therapy curriculum entitled Connections: A 12-Session Psychoeducational Shame-Resilience Curriculum with the intention of helping individuals become aware of their shame and begin living from a place of “wholeheartedness,” a term coined by Dr. Brown to describe those whom she characterizes as living from a place of authenticity, love, and belonging, as well as those who have a resilient spirit (Brown, 2007; Brown, Hernandez, & Villarreal, 2011).

Hypotheses

The current research uses Dr. Brown’s curriculum with a group of individuals who qualify for a diagnosis of complex PTSD based on the ICD-11 (Appendix A) and who report experiencing the internalized shame that often accompanies complex trauma. It is hypothesized
that directly addressing shame and participating in a group that allows individuals to learn and talk about shame, and to develop shame-resilience skills including the ability to identify, tolerate, and speak about shame will help participants be better equipped to address the trauma underlying their complex PTSD diagnoses.

Specifically, the researcher hypothesizes that proactively addressing shame with this specific population will likely produce three outcomes. The first outcome is a reduction in shame-proneness or self-identification with shame. The participants may become better able to objectively identify the feeling of shame, rather than subjectively identifying with the shame-based thought (e.g. “I am feeling shame now” versus “I am bad”). The second outcome is that the participants may experience a decrease in trauma-related symptoms after completing a curriculum that fosters shame resilience. The third outcome is that these individuals will develop willingness to address their underlying traumatic experiences when they are able to separate the traumatic incident from the shame they have associated with it (e.g. “this happened to me” versus “this happened because I am bad” or possibly “this happened and made me bad”).

The following chapters of this dissertation will summarize literature written about the main subjects of the current research, introduce effective interventions for those who have experienced trauma and felt corresponding shame, outline the research design, provide results of the research, discuss further research needs, and identify limitations encountered during this study. This dissertation is intended to convey an understanding of both trauma and shame from a historical perspective including current research theories. This will help the reader understand the context for the current research and the advocated need for change in approaches used to therapeutically treat those who have experienced trauma.
CHAPTER II: REVIEW OF LITERATURE

To gain a complete understanding of the relationship between traumatic experiences and internalized shame, one must develop a historical understanding of the research documenting a) both the effects that result from experiencing trauma and b) the feeling of shame. This literature review aims to inform the reader of the harmful ways shame can reside in people who have experienced traumatic events, as well as the symptoms that can be exacerbated when shame is internalized. This will illuminate why teaching shame resilience skills and directly addressing shame as a standard treatment protocol when working with people who have developed Complex Post Traumatic Stress Disorder (PTSD) is an addition likely to enhance treatment outcomes in the lives of trauma survivors.

The History of Trauma Symptomology

Negative reactions to traumatic events are not a new phenomenon. Authors and historians have noted emotional reactions in people exposed to extreme stress for over 4,000 years (Friedman & Marsella, 1996). Descriptions of PTSD-like reactions to trauma have been traced back to the pre-Christian era (Cantor, 2005). Symptoms such as flashbacks, dissociations, and startle responses were historically viewed as acts of God or manifestations of the devil, or were blamed on various types of spirits (Figley, 2002). During the late 19th century, however, scientific concepts began to replace religious interpretations of trauma symptomology (Figley, 2002).

In the mid-1890s, Pierre Janet of France contributed the concept of hysteria—nicknamed “the great neurosis” by Jean-Martin Charcot—to the study of psychological trauma (Herman, 1992). Hysteria was the medical diagnosis routinely given to women who displayed symptoms such as faintness, insomnia, nervousness, irritability, or loss of appetite for food or sex (Maines,
In 1895, Sigmund Freud and Josef Breuer published *Studies in Hysteria*, which presented Freud’s views on neurosis (Wilson, 1994). Freud had discovered that many of his patients who suffered from hysteria told stories of sexual assault, abuse, and incest (Herman, 1992). In light of his observations, Freud went public with the declaration that hysteria was caused by sexual abuse, but later recanted after experiencing negative societal pressure (Herman, 1992). For Victorians of Freud’s day, if these assertions were true it would mean high-status aristocrats would have to consider the possibility that sexual abuse occurred in their homes; something they had no desire to do. The discussion of traumatic events in relation to neurosis was suppressed for some time.

The effects of trauma, which often resembled the symptoms previously displayed in hysteria, were later described in soldiers returning from combat after World Wars II and I. Military psychiatrists gradually realized the link between “shell shock” and combat trauma when Abram Kardinar ultimately published a study of the psychological effects of war and trauma entitled *The Traumatic Neurosis of War* (1941). The theories of his study largely resembled those in Janet’s original formulation of hysteria (Herman, 1992). In a volume addressing how the scientific view of PTSD has developed, Cantor (2005) writes, “The concept of shellshock in the first world war was erroneous as it did not require shelling to be activated nor was gross neurological shock or damage the cause of the disorder” (Cantor, 2005, p. 172). Cantor believed trauma-related symptomology may have resulted from a combination of already felt experiences – sleep deprivation, energy depletion, extended periods of living with death and futility, combined with perception (e.g., hopelessness in some, not in others). When systems became overloaded, evolutionary defenses emerged and manifested in various ways. For example,
Cantor (2005) called the freeze response “tonic immobility” and was the first to theorize it might be a form of dissociation.

In the 1970s, war stress researcher and traumatologist Charles Figley noticed that Vietnam veterans who showed signs of an unresolved guilt syndrome evinced more similarities than differences with the stress syndromes noted in rape victims, Holocaust survivors, and other groups affected by trauma (Figley, 2002). A literature review published before 1980 indicates that other groups experiencing trauma, such as non-veteran war survivors, domestic violence victims, crime victims, people who have experienced natural disasters, and hostages also exhibited traumatic stress symptoms (Figley, 1978; Figley, 2002). It soon became evident that wide ranges of traumatic events could induce extreme stress symptoms (Wilson, 1994). As Herman noted, “It is now apparent also that the traumas of one are the traumas of the other. The hysteria of women and the combat neurosis of men are one” (1992, p. 32).

**Diagnostic Definitions**

Not until 1980 did PTSD become an official diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders*, third edition (DSM-III), in which it was used to describe the effects of psychological trauma (Herman, 1992). Having an official diagnosis legitimized the symptoms people displayed after experiencing trauma by categorizing it as a disorder, rather than attributing symptoms to personal weakness or to a fault in the individual, as had often previously been the case. Nevertheless, it soon became evident that the impact of trauma was not limited to the PTSD diagnosis. If individuals meet diagnostic criteria for PTSD, it is likely that they will also meet criteria for one or more additional diagnoses; these comorbid diagnoses include major affective disorders or personality disorders (Freidman & Marsella, 1996). This suggests the effects of trauma may be further reaching than the PTSD diagnosis alone, continuing to support
the need for an additional trauma-related diagnosis that includes a wider range of symptomology. Currently in the DSM-5, PTSD is composed of the following diagnostic criteria:

Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: directly experiencing the traumatic event(s); witnessing, in person, the event(s) as it occurred to others; learning that the traumatic events(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental; experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

Presence of one (or more) of the following intrusion symptoms associated with the traumatic events(s), beginning after the traumatic event(s) occurred: recurrent, involuntary, and intrusive distressing memories of the traumatic event(s); recurrent distressing dreams in which the content and/or effect of the dream is related to the traumatic event(s); dissociative reactions (e.g. flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings; intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s); marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following: avoidance of
or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s); avoidance of or efforts to avoid eternal reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following: inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs); persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”); persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others; persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame.); markedly diminished interest or participation in significant activities; feelings of detachment or estrangement from others; persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfactions, or loving feelings).

Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following: irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression towards people or objects; reckless or self-destructive behavior; hypervigilance; exaggerated startle
response; problems with concentration; sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

Duration of the disturbance is more than 1 month. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition. Specify whether: with dissociative symptoms: The individual’s symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

- Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one’s mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
- Derealization: Persistent or recurrent experiences of unreality of surroundings such as the world around the individual is experienced as unreal, dreamlike, distant or distorted. (APA, 2013, p. 271-272)

In 2019, debate continues whether to include a second trauma-based diagnosis stemming from repeated childhood abuse (Complex Trauma) in the DSM. Although the DSM is a manual of mental health disorders, the *International Classification of Disease* (ICD) is an international standard for defining diseases and health conditions, and is typically used by the broader medical field to diagnose illnesses (World Health Organization, 2016). In other countries the ICD is often used to diagnose mental health issues. The eleventh ICD revision (ICD-11) defines complex PTSD as follows:
Complex post-traumatic stress disorder (complex PTSD) is a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). The disorder is characterized by the core symptoms of PTSD; that is, all diagnostic requirements for PTSD have been met at some point during the course of the disorder. In addition, complex PTSD is characterized by 1) severe and pervasive problems in affect regulation; 2) persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the traumatic event; and 3) persistent difficulties in sustaining relationships and in feeling close to others. The disturbance causes significant impairment in personal, family, social, educational, occupational or other important areas of functioning. (ICD-11, 2018, Complex post)

The difference between PTSD and complex PTSD is that PTSD may be diagnosed after experiencing one traumatic event, while complex PTSD is reserved for repeated traumatic events, over an expanded period of time, and presents with a wider and more intensified array of symptomology. Item (2) in the ICD-11 complex PTSD definition appears to be most relevant to the current research, because “persistent beliefs about oneself as diminished, defeated or worthless…deep and pervasive feelings of shame, guilt or failure” are the central focus of the therapy targeting shame.

An Evolutionary Perspective on PTSD
From an evolutionary perspective, the modern-day definition of PTSD is a “complex and persistent reaction to severely threatening life experiences” (Cantor, 2005, p. 7). Cantor characterizes PTSD as over-activation of normal evolutionary defensive states. When combined with Pierre Janet’s view that emotions make events traumatic by interfering with the integration of experience into memory, PTSD could be conceptualized as resulting from an event which caused an over-activation of normal defensive reactions (including emotions) that have not been fully integrated into memory (Cantor, 2005). Viewing responses to traumatic events from an evolutionary perspective creates an additional framework to contextualize a PTSD diagnosis, rather than only viewing PTSD as a disorder or pathologizing a reaction that can make sense when viewed from an evolutionary framework.

Charles Darwin’s Theory of Evolution states that the strong survive; therefore, the individuals within a species with the strongest survival traits will continue the chain of evolution by passing these genes to their offspring (Darwin, 1859/1951). If human adaptive nature is about survival and procreation, viewing PTSD behavior from a survival perspective may add clarity to what otherwise appears to be erratic behavior. From a survival standpoint, when in situations of ambiguous threat, it is adaptive to err on the side of safety, which may explain why PTSD sufferers tend to expect the worst and develop symptoms such as hypervigilance (Cantor, 2005). Unfortunately, what may be adaptive from an evolutionary perspective may be disabling at an individual level. Maladaptations are thus adaptations suited to a different time or place than that in which they are being displayed. For example, aggressiveness is an effective behavioral stance for war, but not for everyday living (Cantor, 2005). Similarly, PTSD symptoms may be adaptive in some contexts, but maladaptive in others.
Researchers who use Evolutionary Theory view PTSD, not as a psychopathological disorder, but as a fear-related reaction, serving vigilance, and the other defensive responses that vary by context (Cantor, 2005). Depending on the situation, particular traumas may induce specific and predictable traumatic responses based on concepts of response rules and psychobiological response patterns (Cantor, 2005). Given the number of variables involved, great variability in traumatic reactions would be expected, which may account for the fact that trauma causes only a portion of the population to develop symptoms of PTSD (Cantor, 2005). Variability in response reactions may also account for why so many other diagnoses are often correlated with PTSD.

Humans respond to trauma from the basic evolutionary responses of fight, flight, freeze, and—as Cantor (2005) believes—an additional response category called “appease,” where those who cannot fight, fly, or freeze submit to the person or thing causing the response. Among trauma victims, it is the appease response that is often linked to a large amount of shame, because in order to survive, one must submit to or even cooperate with the traumatic scenario. In life situations where repeated trauma occurs, this appeasement response may be seen more often in situations of complex PTSD. If a parent or relative is the one causing the abuse, appeasement may often be the only option.

This is similar to what Herman (1992) asserted about the effects added to traumatic situations by the element of captivity. Herman states that a single traumatic event differs from repeated traumatic events in that a single event can occur under any circumstances, whereas prolonged trauma usually occurs in circumstances of captivity (Herman, 1992). Captivity in this context refers to situations from which a person believes escape is impossible, such as abuse experienced at the hands of a caretaker or the abuse suffered by prisoners of war. The element of
captivity may add a dimension to multiple traumatic incidents that is not present for those who experience only one traumatic event. This is why Cantor (2005) maintains that a complex PTSD diagnosis with an appeasement symptom category should be added to the DSM.

If traumatic experiences have such negative consequences for some, one may wonder why everyone who experiences trauma in some form does not develop PTSD. Although the answer to this question may never be completely clear, researchers suspect genetic variance may account for the variability in responses (Cantor, 2005). Perception, or the meaning a specific person attributes to a situation, may also account for why some people are able to cope more effectively than others (Cantor, 2005). Much research has been conducted about resiliency, examining why some people recover from negative life events more easily than others. Unfortunately, the general topic of resiliency is too broad and exceeds the scope of this dissertation. This dissertation will instead focus on the benefits of teaching survivors tools to develop resilience against shame. Since the emotion of empathy is often the best way to reduce experiences of shame in either oneself or others, contextualizing the diagnosis of PTSD from an evolutionary perspective may help sufferers develop empathy toward their own reactions to experiences of trauma.

Developmental Impacts

Traumatic experiences occurring in childhood have numerous ramifications for the development of the child. The Adverse Childhood Experiences (ACE) study revealed that effects of child abuse might constitute the costliest public health issue in the United States (Felitti & Anda, 2000; van der Kolk, 2015). Currently in the United States, as many as three million children are reported as victims of abuse or neglect (van der Kolk, 2015). This dissertation focuses on complex PTSD for this very reason, because most individuals who
 qualify for this diagnosis experienced trauma beginning in childhood and will most likely have health issues that will not only affect them on an individual level, but will also affect the healthcare needs of the general population. As this section will show, the physiological effects, ability to successfully relate to another person, and belief systems learned through experiences of trauma will impact children throughout their lives.

**Neuroplasticity.** A child’s brain begins forming while in utero and continues until about 25 years of age (Wright & Kutcher, 2016). Early childhood experiences shape the brain structures designated to regulate emotions and memory—namely, the limbic system (van der Kolk, 2015). Children who experience abandonment, neglect, or abuse will develop neuronal pathways that differ from those of children who have not. This means the physiological formations of human development are affected by trauma, potentially leading to a deficit in the development of foundational skills of emotional regulation that will hamper individuals throughout their lifetime. This may then impact the way children relate to their world and the decisions they make based upon their perceptions. Luckily, the human brain also exhibits neuroplasticity, meaning neuronal pathways can change with the frequency of use, strengthening either positive or negative patterns (van der Kolk, 2015).

People who report experiencing multiple traumas also report more dissociation, guilt, shame, and interpersonal sensitivity than those who experienced a single trauma; people who experienced multiple traumas also reported a greater tendency to direct their anger toward themselves (Hagenaars, Fisch, & Minnen, 2011). If experiencing multiple traumas increases negative symptomology, then according to the way neuroplasticity functions, each trauma further strengthens the neuronal pathway used in a negative direction (van der Kolk, 2015). Directing associated anger inward most likely correlates to shame also being directed inward and the
formation of internalized shame with repeated experiences of trauma. This would all be occurring simultaneously—the outer experience, the emotions created, and the neuronal pathways developed. These factors together indicate that the relationship between physiological development and outer experiences intensely impacts the future of the child.

The differences in neuronal pathway development between people who have experienced trauma and those who have not might also help explain why reactions and perceptions of life events vary between these two populations. A person who has had neuronal pathways shaped and reinforced by negative life situations, may see and respond much differently than a person who did not experience trauma. Luckily, neuronal plasticity also means that individuals have the ability to change responses in a positive way after experiencing trauma. This human ability to change provides hope for positive treatment outcomes.

**Attachment influences.** PTSD and complex PTSD also differ in the effects early childhood abuse can have on the way a person learns to relate to others and sustain meaningful relationship patterns throughout life. John Bowlby (1969) was among the first researchers to address the element of attachment. The attachment style that forms between children and their caretakers comprises a foundational experience for how children will self-regulate emotions and interact with others throughout their lifespan (Teyber, McClure & Weathers, 2011; van der Kolk, 2015). Children develop secure attachment styles when they have attentive caregivers, and they learn that the world is a safe place where their needs will be met. When they do not receive dependable care or have caretakers who are themselves the source of harm, children may develop a disorganized attachment style that manifests as needing to be close, yet experiencing a fear of getting close, or “fright without solution” (van der Kolk, 2015, p. 119). If a caretaker struggles with addiction or is abusive, it is likely that a child will not form a secure attachment
style, and will instead learn that the people who are supposed to provide protection are actually the source of pain. Kohut describes a similar concept as “empathic failure,” which can cause children to believe their needs are unacceptable and shameful if their needs are not met or mirrored appropriately by caretakers (Morrison, 1987; Wurgaft & Kohut, 1987). Not forming secure attachment styles might be the beginning of children internalizing the idea something is wrong with them, a hallmark of internalized shame.

Van der Kolk identifies a correlation between a) children who reportedly experienced abuse or neglect and b) disorganized attachment styles (2015). A child whose needs are repeatedly unmet may develop an insecure, incohesive sense of self that is sensitive to experiences of shame, described by Kohut as failure of the mirroring self-object (Dearing & Tangney, 2011; Wurgaft & Kohut, 1987). Due to disruptions of basic trust, feelings of shame, guilt, inferiority, and the need to avoid reminders of the trauma, traumatized individuals may alternate between isolation and anxious clinging to others (Herman, 1992). An internal conflict can arise toward relationships, since relationships present a conduit for the external validation needed for a positive self-perception, yet also pose a threat in the anticipated pain of rejection (Harvey et al., 2011). This causes severe internal conflict as the need for connection competes with a need for safety. Some people might have learned that safety was not possible in relationships.

Because meaningful connection to others is a large part of reducing the experience of shame, individuals who never learned how to form solid attachments as children still need to learn how to become vulnerable and relate to others in healthy ways (Bowlby, 1969; van der Kolk, 2015). This is one of the reasons teaching techniques about shame resilience might help people learn how to connect with others if they do not already possess these skills. The skills
taught in the *Connections* curriculum include teaching the benefits of reaching out to trusted others as a healthy coping skill for reducing shame (Brown, 2009).

**Continuance throughout the lifespan.** Unfortunately, patterns learned in childhood can have effects that reverberate throughout the lifespan. Research has shown that adults with complex trauma histories are vulnerable to re-traumatization throughout their lives (Briere & Scott, 2006; Courtois & Ford, 2013). Many factors might contribute to this pattern. Children or adults functioning with a disorganized attachment style have not developed an internal sense of safety and may have a hard time distinguishing between safety and danger regarding either situations or people (van der Kolk, 2015). Without an internal compass to distinguish between what is safe and what is not, it is not surprising that people with a history of abuse may receive additional abuse by engaging in relationships or situations that produce further harm such as domestic violence. Secondly, in an attempt to overcome the internal feeling of numbness that can occur in relationship to trauma, such people may seek out high risk or dangerous situations as a means of feeling alive, with the rationale that any feelings are better than none at all (van der Kolk, 2015). Finally, if the people having experienced complex trauma have concluded they are a terrible human beings, they may begin to expect others to treat them poorly and even believe they deserve it or are helpless to stop it (van der Kolk, 2015). These situations may cause further traumatic experiences, keeping the cycle of trauma in place.

When victimization continues to occur, survival reactions may become habitual and affect a person’s entire sense of self and ability to relate intimately with others (Courtois & Ford, 2013). Unresolved developmental conflicts related to autonomy, which may occur after experiencing abuse or neglect, may leave a person prone to shame and doubt (Herman, 1992). If a child never learned to successfully function independently, dependence on another person may
create relationships in which people believe they have to tolerate negative behaviors because it is better than being alone. All of these factors may establish patterns that, without intervention, may continue to manifest as traumatic experiences in the person’s life. Most survivors may not be aware this pattern exists or that they have the ability to learn to relate to others in new ways.

In addition to attachment-related impacts of trauma, humans also develop a belief system about how the world works (Herman, 1992; van der Kolk, 2015). This belief system is initially created during childhood as one develops a sense of self (Dearing & Tangney, 2011). However, as with brain neuroplasticity, one’s beliefs about the self can also be modified as one grows, learns, and experiences life (van der Kolk, 2015). If children learn that they are beautiful, safe, and worthy individuals, they will go through life behaving much differently than if they had learned that the world was unsafe and marked with contempt and humiliation if their caregivers often reacted with looks of disgust in reaction to typical childhood behavior (Platt & Freyd, 2011; van der Kolk, 2015). Such core beliefs frame the view in which day-to-day stressors are interpreted; if those beliefs are negative, then even neutral stimuli may be interpreted as confirming the negative core belief (Platt & Freyd, 2011). This foundation may result in a belief system in which protesting mistreatment is futile, or even that mistreatment is normal.

Traumatic events can erode a person’s sense of safety, positive view of self, and belief in a meaningful order of creation (Herman, 1992; van der Hart et al., 2006). Children who have not experienced abuse tend to learn the difference between how it feels to be treated with respect versus disrespect, which helps them learn to challenge or avoid someone who mistreats them—a skill that a maltreated child may never learn (van der Kolk, 2015).

**Vulnerable populations.** While everyone who experiences a traumatic event has the potential to experience negative symptomology, certain populations are especially vulnerable
due to their propensity to experience multiple and repeated traumatic events. Victim variables that may be associated with the likelihood of repeat traumatization or that may predict risk for future PTSD or complex PTSD include the following: female gender, young children, older adults, African-American or Hispanic race, lower socioeconomic status, previous psychological dysfunction or disorder, less functional coping styles, family dysfunction or history of pathology, previous history of trauma exposure, hyperactive or dysfunctional nervous system, or genetic predisposition (Briere & Scott, 2006). Many individuals might belong to several of the categories listed above.

The populations listed above may also experience a greater amount of prejudice and discrimination, which most likely contributes to the multiple types of disparity these groups experience when compared with other populations that are considered to be less vulnerable. Being female or a non-Caucasian in the United States presents a risk factor largely because women and racial minorities are more frequently exposed to events that result in post-traumatic disturbance (Brier & Scott, 2006). Systemic social factors such as sexual and racial inequality appear to be the causes of this phenomenon rather than individual deficiencies (Briere & Scott, 2006). Sexual minorities, such as members of the LGBTQIA+ community, often experience social rejection and stigmatization in certain social circles, which may intensify a deep-rooted sense of shame (Tangney & Dearing, 2002). People are affected individually by the attitudes and behaviors implemented by the culture at large.

In short, trauma and shame might have a greater effect on vulnerable populations. Clinicians must consider the complexity involved in working with vulnerable populations when formulating treatment protocols. Because these populations have often been exposed to a greater number of shame-producing stimuli, they may have a greater need to learn shame resilience
skills, so they can not only reduce current shame, but they can have tools to protect themselves from continuing to internalize feelings of shame in the future.

**Culture.** It is important to note that social constructions of reality, and thus perceptions of what constitutes a traumatic experience, vary from culture to culture, affecting the ways an individual may frame their experience (Freidman & Marsella, 1996). What a person from the United States finds traumatic may be very different from what a person living in Syria perceives as traumatic. Likewise, traumatized individuals who are situated in a culture where open discussion of the trauma is encouraged, survivorship is honored, victimization is not stigmatized, and posttraumatic problems are normalized would most likely attain better long-term outcomes (Friedman & Marsella, 1996). This may be especially important to know when working with people from cultures in which the discussion of trauma is discouraged. Because many countries are composed of people from all over the world, remembering to account for cultural difference during treatment is imperative.

As will be discussed in more depth in the section on shame, culture can exist in larger contexts such as a country, society, or ethnic group, and also in smaller contexts, such as a community, family, or therapy group. When working with trauma, not only is it important to consider the culture each individual comes from in the larger sense, it is also important to consider the therapeutic culture that will be created when the person begins treatment. If cultures that regard people who have experienced traumatic events in a positive way attain better treatment outcomes as posited above, fostering this positive cultural attitude into clinical treatment may prove beneficial.

Group therapy has often been a successful means of addressing trauma, perhaps because groups resemble small communities. The culture, or container, created in the group may help
survivors normalize their experience and create an atmosphere of healing, something that may not be obtained outside the group. This may be especially important for those who do not experience a larger culture of survivorship being honored and viewed with respect. Dr. Brown’s focus on fostering empathy for the individual and toward others creates a sense of safety or positive culture and allows cultural differences in the larger sense to be approached with an attitude of acceptance in group therapy. This is why group therapy was selected as a forum to teach shame resilience skills.

**The History of Shame**

This section will focus on understanding the emotion of shame. This includes a general overview of emotions, followed by specifically looking at shame and how people are affected by it on individual, relational, and cultural levels. Multiple developmental theories are also considered.

**Emotions**

Before considering the emotion of shame specifically, it is reasonable to get an understanding of emotions in general. Half a century ago, only a few researchers studied human emotions, but in recent years experiments in this field have expanded exponentially (Ekman, 2016). The word “emotion” in its present sense dates back to when Descartes’ 1649 *Passions de l’Ame* (Frijda, 2008). Though researchers from different fields have studied emotions, from a psychologist’s perspective, “emotions point to a domain of phenomena of feelings, behaviors, and bodily reactions” (Frijda, 2008, p. 68). There are two interconnected implications to this view, (a) the focus is on phenomena experienced by individuals, and (b) the explanations for these phenomena require theories about interpersonal causal processes (Frijda, 2008). Emotions can serve as an indicator of intrapersonal mechanisms and processes.
As with most subjects, views about the purpose of emotions have changed over time. Earlier philosophers such as Thomas Aquinas and Immanuel Kant saw emotions as capital sins or illnesses of the mind (Frijda, 2008). Most modern day theorists view emotions as being functional and adaptive. Feeling fear in response to a poisonous snake most likely saved lives. At the same time, Frijda (2008) urges readers to remember that while emotions can have functional purposes, the adequacy of people’s appraisal of the situation that led to the emotion, their choice and control of the behavior motivated by the emotion, and adequately evaluating the impact those feelings and behaviors will have on others, all determine how functional an emotion is at any given time. While some emotions are adaptive, others can be maladaptive.

There are two primary hypotheses regarding the origins of emotions (Frijda, 2008). The first is known as the “basic or primary emotions hypothesis” in which researchers believe that emotions fall into basic categories such as anger, love, and fear, which are universally present in most humans. This theory is supported by Buck (1999), Ekman (1992), Izard (1977), Tomkins (1962), and others (Frijda, 2008). Ekman (1983) conducted scientific experiments that linked facial expressions to six different types of emotion that he deemed basic and universal to humans: anger, fear, sadness, happiness, disgust, and surprise. The facial expressions were linked to changes in the person’s biological state, as measured in heart rate or skin temperature. Studies have been inconsistent about whether specific emotions cause specific autonomic arousal symptoms (Larsen, Berntson, Poehlmann, Ito, & Cacioppo, 2008).

The second theory, which might help explain the inconsistencies related to the first theory, is known as the “multicomponenental view,” in which emotion consists of many different components that can include subjective feelings, social messages, action tendencies, and appraisals (Shuman, Clark-Polner, Meuleman, Sander, & Scherer, 2015). This theory asserts that
bodily, hormonal, and affective reactions start the emotional process, and that “cognitive appraisal processes act like a sculptor, shaping general affective reactions into specific emotions” (Clore & Ortony, 2008, p. 629). Emotions are not viewed as distinct states with clear boundaries that are encoded in the brain and produce specific psychophysiological symptoms and facial expressions (Clore & Ortony, 2008). Emotions do involve facial expressions, psychophysiology, and specialized brain areas, but the reactions do not relate to specific emotions such as anger, fear, and shame.

According to the multi-componential view, instead of emotions reflecting clearly identifiable neural responses in the brain, emotions involve combinations of processes with much more variability than is implied by the basic emotions view (Clore & Ortony, 2008). In this view, what makes emotions universal is not their biological status, but the situations to which they are responses. All people are exposed to stimuli that produce fear, anger, and other emotions; however, what specifically produces the response in an individual, and the exact response experienced might be slightly different for each person. The experience of specific, distinct emotions arises partly from cultural knowledge about emotions (Clore & Ortony, 2008). Emotional labels (i.e. anger, love, fear) are still used, but are on subregions of the multicomponential space and include the culturally, linguistically, or ecologically determined scripts that are associated with them (Frijda, 2008). This theory is supported by theorists such as Lazarus (1966), Mandler (1984), Russell (1991), and Scherer (1992), among others (Frijda, 2008).

Although these two theories may seem very different, they actually share similarities. The moderate correlations between components can be easily accommodated by the primary emotions view; emotional labels of subregions still apply (Frijda, 2008). For instance, feeling
some anger is universal. What varies is a belief in the existence of components that all work together to achieve that individual’s exact emotional experience in that moment. One theory puts anger in a clearly defined box; while the other says there are far more factors present that contribute to an emotional experience. The basic emotion theory would incorporate facial features along with emotional reactions to determine which category of emotion a person was experiencing at a particular time. The multicomponential theory would ask the following questions:

Which processes are linked to which other processes and to what degree? Which linkages are due to joint response from the same antecedent contingencies, and which to their forming coordinative motor structures? Which linkages represent functional dependence? Which represents the effects of a shared command system? (Frijda, 2008, p. 77)

For purposes of the current research, both theories play an informative role. The basic emotion theory helps put language to similarly felt emotions. When a person says, “I am feeling sad,” people can use empathy to understand, even if what “sad” feels like for one person is slightly different from how sad feels to another. The nuanced causation is not as important for conversation, but when attempting to understand the relationship between the feeling of shame and complex PTSD, a multicomponential approach might help explain the interrelationship and all the pieces it entails. Both Freud’s (1911) theory on emotion and Bowlby’s (1969) theory on attachment support an appraisal aspect to emotion (Clore & Ortony, 2008). Because the basic emotion theory can be incorporated into the multicomponent theory, both hypotheses will be considered in understanding emotions.
Developmentally speaking, in both theories of emotion, there are certain ages at which specific emotions are believed to appear. Basic emotions are called basic, or primary, because the six emotions Ekman (1983) identified are present by age six to nine months (Lewis, 2008a). Somewhere in the second year of life, what is known as the “self-conscious emotions” begin to emerge and include embarrassment, envy, and empathy (Lewis, 2008a). They are called self-conscious emotions, indicating that the child has begun to formulate a sense of self that is separate from others. By the age of two-and-a-half, the child has learned to evaluate its behavior in comparison to that of others, which manifests as feelings of guilt, shame, or pride, among others (Lewis, 2008a). These emotions are called “self-conscious evaluative emotions” although most people include them in the category of self-conscious emotions (Lewis, 2008a). There are five features that distinguish self-conscious emotions from basic emotions: (a) require self-awareness and self-representations, (b) emerge later in childhood than primary emotions, (c) facilitate the attainment of complex social goals, (d) do not have universally recognized facial expressions, and (e) are cognitively complex (Tracy & Robins, 2008).

The self-conscious emotions are also considered moral emotions because they play an important moral self-regulatory role (Tangney, Stuewig, & Mashek, 2008). Because the current research focuses on the role shame plays in perpetuating negative symptomology and preventing some individuals from seeking treatment for underlying trauma, recognizing the role moral emotions play in behavior is pertinent. Ekman (1994), Tomkins (1962), and Izard (1991), share the view that originated with David Hume, an 18th century empiricist philosopher (1739/1948), and Charles Darwin (1872/1998), that emotions are primary motivational forces in humans and that much of human behavior serves emotion-related functions and goals (Camras & Fatani, 2008). Izard (1991) has argued that emotions, rather than Freud’s theories on drives, are the
primary motivators for human behavior (Camras & Fatani, 2008). Moral emotions can provide the motivational power and energy to make “good” choices and avoid doing what may be considered “bad” (Tangney et al., 2007). Of the self-conscious emotions, guilt tends to be more adaptive (e.g. I’ll make amends for said action) while shame is more likely to be maladaptive (e.g. I’ll hide and avoid repair; Tangney et al., 2007). If the moral emotions play such an important role in behavior, then it is reasonable to focus on these emotions when behavioral change is warranted.

Shame has been referred to as the “master emotion” because it has more functions than other emotions (Scheff, 2003). First, as mentioned above, it can play a role in moral regulation. Second, it arises in situations of connection to others; it signals trouble in a relationship or interaction with people. Third, shame plays a central role in regulating the awareness and expression of other emotions—individuals are progressively less likely to express emotions outwardly such as anger, fear, greed, and love in proportion to the degree to which they are ashamed of those emotions (Scheff, 2003). People can be so ashamed of their emotions that they repress their emotions completely. Freud (1895) originally asserted that shame was a repressor of emotions, but abandoned his findings (Scheff, 2003). Feeling and expressing emotions is a core component of trauma treatment, so addressing the shame that may be repressing other emotions would most likely benefit the further treatment of trauma.

Shame

Although shame has been recorded in historical documents as old as the book of Genesis in the Old Testament, it is only in the past hundred years that research has really begun to explore this emotion and its effects (Tomkins, 1987). Distinguishing between types of shame,
establishing a definition of shame to be used in the current research, and examining the levels at which humans are affected by shame will all be discussed.

*TWO TYPES OF SHAME.* Some research distinguishes two types of shame that have evolved in humans over time. The earliest references to shame tended to pertain to an *external* shame, one imposed on a person or group of people by others and often used historically by an outer authority as a means of power or control (Stearns, 2016). This cultural type of shame was reflected in society at large and then incorporated into the family as a means of child rearing. Criminals were publicly shamed in town squares and children were reprimanded in front of other family members as a way of implementing behavior modification. This tactic was often considered a constructive means for regulation as an alternative or addition to corporal punishment (Stearns, 2016). The application of this type of shame can be traced back historically; not until the first part of the 19th century did views toward shame begin to change (Stearns, 2016).

With time, a noticeable shift in the function of shame began to occur. In America, with the development of a prison system in the 19th century, public shaming came to be seen as an inappropriately harsh and ineffective form of punishment (Stearns, 2016). As society shifted from interdependency towards independency, especially in Western cultures, shame also shifted from a social to a psychological effect (Stearns, 2016). The second type of shame is one not dependent on an audience, but rather is *internal*, involving a deep sense of self-deprecation (Stearns, 2016). Schneider (1987) posits a similar view of the evolution of shame, noting a difference between a “sense of shame” and “being ashamed.” In the former view, shame is merely human; in the latter, it denotes viewing oneself as bad.
Many European languages other than English have words to distinguish two kinds of shame (Scheff, 2003). One represents “everyday shame” and the other represents “disgrace shame.” Everyday shame would function more like guilt – people might believe they needed to do better when they violated a social norm (i.e. externalized shame); disgrace shame functions pathologically (i.e. internalized shame). Because the English language combines both positive and negative aspects of shame into the same word, it is no surprise that confusion often occurs in reaction to the singular English word shame (Scheff, 2003). The word shame is derived from an Indo-European word meaning to hide or to cover (Nathanson, 1987; Schneider, 1987).

Pathological internalized shame is a significant cause of human suffering and a silencing mechanism that keeps misery secret (Goldberg, 1991). This second type of shame, one not associated with constructive outcomes, will be focused on in the current research.

**Shame defined.** This section is constructed to guide the reader through the evolutionary process the definition of shame has undergone. In approximately 384 BC, Aristotle, the Greek philosopher and student of Plato, believed shame was indicative of faulty character, afflicting people who lacked self-control (Schnieder, 1987). René Descartes, the French Rationalist philosopher, briefly mentioned shame in 1649, calling it a form of sadness founded on self-love that comes from a fear of being blamed by others (Wilson, 1987). William James, often dubbed the founder of American psychology, noted in 1890 that a man’s social self is the result of a desire to be noticed favorably by others, and self-esteem is a simultaneous evaluation of self in one’s own and others’ eyes (i.e. both internally and externally derived; Block, 1971). Therefore, feelings that violated this favorable view of self were associated with shame. Later, French existentialist philosopher Jean-Paul Sartre (1943/1956) characterized shame as an indication of a basic relatedness to others (Wilson, 1987). French psychoanalyst Jacque Lacon (1978) identified
the concepts of “the other” and “a sense of self in the mirror” and referenced Sartre’s theories related to how “perversions” such as narcissism, control, dominance, and submission develop related to shame (Wilson, 1987). Regardless of whether the stimulus causing shame was external or internal, the common component for those experiencing it seemed to be an association with “being bad,” which resulted in scholars using the words guilt and shame almost interchangeably (Lewis, 1971; Stearns, 2016; Tangney & Dearing, 2011).

In 1971, Helen Block Lewis proposed a clear distinction between guilt and shame. Simply put, guilt is a feeling experienced when people have done something bad or wrong in their own (or in society’s) perception. Shame is a feeling experienced when one perceives oneself as bad or deeply flawed. As Lewis (1971) clarified, guilt is about the act; shame is about the self.

Shame is a feeling that has had different meanings and definitions over time. As research continues to be conducted about shame and its affects, most modern day theorists have agreed on a basic definition of shame very similar to what Helen Block Lewis proposed in 1971. This study is based upon research conducted by Brown (2007) and the resulting Shame Resilience Theory she developed. Her theory will be expanded upon in future sections of this dissertation, but her definition of shame is: “the intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging” (Brown, 2007 p. 5).

Bronfenbrenner (1977) believed that human development must be approached through a larger viewpoint that included observing not only the individual, but also the changing environment in which that individual lives and grows. Such observation can be carried out on several levels, with the culture being the macrosystem, the family system in which one is raised the mesosystem, and the individual and the settings they occupy being the microsystem.
(Bronfenbrenner, 1977). Shame can also affect people on multiple levels. In an effort to conceptualize shame in all its forms, this dissertation is designed to briefly address the different levels in Bronfenbrenner’s system, beginning with the microsystem and later expanding into the mesosystem and macrosystem.

**Shame at the individual level.** Shame has been noted to affect humans on a physical, emotional, and cognitive level. In 1872, Charles Darwin referenced shame in a book on emotions in humans and animals. He attributed the physical phenomenon of blushing to the emotion of shame and believed it manifested in most, if not all, human races. Darwin may have adopted the connection between blushing and shame from an earlier essay written by Thomas Burgess in 1839, stating that shame was not a negative characteristic, but rather a sign of humanity (Schneider, 1987). By observing case studies and consulting with physicians, Darwin (1872) noted that blushing “confuses the mind” and seems to have a cognitive component as well as an emotional one. Helen Block Lewis later suggested that blushing might be a signal of feeling separated, or experiencing a threat of separation from another (Nathanson, 1987).

Darwin (1872) also identified shame as a parent emotion in a cluster of closely related emotions that preserve the human species by responding to potential dangers in the environment with rapid and strong reactions (Goldberg, 1991). Although Darwin was able to name the cluster of emotions associated with shame, he was not able to differentiate between them (Lewis, 2008b). Although Goldberg (1991) has characterized shame as a universal experience to which even the most successful of individuals are susceptible, he posits that it may vary in its presentation relative to a given situation, because the same circumstances that cause one person to experience anger and distress can cause another to experience shame. This fact makes researching shame more difficult than researching primary emotions (Lewis, 2008b). Because
research is generally helpful in clarifying a topic in more depth, the difficulty in understanding and agreeing upon shame’s exact placement in the emotional realm might be due to its elusive nature.

There has been debate among researchers about whether shame is a primary emotion. Shame is not commonly featured in most theorists’ lists of basic emotions, but Ekman (1992) acknowledged that it was a strong candidate (Gruenewald, Dickerson, & Kemeny, 2007). Tomkins (1962/1963) included it in his list of innate hardwired emotions (Gruenewald et al., 2007). In 1985, E. Virginia Demos conducted what is referred to as the “still face” experiment in infants and found that shame was present in facial expressions in babies as young as two-and-a-half months when the mother would not mirror the babies’ affect when they tried to get her attention (Nathanson, 1987). Due to studies like the one previously mentioned, there is reason to believe with more research shame could fit the criteria of a basic emotion found universally in humans and other animals. Although shame is not universally associated with a specific facial expression, it does have a unique bodily display that includes gaze aversion, head tilted to the side or downward, and a slumped posture (Gruenewald et al., 2007). For purposes of the current research, whether shame is a basic emotion does not affect the proposed measures for teaching shame resilience. What is important is understanding the complexity and debate surrounding shame and how it influences and shapes people’s lives.

In 1971, Helen Block Lewis specified three characteristics of shame. The first is that people have difficulty identifying the shame they are experiencing. The second is people have difficulty maintaining a functional sense of self during the shame experience. The third is people have difficulty discharging the hostility evoked due to the shame experience. She also believed that when shame and guilt are not properly identified and discharged, symptom formation may
result and manifest as depression, obsessive ideations, paranoid ideation, aggression and hysterical behavior (Lewis, 1971). Goldberg (1991) agrees with H. B. Lewis’s first characteristic, stating, “despite how intensely afflicted sufferers of shame are, rarely can they do anything about their despair because they lack the awareness that their suffering is rooted in shame” (p. x). Dr. Brown’s Shame Resilience Theory corroborates these properties of shame and specifically prescribes intervention for them in the *Connections* curriculum (Brown, 2009).

According to Leon Wurmser (1987), shame can be divided into three phases. The first is a fear of disgrace, or an anxiety that develops in anticipation of being viewed with contempt. The second is the actual experience of shame caused by contempt imposed by the self or others, which results in people trying to hide themselves from others. The third is a character trait from which people attempt to prevent themselves from ever having to experience again those feelings that arose in phase two. In this phase, the person adopts a preventative attitude that may in some instances be helpful, but in other instances proves dysfunctional if the only way to hide or prevent potential shame circumstances amounts to unhealthy coping mechanisms or a life lived from an inauthentic presentation. In Wurmser’s theory it is obvious that when shame becomes pathological, it can create a negative cycle that keeps a person from taking action in life for fear of shame, instead choosing to withdraw or become hidden. This tendency may be especially harmful if a person believes contempt exists in people or places when it does not, such as when the person is sharing a humiliating story with a therapist.

**Developmental theories.** Listed in this section are the various theories that have been created to conceptualize how a person adopts a shame-prone sense of self from a developmental standpoint. As with the definition of shame, there have been many different theories that have evolved over time. For purposes of the current research, the origin of how one becomes shame-
prone is less important than the intervention used to help people emerge from the limitations inherent in having a shame-based sense of self.

Researchers have proposed various explanations regarding the origin of shame from a developmental standpoint. Freud described what he referred to as anxiety in children as young as six to eight months of age, but in the years since, other scholars have wondered if what Freud observed was actually shame (Nathanson, 1987). Mannoni (1982) also believed Freud had developed a theory about shame, though Freud never used the word “shame” to describe it (Wilson, 1987). Helen Block Lewis (1971) explored this theory in more depth, writing Freud (1893–1895) had identified “mortification” (a variant in the shame family) and the role it played in symptom formation in women who displayed hysteria. In 1939, 44 years after Freud’s hysteria publication, he again discussed the role of mortification in neurosis (Lewis, 1971). Building on Freud’s claim that some component of sexual life was tied to neurosis, Lewis stated that research had also uncovered the tie between the sexual life and shame (Lewis, 1971). Freud’s earliest works on hysteria (1893–1895) included shame in the first list of traumatic effects. Alfred Adler (1933) used the terms “organ inferiority” and “inferiority complex” as the cause for neurotic suffering. Although he did not use the term shame directly, it seems Adler supported Freud’s views on what we now call shame (Goldberg, 1991). These preliminary theories highlight the role shame and its associated emotions play in neuroses, or what are referred to now as the effects of trauma.

Silvan Tomkins believed shame was an innate feeling experienced from birth and was not socially learned (Nathanson, 1987). Over time, Tomkins maintained, the infant is able to use feelings of shame or humiliation appropriate to situational cues. Tomkins’ theory also stated that other emotions are innate from birth, such as interest-excitement and enjoyment-joy. He
believed shame to be triggered when a person strives for one of the positive affect states but does not achieve it (Nathanson, 1987). Failure would be an example of a situation that may cause shame-humiliation. Along similar lines, Wurmser (1987) stated that shame was caused by a discrepancy between expectation and realization – how one wants to be seen versus how he or she actually is seen.

Eric Erikson (1959) developed a series of developmental stages that he maintained children must experience and successfully complete to develop into healthy adults. Erikson claimed the individual develops on three levels simultaneously: biological, social, and psychological (Fishkin, 2016). What happens during bonding and interaction with parents and caregivers provides the foundation of self-worth (Fishkin, 2016). The foundations children receive would either help or hinder their ability to reach subsequent stages of development. In Erikson’s second stage of development that begins at approximately age two, which he refers to as “autonomy versus shame and doubt,” shame emerges from a sense of helplessness and loss of self-control (Kinston, 1987). If children learn that it is safe to individuate, and that support will be there, children will succeed in developing autonomy. If children do not have the necessary support, they may instead learn to approach life from a perspective of doubt or shame. Some theorists believe pathological consequences, such as narcissistic personality development, may occur if children do not attain individuality (Kinston, 1987).

An example of a situation that may create pathological consequences would be when the child tries to establish individuality, but the parent may feel attacked or as if the child’s love or approval has been lost (Kinston, 1987). Such a parent may respond to the child’s attempt at autonomy in a negative fashion, possibly leaving the child to infer, “I must be bad,” rather than allowing healthy individuation to occur. Children could learn to disown their own needs,
developing feelings of dependency, imperfection, and conflict in internal feelings (Kinston, 1987). According to this theory, not successfully completing the autonomy versus shame and doubt stage could be the beginning of developing a shame-prone sense of self.

Miller’s (1996) theory is slightly different from the ones examined thus far in that Miller does not consider shame to be part of a developmental stage. Rather, he believed the shame stimulus is external at the beginning of life but as the child ages, becomes a combination of internal mental structures and external stimuli, continuing to strengthen with age (either toward shame-prone or non-shame-prone). Once the child has established a personal view of people and situations, this view largely determines how external stimuli are perceived. This theory more closely resembles shame considered as a moral compass or as an emotion framing beliefs and actions. Accordingly, when adults notice potentially neutral stimuli, those stimuli would register as a) shaming if internal structures were shame-prone, or b) neutral if they were not. If a person’s internal structures were not shame-prone, even a shaming situation might not be taken personally. Miller (1996) also differentiated between internalized and reactive shame, stating that internalized shame does not require an external stimulus, whereas reactive shame usually does. In the same sense, internalized shame is typically pathological, while reactive shame can serve a constructive purpose if the behavior change that results is positive, further addressing the two types of shame previously noted in this dissertation. Miller disagreed with Tomkins, Nathanson, and Izard, stating that shame changes throughout development in response to a variety of experiences; it is not a core affect that is either occurring or not occurring at any given time (Miller, 1996). Goldberg (1991) also agreed that shame occurs at every level of development, rather than being restricted to a specific phase of development.
Kohlberg and Piaget both created developmental theories that include moral judgment as an aspect of development (Rest, Turiel, & Kohlberg, 1969). Kohlberg’s six stages of development build on each other; one must attain one level before moving on to the next. In stage six, the highest stage, a person is not only motivated by external forces but has an internal compass that functions as a consistent directing agent toward mutual respect and trust (Rest et al., 1969). Because shame is often considered a moral emotion, and because pathological shame is historically linked to neurosis in research, it is important to separate the two types of shame that could be functioning in relation to this theory.

Shame in the external or positive sense is most likely associated with Kohlberg’s moral theory, allowing a person to advance to stage six. Pathological or internalized shame, on the other hand, might not be related to moral transgressions nor would it prevent a healthy internal compass from developing (e.g., a person could still differentiate between right and wrong behaviors even if they viewed themselves as bad). Research conducted by Block (1971) further expounds on this differentiation. In subjects who displayed neurotic symptoms, research showed no evidence they committed more or fewer moral transgressions when compared with the general population, although they did struggle to maintain a balanced self-evaluation (Lewis, 1971). This struggle most likely reflected a shame-prone sense of self that often occurs due to trauma and may manifest as neurotic symptomology. Lewis (1971) observed that her neurotic clients appeared highly ethical and generally sought progress in treatment because of a moral commitment to self-improvement. The current research suggests that pathological shame is not a moral deficit of character, but rather an internalized view of self that frames the way people experience the world.
Earlier research by Rogers and Dymond conducted in 1954 used a Q Sort assessment test to measure the difference between a people’s idealized sense of self and their actual self-image (Lewis, 1971). Results showed that people who were known as neurotic showed a higher discrepancy between the idealized and actual versions of themselves. Rogers and Dymond’s findings led Lewis to conclude that neurotic people most likely have a greater sense of internalized shame than non-neurotic people and that shame plays an important role in neurosis (Lewis, 1971). Lewis (1971) also observed that people who displayed neurotic symptoms tended to encounter difficult life experiences such as disappointment, failure, defeat, helplessness, or moral transgressions. The relationship between shame, trauma, and negative symptomology is again highlighted by comparing the relationship noted by Lewis with a prior section of this dissertation on how traumatization can reverberate throughout the lifetime.

**The voice of shame.** The philosopher David Hume believed that people’s perception of reality is rooted in their past experiences (Fishkin, 2016). Scientists are learning that abuse, neglect, trauma, abandonment, and other chronic violations of the self in childhood develop and shape an individual’s inner voice into an intrinsically negative instrument (Fishkin, 2016). Because the multicomponential theory of emotion includes both a cognitive and an appraisal aspect, negative self-talk is an example of yet another way shame can manifest. People’s inner voice can bring up the most humiliating memories of the past and throw them back, constantly reinforcing people’s view of themselves as being the worst of who they think they are (Fishkin, 2016). The inner critic is often a constant companion of a person who suffers from internalized shame. Stated differently, a shame attack is like a bully within; individuals can be self-critical and self-persecuting (Fishkin, 2016; Gilbert, 2007).
The view of early-life trauma and abuse as the antecedents to the affective reactions of shame, with a defined neurological correlate, allows for a more empirical and clinical understanding of shame and leads to effective treatment approaches for shame and shame-based behavior (Fishkin, 2016). Fishkin addresses the neuroscience behind the role the basal ganglia play in the formation of the negative self-talk related to feelings of shame. The field of neuroscience is constantly advancing and providing explanatory information on how the brain works. Detailed neuroscientific explanations fall outside of the scope of this dissertation, and to this author’s knowledge have not been fully developed. Nonetheless, knowing that some research is available and providing the reader with a potential source for further examination is relevant to continuing this line of research.

Shame-based, internalized self-criticism is not only a set of judgments or thoughts about the self, but also includes powerful emotions of anger or disgust with self (Gilbert, 2007). In a study conducted in 2005, people who had low self-criticism found it relatively easy to dismiss their own criticisms (Gilbert, 2007). One theory is that these individuals find it easier to activate self-soothing when confronted by their own failure and criticisms (Gilbert, 2007). An additional study showed self-criticism was associated with difficulties in forming images of supportive and compassionate aspects of oneself (Gilbert, 2007). Implications are that internalized shame is linked to both the power of hostile emotions (e.g. contempt and anger) directed at the self and the inability to access self-soothing via positive images of and feelings for the self (Gilbert, 2007). Because Dr. Brown developed her Shame Resilience Theory by studying individuals who did not seem to struggle with a shame-prone sense of self, here too, seeing what skills those who are able to combat self-criticism have that others do not may be an important step for clinicians to notice when treating internalized shame.
According to Greenberg (2008), founder of Emotion Focused Therapy, for people to transform their emotions, there is a process of exchanging one emotion for another. A maladaptive emotional state can be transformed best by replacing it with another, more adaptive emotion. In Brown’s Connections curriculum, empathy is the positive emotion taught to be used instead of (or along with) shame (Brown, 2009). In time, the activation of the more adaptive emotion along with or in response to the maladaptive emotion helps transform the maladaptive emotion. Greenberg (2008) posits that, although thinking changes thoughts, only feeling can change emotion. The Connections curriculum includes components from Cognitive Behavioral Therapy as well as Emotion Focused Therapy, thus targeting symptoms from both thinking and feeling.

The process of transforming maladaptive emotions by using adaptive emotions is considered part of emotional intelligence. The concept of emotional intelligence came to bridge the relationship between emotions and reason, given that humans have both emotion and reason, rather than being limited to one or the other (Salovey, Detweiler-Bedell, Detweiler-Bedell, & Mayer, 2008). Emotional intelligence is described as the ability to perceive and express emotions, to understand and use them, and to manage emotions in ways that foster personal growth (Salovey et al., 2008). A positive side effect of teaching the Connections curriculum to survivors would be to increase emotional intelligence in trauma survivors.

**Shame in family systems.** Because shame-proneness is often formed during childhood, examining the larger context of the family system can help explain how an internalized sense of shame can be reinforced by external dynamics. A family that is shame-bound is a family with a multigenerational, self-sustaining system with a cast of characters who are (or were within their lifetime) loyal to a set of rigid rules and injunctions that demand control, perfectionism, blame,
and denial (Fossum & Mason, 1986). This pattern inhibits the formation of authentic intimate relationships, promotes secret keeping, encourages vague personal boundaries, unconsciously instills shame as well as chaos in the family members’ lives, and binds them to perpetuate this shame cycle in themselves and other family members (Fossum & Mason, 1986). This pattern is how multiple generations can be affected by shame until someone who learns to relate differently finally breaks the cycle.

Relationships in shame-prone system involve repeated abandonment, rejection, and punishment or threats of these actions, sometimes alternating with feelings of intense contact (Fossum & Mason, 1986). Addictive behavior is one of the most clearly recognized aspects of shame in families (Fossum & Mason, 1986). As the effects of a disorganized attachment style have previously been discussed, looking at how these styles are formed from the perspective of shame further conveys how interrelated are trauma, shame, and resulting pathology. Since this study is also focused on the role substance abuse can play in moderating the effects of shame and trauma, the underlying pieces begin to connect. Few people are aware that destructive shame may be what blocks intimate connection with others (Goldberg, 1991). Learning to help people alter this process of relating with both oneself and others in a way that reduces shame is how the Connections curriculum received its name, and also how learning skills on an individual level can provide larger family systems with opportunities to change.

When relationships are bound in shame, people are judged on a goodness-badness scale, which tends to be rigid and extreme (Fossum & Mason, 1986). The system is kept in place by cycles of control-release behaviors that have a positive feedback effect, meaning that the more they happen, the more they tend to continue to happen, on each other and that can interact with the same cycle in other family members (Fossum & Mason, 1986). Identifying this pattern
within oneself and the family must occur before the pattern can be stopped, which is where the potential for therapeutic intervention lies (Fossum & Mason, 1986). Where the family is located on the respectful versus shame-based continuum can be assessed in three ways: (a) violation of values versus violation of person, (b) self as separate and part of a larger system versus self with vague boundaries, and (c) accountability versus perfectionism (Fossum & Mason, 1986).

Families scoring on the left side of those scales function with higher respect and are most likely healthier than those scoring on the right. The subdivisions of this scale are similar to some of the individual developmental scales created by Erikson (1959).

How then does one begin to change these patterns? According to Fossum & Mason (1986), “The roots of shame are in abuse, personal violations, seductions, and assaults where one’s sense of self has been trampled, one’s boundaries defiled” (p. 6). Lewis (1971) surmised that persons with more permeable self-boundaries would be more shame-prone. These authors have found that facing shame directly reduces dependence on the family system and helps shape identity, leading to a reduction in addictive behaviors and obsessions. “By facing shame, people begin the human recovery process, the growing of that budding self within, to a self with respect and integrity, capable of intimacy” (Fossum & Mason, 1986). Goldberg (1991) stated that shame-proneness could also be caused by multiple sources on the mesosystemic level other than critical and unresponsive families. These include disregard by playmates, classmates, teachers, and other authority figures outside the home and can extend to intimidations exhibited by lovers and spouses later in life (Goldberg, 1991). Helping individuals understand the multiple levels that may have helped create their shame-prone views of life, including their own choices that caused outcomes, which reinforced their beliefs, may empower them to make the individual changes necessary to begin the recovery process.
**Shame in cultures.** To the extent that cultures vary in self-evaluative processes, in the structure of relationships, or in values against which individuals assess themselves, members of different cultures probably vary in their experience of shame and other self-conscious emotions (Goetz & Keltner, 2007). In the positive sense, shame can help the individual act according to group norms, and these group norms vary greatly across cultures. For example, Western cultures value an independent self, whereas many Eastern cultures value an interdependent self (Goetz & Keltner, 2007). Although shame may be evoked for different reasons in each culture, it is still evoked in both. In collectivist cultures, shame may not have the same negative associations it has in more individualized cultures. Some authors have observed that, as certain cultures become individualistic, shame shifts from external to internal, which aligns with the way views of shame have shifted historically (Goetz & Keltner, 2007; Stearns, 2016). Because the current research was conducted amidst Western culture, the Western view of shame will be the primary focus in this section.

Goldberg (1991) identified five major sources of shame: (a) family of origin, (b) genetic and biochemical disposition, (c) self-shaming thoughts and feelings orchestrated by one’s narrative self, (d) current humiliating relationships, and (e) contemporary American culture. Views of shame have evolved over time from the original constructive means of behavior modification to the later, more individual pathological definition. Culture apparently plays a major role in generating both forms. Discovering what benefit cultures gain from maintaining shame as an active element in society is useful in understanding how the dynamics are kept in place.

Goldberg (1991) asserted four main reasons shame is little recognized and often fostered in Western society: (a) Freud’s guilty conscience theory served as the foundation for much
understanding about human nature; (b) societal agents in positions of power and affluence recognize that people can often be spurred by guilt and shame to be more productive, as demonstrated by historical industrial evolutions; (c) from infancy onward, children are pushed toward competition in a high-achievement oriented society that is laden with strong themes of humiliation and shame; (d) modern technology has hindered time-proven ways of coping with and healing emotional wounds, with social forces that encourage people to ignore the suffering of others or “get on” with grief, compared with pre-technology eras when face-to-face interaction was the primary mode of connection. Regarding reason (d), according to Brown’s Shame Resilience Theory, reducing face-to-face interaction would reduce empathy and connection, thereby increasing shame. A reason not included in Goldberg’s theory, but equally relevant, is America is a society based on capitalism with success often equating to worth. Each of these components combines to create an atmosphere ripe for fostering shame and encouraging people to seek culturally endorsed types of success as a pseudo solution for feeling better about oneself.

Shame and power exist at all levels of society (Morrison, 1987). Like blackmail, shame can be used by those in power to force people to conform to desired behavior, providing reason for those in power to continue using it (Morrison, 1987). Advertisers in Western culture, seeking profits from sales, often use shame to convince people they are not good enough without the positive influence a certain product will bring. However, the series of products people “need” to redeem themselves never ends (Brown, 2008). When society establishes a perfectionistic standard of unattainable goals and when society labels people as individually defective if they cannot live up to those expectations, shame can and often does result. This is especially saddening because people who carry an internalized sense of shame may be more susceptible to cultural messages intended to elicit shame.
In Western cultures, men and women differ regarding what is considered shameful (Goldberg, 1991). Males in the United States are “shame phobic” with values placed on pride and love of self (Goldberg, 1991). Dr. Brown (2012) wrote that men live with the unrelenting message, “do not be perceived as weak” (p. 92); women receive conflicting messages from society targeted at multiple domains in life that say, “be perfect, but make it seem effortless” (p.87). To some, having to fit into a specific gender role in and of itself can be shame producing. Regardless of gender, individuals can be said to have a “shame button” through which they can be manipulated psychologically to act in certain ways (Goldberg, 1991). Brown refers to these as “shame triggers” (Brown, 2008). Different cultures, not surprisingly, have different shame triggers based on what is considered shameful for that culture.

Shame may also be inadvertently kept in place by religious messages or widely established belief systems. For example, In the Christian tradition, several basic human emotions have been deemed evil or bad: envy, anger, greed, lust, and jealousy (Berke, 1987). Unfortunately, most Westerners experience a culture where these feelings arise regularly and naturally, which may evoke a sense of shame in people who view themselves as evil or bad for having those feelings. This is why to understand shame on an individual level one must also examine the cultural systems that keep shame in place (Berke, 1987). Fortunately, one of the first things the Connections curriculum does is to address the cultural layers that affect shame and to help individuals understand its intricate layers.

**Shame and Trauma**

Although shame and trauma are separate constructs, they often co-occur and influence each other. The complexity and relationship between the two can manifest in various ways, and will be explored in this section of the dissertation by illustrating the ways in which shame and
trauma interrelate, and by exploring how treating one construct can affect the other. The assessment measures used in the current research are introduced in this section.

**Interrelationship**

The role shame plays in people who have experienced trauma is insidious. Research continues to document the relationship between shame, experiences of trauma and negative symptomology. Data has shown shame may be a causal factor between the experience of childhood sexual abuse and adult emotional distress (Whiffen & MacIntosh, 2005). Additional research has shown that shame may be a mediator between childhood abuse and adult psychopathology (Holl et al., 2016). Negative self-cognitions in people with a history of complex trauma have been strongly associated with trauma symptoms in adulthood (Platt & Freyd, 2011). The background information presented in this dissertation has highlighted the correlation between shame and negative self-talk. Additionally, higher levels of depression and shame have been significantly associated with higher levels of negative thoughts of self (Beck et al., 2013). Not only are shame, trauma and negative symptoms correlated, but empirical studies have shown that, in trauma survivors, subsequent experiences of failure may more readily trigger feelings of shame because the sense of self becomes more fragile and easily shattered (Platt & Freyd, 2011). Without intervention, people’s symptoms can increase and their self-worth may continue to decrease because of shame.

According to Bessel van der Kolk, M.D., one of the leading advocates for establishing an official diagnosis of complex PTSD in the DSM-5, shame is often the hardest issue for traumatized people to confront, whether the trauma occurred due to objectively warranted situations (i.e. if people feel shame because they murdered someone in self-defense), or not objectively warranted (i.e. a victim of abuse who tried to placate the abuser; van der Kolk, 2015).
People’s view of themselves may be negatively altered after experiencing trauma, causing them to despise themselves for how terrified, dependent, excited, or enraged they felt when the trauma was occurring (van der Kolk, 2015). Other reactions to trauma, such as intense and barely controllable physical and emotional sensations, as well as numbness when people believe they should have emotions, can leave people perceiving themselves as crazy or monstrous, which may further fuel their shame reactions, causing them to isolate and hide their truth (van der Kolk, 2015). When badness is felt in such an intense way, convincing people to look at what caused the reaction, or asking them to share it with another person can be an incredibly difficult unless people are first helped to understand how shame works.

For children to draw the conclusion that they are defective and worthless is fairly easy after having experienced molestation, beatings, or other types of maltreatment (Briere & Scott, 2006; van der Kolk, 2015). Victims may be consumed with a sense of failure, self-loathing, and shame (Dearing & Tangney, 2011; Herman, 1992; McCann & Pearlman, 1990). In fact, children might begin to believe that their own badness is the cause of the abuses they are receiving (Herman, 1992). Even if the abuse a child experiences is not overt, much literature recognizes the role excessive criticism, parental rejection, persistent invalidation, perfectionistic standards, and denigration play in the development of a toxic, shame-based self-identification (Bennett, et al., 2010; Teyber, McClure, & Weather, 2011). A slight alteration to the popular childhood motto captures the insidiousness of shame: “Sticks and stones just break your bones. It’s names that really harm you” (Nathanson, 1987, p. 269).

Some researchers believe it is remembering the shameful events rather than independent feelings of shame that build self-identity and keep internalized and externalized shame present (Matos, Pinto-Gouveia, & Duarte, 2012). Researchers Platt and Freyd asserted that it may be the
negative underlying assumptions that some people create after experiencing trauma that cause some people to develop shame-proneness while others do not (2011). They maintained that some people are able to distinguish the feelings of shame that occur in direct response to trauma while people who do not identify the feelings of shame as being elicited in direct respond to trauma inadvertently extend those feeling of shame to a general sense of self (Platt & Freyd, 2011). By recalling memories of experiences that caused shame, people’s negative sense of self may continue to be reinforced unless they become aware of how the feelings of shame influence the interpretation placed on memory. This explanation would most likely be for people who internalized shame after childhood due to repeated trauma, but did not develop a sense of internalized shame early in childhood in response to attachment or caregiver issues.

No matter how shame-proneness developed, it tends to have associated side effects. These include a tendency to overreact to slight frustrations, which may interfere with the ability to make friends, thus furthering people’s isolation and strengthening their convictions of inner badness (Herman, 1992; van der Kolk, 2015). Defenses against feeling shame may appear as contempt or enviousness towards others, or depression. Shame may also manifest as grandiosity if people create a persona toward the outside world to make them look like they have an exaggerated sense of self to compensate for feeling flawed on the inside. Shame is such a painful emotion most people will do anything to avoid feeling it. Some shame-prone individuals may simply withdraw (Dearing & Tangney, 2011).

Research has also linked internalized shame to problems with hostility, anger, rage, and the tendency to externalize blame (Dearing & Tangney, 2011). Dissociated rage or shame rage may be the reaction to frequent experiences of humiliation (Teyber, McClure & Weathers, 2011). This can manifest as a sense of retribution, which may arise in shame-prone individuals almost
immediately after experiencing shame with the thought, ‘You hurt me so I must punish you’ (Nathanson, 1987). In a research article comparing individuals with PTSD to individuals who show symptoms of complex PTSD, shame was a more significant predictor of aggression and self-harm in those with complex trauma (Dyer et al., 2009). This result lead researchers to believe that shame, not biological hypervigilance due to re-experiencing symptoms, could be what fuels anger and aggression in this population (Dyer et al., 2009). If this is true, then a reduction in shame could lead to a reduction in aggression. Helping survivors learn how to channel aggression and anger in positive ways, such as through courageously embarking on recovery, rather than inwardly channeling hurtful feelings, is a large part of therapeutic interventions directed toward helping people resolve shame.

To understand the interpretive view the participants in this study use to evaluate life circumstances, The Test of Self Conscious Affect, third edition (TOSCA-3S) was given to participants before and after participating in the Connections group. The purpose of this scale is to measure if an individual views ambiguous life circumstances from a place of shame, guilt, or blame toward others. This measurement tool has been frequently used in research and was selected by Dr. Brown to be used in the Connections curriculum as a standard measurement protocol. The TOSCA-3S asks participants to choose responses to different scenarios describing a life event. The responses are reflective of whether the participant typically uses shame self-talk, guilt self-talk, or blames others for the outcomes of the events (Brown, 2009).

The original scale was generated from college students’ and other adults’ descriptions of personal experiences of pride, guilt, and shame (Tangney, Dearing, Wagner, & Gramzow, 2000). These descriptions formed the basis for the five positive and ten negative life scenarios that compose the scale (Tangney et al., 2000). Descriptions written by adults not attending college
formed the basis for the multiple-choice-styled response set (Tangney et al., 2000). These scales are dispositional measures, and are very frequently used in the social-personality literature to assess shame and guilt proneness (Robins, Noflile, & Tracy, 2007). These scales are included in this study, not only because they are used as a measure in the *Connections* curriculum, but also to assess if change has occurred in the way participants see ambiguous events after completing the *Connections* group.

**Effects**

Although in some instances trauma may constitute the wound that allowed shame to grow, it is often difficult, if not impossible, to tease out whether trauma or shame-proneness occurred first in a person’s life. In this section, the interrelationship between trauma and shame will be explored and the negative life effects that stem from how they are intertwined will be discussed, supplying supporting evidence about why including direct shame intervention is necessary to improve the treatment of the effects of trauma.

*Physical health.* The ACE study, previously reviewed in this dissertation, is not the only study to identify long-term medical effects of traumatic experiences. Bessel van der Kolk has also noticed a correlation between incest survival and the development of autoimmune disorders (2015). This may be explained by examining the psychoneuroimmunology of chronic disease, in which researchers have noted that constant activation of the stress response may overexert the immune system; patients diagnosed with an autoimmune disease appear to have had excessive activation of the stress response, which affects the immune system, while healthy individuals have not so frequently had stress responses that affect their immune system (Kibler, Joshi, & Hughes, 2010). Since PTSD and Complex Trauma are both categorized as stress disorders, a
link associating trauma-related stress with autoimmune disorders may someday be more solidly confirmed. Bodily self-regulation may have been inhibited by abuse if the child’s body was at the disposal of the abuser, a disruption that could manifest later in life as chronic sleep disturbances, eating disorders, gastrointestinal complaints, and other bodily distress symptoms (Brier & Scott, 2006; Herman, 1992).

Shame has previously been noted as an emotion that pertains to the social self—how one is viewed by others, or in comparison to one’s own standard of how oneself should relate to the world. Life events that threaten the social-self elicit activation of the hypothalamic-pituitary-adrenal (HPA) and proinflammatory immune systems, leading to the release of cortisol and inflammatory cytokines (Gruenewald et al., 2007). Associations between biomarkers of these systems and the shame experience have been tied to threats of the social self and are most likely involved in the activation of the HPA system, which may link shame to health issues affected by excessive cortisol and inflammatory processes (Gruenewald et al., 2007). Elevated levels of proinflammatory cytokines are characterized in many health disorders including metabolic syndrome, diabetes, cardiovascular disease, and chronic inflammatory diseases (Gruenewald et al., 2007). This information further connects shame, trauma, and the occurrence of physical disease.

Due to the relationship between shame and physical symptomology, the current study was designed to see if, after people learn shame resilience skills, they experience a reduction in physical symptoms. To test this hypothesis, participants were asked to fill out the self-report measurement Trauma Symptoms Checklist (TSC) created by Briere & Runtz (1989) before and after taking the Connections group. This measurement lists 40 different symptoms such as headaches, insomnia, and anxiety attacks, and asks the participant to rate how often these
symptoms occur on a “never to often” Likert scale. This researcher hypothesized that a reduction in symptoms will occur in participants after completing the Connections group.

**Psychological health.** Physical health symptoms are not the only by-product of experiencing trauma and shame; mental health is often affected as well. Due to repeated experiences of terror, rage, and grief, the emotional state of the traumatized child may have oscillated between anxiety, dysphoria, panic, fury, and despair, which may explain why high correlations of trauma with chronic anxiety and depression continue into adult life (Herman, 1992). Furthermore, children who have experienced neglect have reported more shame-proneness and depressive symptoms compared to children who have not experienced neglect, leading researchers to believe that shame may be an explanatory variable connecting neglect and depression (Bennett et al., 2010). Research has shown that a history of complex trauma has a high comorbidity with postpartum depression, indicating that shame from childhood trauma can adversely impact offspring through maternal emotions and reactions (Oh et al., 2016). If postpartum depression leads to attachment issues with the newborn child, this could begin the cycle of internalized shame in a new generation.

Courtois and Ford (2013) developed a list of potential sequelae of exposure to complex trauma that includes the following conditions:

- extreme mood lability, social isolation and detachment, excessive self-sufficiency and fear of intimacy in relationships, excessive dependency and compliance towards others, addictions, compulsions, impulsivity, uncontrolled anger, cruelty towards others or animals, self-injury, lack of social skills, mistrust of others, persistent dissociation, pathological relationships, chronic medical conditions, chronic low self-esteem, inability to tolerate emotional distress, pervasive feelings of hopelessness regarding feeling
misunderstood or not “normal,” alienation from spiritual or religious beliefs, information processing problems such as attention deficit, conduct disorders, and psychotic-like experiences of auditory hallucinations. (p. 24)

If symptoms of complex trauma can include psychotic-like manifestations, how many individuals who are survivors of complex trauma are diagnosed with disorders where trauma is not considered as the etiology? Although only a small percentage of trauma survivors become psychiatric patients, a large percentage of psychiatric patients are survivors of childhood abuse (Herman, 1992). One must wonder if this is coincidence. In female psychiatric patients, shame-proneness was associated with higher levels of dissociation, which is a common symptom of complex trauma (Talbot et al., 2004; van der Hart et al., 2006). Talbot et al. (2004) further linked sexual abuse, shame-proneness, and dissociation. The impact of the wide range effects of trauma and shame may be staggering.

Three diagnoses often applied to survivors of childhood abuse that carry negative connotations are somatization disorder, borderline personality disorder, and dissociative identity disorder, any of which may leave victims of complex trauma with fragmented and incomplete treatment of the underlying issue (Herman, 1992; Taycan & Yildirim, 2015). These apparent disorders may actually be variants of complex PTSD—the features being adaptations to the traumatic environment (Herman, 1992). Research linking emotional abuse, shame-proneness, and symptoms of Social Anxiety Disorder might show that various anxiety disorders might be correlated with an underlying trauma basis as well (Shahar, Doron, & Szepsenwol, 2015). These possibly incorrectly diagnosed sets of symptoms again demonstrate the potential for errors in accurately conceptualizing what is really happening if underlying trauma is not considered a reason for the symptoms displayed. Encouraging survivors to talk about traumatic experiences
and begin receiving treatment for them may help prevent providers from writing incomplete treatment protocols for these individuals, lacking attention to trauma experiences, if the true underlying issues are not identified.

Trauma experiences and shame can be life threatening. Trauma survivors may direct their rage and hatred inward (Herman, 1992). One manifestation of this self-destructive onslaught is suicidality (Bryan et al., 2013; Dearing & Tangney, 2011; Courtois & Ford, 2013; Herman, 1992; Rizvi et al, 2011). Self-inflicted injury, which often arises in those with Borderline Personality Disorder, may also be triggered by feelings of shame (Rizvi et al., 2011).

Helen Block Lewis (1987) has stated that shame is found at the root of many personality disorders, including narcissistic personality disorder and borderline personality disorder, further strengthening the tie between shame and trauma. The symptoms of borderline personality disorder and a history of childhood trauma have been correlated in numerous studies, which are inclusive of the link to high levels of internalized shame (Chan et al., 2005; Herman, 1992; Rizvi et al., 2011). Narcissism has been found to be a defense against hatred of the self, rooted in shame (Block, 1987). In 1971, Kohut found that people with narcissistic personalities are unable to regulate self-esteem, warding off humiliation or shame by assuming conceited airs (Block, 1987). Narcissistically wounded individuals find their feelings of inadequacy, patheticness, hideousness, etc. so intolerable that they retreat into abject narcissism (Kinston, 1987). The only way to resolve these pains is by learning to feel and tolerate them, but once the narcissistic personality is developed, the defense against those negative feelings is so strong that reversing them can prove extremely difficult (Kinston 1987). Kohut has noted the tie between narcissism and depression, and today scholars recognize a solid tie between shame and depression (Lewis, 1987).
Not only does shame and trauma have the potential to produce mental health symptoms, they can also play a role in preventing people from forming healthy relationships, which can, in turn, exacerbate the issues of psychological health. The Connections curriculum focuses on the importance of relationship with others to help combat the toxic effects of shame and to achieve psychological health (Brown, 2009). Relationship to self also affects relationships with others, as it is nearly impossible to achieve intimacy with another in the absence of intimacy with self (van der Hart et al., 2006). Because shame involves the belief that an individual is deeply flawed, shame also serves as a barrier to a positive relationship with oneself. The association throughout the lifespan between feelings of shame and interpersonal relationship disconnectedness is supported empirically, second only to dissociation, which has been shown to be the main cause of interpersonal disconnectedness in people who have complex trauma (Dorahy, 2010). Combating shame by restoring one’s beliefs about the self by reducing internalized shame and introducing shame resilience skills, which include reaching out to others for support, is part of the focus of this research.

Substance use. According to the ACE study, the likelihood of drug use via injection was 4,600 percent higher in people who reported having undergone six or more adverse childhood experiences compared to those who had undergone none (Felitti & Anda, 2000; van der Kolk, 2015). Although substance abuse in general positively correlated with ACE scores (Felitti & Anda, 2000; Herman, 1992), this fact carries particular significance for this study because some of the study participants are associated with a methadone clinic in Seattle, WA, and have a history that involves injection drug use. To assess this particular population’s ACE scores, a questionnaire was given before beginning the Connections group to examine the potential correlation between ACE scores, substance use, and a qualifying diagnosis of complex PTSD.
The World Health Organization (WHO) has developed the Adverse Child Experiences International Questionnaire (ACE-IQ) as an assessment tool to measure the frequency and amount of adverse childhood experiences that an adolescent or adult experienced earlier in life (World Health Organization, 2011). This scale is an international version based on the original scale used in the Felitti and Anda (2000) studies referenced earlier in this dissertation. It is composed of 44 questions that include basic demographic information, plus questions assessing a wide range of scenarios that would be considered adverse experiences. Answers are multiple choice and vary between Likert style frequency scales, Yes/No/Refused choices, and more focused choices related to a specific question such as, “How were you bullied most often?” (World Health Organization, 2011).

The ACE-IQ was chosen for this study to infer qualifications for a diagnosis of complex PTSD, since this diagnosis has not yet been included in the DSM-5. Most mental health agencies in the United States diagnose based on the DSM-5, and not the ICD-11 where it is an included diagnosis. It was also chosen because of the prior usage in many studies that include and expand from Felitti and Anda’s (2000) original work. This study was designed to address the role that teaching shame resilience skills has in a population that has experienced multiple adverse childhood events, to assess possible correlations between number of adverse events experienced and the changes seen on other measurement tools used in this study after the individual has participated in the Connections group.

Much research has been conducted in an attempt to understand how substance abuse relates to traumatic symptoms and shame, some of which will be documented here. Shame and low self-esteem often play a large role alcohol abuse or other drug abuse as a means of reducing painful emotions (Holl et al., 2016; Morrison, 2011; Potter-Efron, 2011). The intensity of
people’s shame and sadness has been found to be positively correlated with the amount of substances they use (Holl et al., 2016). Given that each shaming experience depletes a person’s sense of self-worth, it is easy to see how, without intervention, the cycle of shame and substance use can continue (Goldberg, 1991).

Helen Block Lewis (1971) called attention to the shame spiral, a concept currently used in many substance abuse and addiction theories. Substances such as alcohol can keep people from feeling the shame experience, thus allowing them to act in ways that, after the alcohol wears off, cause them to feel additional shame. In order to numb these additional feelings, people often drink (or use substances) more, continuing the spiral. Unfortunately, this pattern can allow people to cause great damage to themselves and others, especially family (Lewis, 1971). Step 1 of Alcoholics Anonymous invites people to admit that they are powerless over alcohol—a conclusion that may be encouraged with a healthy shame experience (Nathanson, 1987). This view implies that internalized shame can contribute to maintaining the cycle, but if external shame reaches a tipping point of intensity, people might surrender to the realization that they need help.

Studies have uncovered a higher rate of shame-proneness among adults in recovery than in the general community, and that shame-proneness may continue to create problems even after people cease using substances (Held et al., 2015; Potter-Efron, 2011). Shame-proneness may also be a risk factor for relapse, yet many alcoholics and addicts in recovery avoid talking about their shame, thus protracting the shame-addiction spiral (Held et al., 2015; Potter-Efron, 2011). Surprisingly, most standard addiction treatment programs fail to address shame directly, and longer-term therapy needed to address the underlying roots of shame may not be available to a
newly sober individual (Held et al., 2015; Potter-Efron, 2011). These facts illustrate the benefits of introducing the *Connections* curriculum to a population that struggles with substance abuse.

To determine if the participants in this study have internalized their shame, The Internalized Shame Scale (ISS) was given before and after participating in the *Connections* group. The ISS is a self-report measure designed to assess internalized shame with specific application for use with drug and alcohol dependent populations (Rybak & Brown, 1996). The ISS focuses on evaluating the extent to which the negative affect of shame becomes magnified and internalized in an individual (Multi-Health Systems, Inc., 2003). Participants are asked to rate 30 items on a five-point Likert-type scale ranging from Never to Almost Always (Multi-Health Systems, Inc., 2003). Of the 30 questions, 24 assess internalized shame and six assess self-esteem.

The reason this measurement tool was chosen for this study is twofold. The first is because the ISS is a frequently used measurement of internalized shame and can be used as a screener to ensure that participants meet criteria for this study (Robins, Noftle, & Tracy, 2007). The second is due to its effectiveness in reflecting treatment progress if it is given within four weeks after fairly intensive treatment has begun (Multi-Health Systems, Inc., 2003). Because the *Connections* course has a 12-week curriculum, this assessment can be re-administered at the end of the course. One of the hypotheses in this study is that there will be a reduction in internalized shame after shame resilience skills have been taught. The ISS is a way of measuring the differences pre- and post-course.

Experiencing shame is not the only factor related to substance abuse. The rate of dual diagnosis for PTSD and substance abuse is common, with women having a higher comorbidity than men (Najavits, 2002). Most women with dual diagnosis experienced childhood physical or
sexual abuse; most men experienced crime victimization or war trauma (Najavits, 2002). Abstaining from substances does not resolve PTSD, and some symptoms may even increase (Najavits, 2002). A cycle is then created if the increased feelings of shame intensify symptoms of traumatic stress, spiking the desire to numb these feelings through substances (Held et al., 2015). Successful treatment outcomes are lower for people who have both PTSD and substance abuse issues than for people with substance abuse issues alone, or in comparison with other types of dual diagnosis (Najavits, 2002). Having a trauma informed treatment approach available for people who have struggled with substance abuse and shame would most likely address the underlying issues that may be keeping the substance use in place.

Another insight to be gleaned from the ACE study is that what may appear on the surface to be the problem (e.g. behaviors such as smoking, drinking, drugs, obesity), might actually be what provides the individual relief from the real underlying problem – trauma (Potter-Efron, 2011; van der Kolk, 2015). Past trauma may be buried by time, shame, secrecy, and sometimes amnesia or clinician discomfort (van der Kolk, 2015). This is another reason why targeting traumatic experiences in therapy may get at the root of the problem and lead to real change. Although an ideal solution would to prevent child abuse in all forms, helping those who have experienced trauma to heal might be a realistic alternative.

**Treatment**

Now that an overall understanding of the effects of trauma and shame has been gained, one must understand how these effects can begin to change. According to Judith Herman, M.D., (1992) healing from trauma involves three main steps: establishing safety, reconstructing the trauma story, and restoring connection between survivors and their communities. Addressing the role that shame plays in survivors’ lives is a necessary part of reconstructing their story. In
shame, the victim experiences a loss of connection with what is familiar and safe (Goldberg, 1991). According to Herman, a traumatic wound is resolved only when the individual can create a new mental “schema” or worldview that incorporates understanding what has happened (1992). Psychoeducation and working with the survivor to integrate new understanding into their overall perspective is an important part of trauma therapy (Briere & Scott, 2006).

Often the cultivation of shame’s opposites – a sense of self, personal pride, increased awareness of the inner self, impulse reduction techniques, and basic communication skills – can also help people (Dunnegan, 1997). Carl Rogers’ work (1962) stressed the importance of the therapist empathically attuning to patients just as they are, without judgment (Lewis, 1971). Knowing the role negative judgments play in shame, Rogers may have begun a shame-focused intervention without even realizing it.

In light of insights from those who have displayed resiliency or who have successfully dealt with traumatic events, information can be gleaned to help those who are currently suffering. Studying a large group of children from birth until adulthood, Herman (1992) found that one in ten showed resilience against childhood adversity and was characterized by an alert, active temperament, unusual sociability and skill in communicating with others, and a strong sense of being able to affect their own destiny (also referred to an internal locus of control). Similarly, combat soldiers who were exposed to heavy combat but did not develop PTSD demonstrated the following three characteristics: task-oriented coping strategies, strong sociability, and internal locus of control (Herman, 1992). Therapeutic interventions targeted at increasing these skills in sufferers may help therapists improve outcomes in treatment.

Because trauma-related guilt and shame are generally part of PTSD symptomatology, addressing them directly may reduce PTSD severity, the urge to use substances, and the risk of
relapse (Held et al., 2015). In a literature review exploring the relationship between shame and PTSD in military veterans, researchers noted that shame can increase with time and that it amplifies the impact of trauma across every cluster of PTSD symptoms (Gaudet et al., 2016). Research conducted in Norway revealed that reduction in shame and guilt among participants led to a corresponding reduction in symptoms of PTSD (Oktedalen, Hoffart, & Langkaas, 2014). Similar findings were noted by Herman (2011), as shared with her by a colleague: “a patient’s vicarious PTSD symptoms resolved once shame issues were understood and directly addressed” (p. 268). Because of this connection, identifying trauma-related shame and guilt as early as possible in treatment may help increase the effectiveness of treating PTSD symptoms (Oktedalen et al., 2014). The Connections curriculum targets many of the aspects mentioned above by increasing social connection, increasing empathy for self and others, and teaching empowerment skills that help people realize that their negative self-talk may not be true, thereby increasing self-esteem and regard.

**Individual Work**

Debilitating shame prevents people from facing life courageously, honestly, and with full confidence in their ability to deal competently with life’s problems and opportunities (Goldberg, 1991). As Dunnegan (1997) expresses, “When we deal with trauma, we are dealing with shame” (p.348). By the time children who have experienced traumatic situations become adults, they most likely have spent many years believing something is deeply wrong with them. Children who were subjected to prolonged, repeated trauma may have developed a form of PTSD that invades and erodes the personality, causing the sense of shame to become a stable part of their personality (Herman, 1992). Believing they are responsible for the abuse is a survival tactic that often helps children maintain their attachment with their caregivers; if the
inner sense of badness has helped to preserve a relationship, even after the abuse has stopped the individual may be unable to give it up (Herman, 1992). Therefore, clinicians must both empathize with the client’s feelings of responsibility and yet gently challenge these beliefs (McCann & Pearlman, 1990).

Many people may be unaware that shame occurs commonly with trauma and is often based on false negative self-judgments made in childhood. Thus, an essential part of the healing process involves helping adults understand how this condition developed and providing them with ways to combat their shame, encouraging them to feel comfortable enough to share their traumatic experiences. Focusing on functional or healthy thought processes as an intervention may serve as a protective factor to trauma (Platt & Freyd, 2011). “When survivors recognize the origins of their psychological difficulties in an abusive childhood environment, they no longer need to attribute them to an inherent defect in the self” (Herman, 1992, p. 127). As the understanding of shame evolved over time, one of the hypotheses on healing shame that most closely anticipated the modern research conducted by Brené Brown came from Goldberg (1991). Goldberg listed five steps to healing shame: (a) recognize the presence of shame, (b) give shame a clear voice, (c) share these feelings with a concerned and caring person, (d) learn skills to stop the destructive cycle of shame in one’s life, and (e) use self-awareness and newly learned skills to repair existing relationships and explore challenging new ones (Goldberg, 1991).

Developing self-compassion has also been found by many researchers to offer an effective method for regulating shame (Dearing & Tangney, 2011). Compassion is a component of empathy, one of the essential skills to cultivate as part of developing shame resilience (Brown, 2007). Working to increase self-compassion for what the individual may judge as imperfections, specifically developing a realistic self-appraisal that allows for mistakes and other human
foibles, is essential to this process (Teyber, McClure, & Weathers, 2011). Developing self-compassion may be easier for the survivors if they understand that the defensive coping mechanisms that no longer serve them as adults (e.g., pleasing, complying, isolating) may have been what kept them alive as children. In other words, these strategies served a good purpose at an earlier stage in life, but are no longer useful (Gilbert & Proctor, 2006; Teyber, McClure, & Weathers, 2011). Learning healthy alternate skills that encourage the survivor’s ability to speak their authentic truth is another component of building shame resilience (Brown, 2007).

In a clinical environment, shame-proneness may also be detrimental to the therapeutic process, although it is likely a large part of why the person initially sought treatment, even if not directly presented to the clinician (Dearing & Tangney, 2011). This hidden factor of shame may interfere with therapeutic intervention, which poses a complex problem since intervention is an important component to changing life patterns formed due to the results of shame and trauma. Exploring shame with clients and assessing their levels of internalized shame may be necessary for treatment progress.

Clinicians may not be aware that clients are not the only ones who may feel shame during sessions. As Heinreich Racker highlighted in 1954, shame can be contagious: when evoked in the patient, it may also be evoked in the therapist (Lewis, 1971). Therapists therefore need to develop skills for handling their own shame when exposed to the shame of others. Dr. Brown suggests that before group leaders begin running a Connections group, they do their own work regarding shame and go through the curriculum at least once on a personal level so that they can be with clients who are experiencing shame and not be overcome with their own shame reactions (Brown, 2009). Some clinicians believe that occasional candid self-revelation about the therapist’s own struggles with shame during sessions can encourage clients to speak about their
own (Brown et al., 2009; Goldberg, 1991). Because shame often comes with the message, “I am alone in this and something is very wrong with me,” humanizing shame by sharing personal experience can help people free themselves from isolation.

**Dual Diagnosis with Substance Use**

Although standard treatment for symptoms of complex PTSD and internalized shame are applicable to all individuals with this diagnosis, certain awareness must be included when working with those who have an added dimension of substance abuse. These individuals may lack healthy coping skills needed to feel the difficult emotions associated with trauma, which could be why they were numbing their emotions with substances. Treatment for shame-prone clients in addiction recovery should include identifying shame defenses, understanding how these defenses perpetuate shame and exposing secrets that may cause shame while clients are in a safe and accepting environment (Potter-Efron, 2011). Greenberg’s emotion-focused therapy framework, which is well suited to addressing shame, is composed of four domains: relational validation, accessing and acknowledging shame, shame regulation, and transformation of shame (Dearing & Tangney, 2011). All of these domains are touched upon in the *Connections* curriculum, making it ideal for this population. The goal of using these four domains is to transform problematic emotions into adaptive, meaningful, and empowering emotions that can serve as an internal resource for the individual (Dearing & Tangney, 2011).

Another means of decreasing the need to use unhealthy methods of coping is to help individuals understand that healthy self-esteem does not mean feeling good all the time. Instead, it is having the ability to increase tolerance for uncomfortable feelings like inadequacy, incompetence, weakness, or guilt (Kinston, 1987). In order to connect with one’s own feelings and the feelings of others, it is necessary to learn to tolerate and manage negative self-feelings;
hence, developing emotional tolerance skills may also help increase the ability to connect with others (Kinston, 1987). Creating a safe container, or environment, to help the individual learn how to be with uncomfortable emotions is often why group work is suggested for reducing shame in substance abuse populations.

Group Work

Although shame may feel like a deeply personal emotion, it permeates many levels of our society, including the family, institutions, and community (Dunnegan, 1997). Healing from trauma often requires communalizing it. Whether in a group, dyad, friend-to-friend, or therapist-to-patient setting, others must bear witness to the person’s wounds while exploring shame (Dunnegan, 1997). However, clients rarely initiate discussion of shame, a topic that in Western culture is typically reserved for academia and perhaps a few shame-focused addiction treatment methods (Dearing & Tangney, 2011).

According to van der Kolk (2015), one of the first steps to recovery is learning to sense, name, and identify one’s internal sensations and emotions. Creating the ability to “observe” or “witness” family or childhood dysfunction can help survivors understand and prevent the shame legacy from being passed on (Teyber, McClure, & Weathers, 2011). After 40 years of working with adults who have experienced severe childhood trauma, Dr. van der Kolk noted, “All of them are ashamed about what happened to them and they blame themselves—on some level they firmly believe that these terrible things were done to them because they are terrible people” (2015, p. 134). In a sense, all of them are suffering alone together without even realizing it.

One of the most powerful ways to eradicate shame is by sharing it with others to recognize the distortion of one’s thinking, which often reduces shame’s effects (Brown, 2007). Yet, how do children who have learned they cannot trust anyone come to speak of their shame as
an adult? Silence means those assumptions and beliefs about the self are often left unexamined, with no way for the person to question their truth. Survivors may also believe themselves to be so uniquely maimed that no one else could possibly understand or help them (Courtois & Ford, 2013). Guiding individuals to develop a balanced, rather than polarized, sense of self by reclaiming all the components (good, bad, and in between) that compose their unique selves is one of the most powerfully healing interventions (Teyber, McClure, & Weathers, 2011). As long as individuals fear examining their inner life, they will not be able to integrate their internal experiences (van der Hart, Nijenhuis, & Steele, 2006).

Group psychotherapy is a preferred intervention for addressing shame for a number of reasons. Goldberg (1991) was among the first researchers to recommend group therapy as a positive experience for shame sensitive individuals, assuming the atmosphere was one of safety and trust. Modern research supports this theory, identifying group psychotherapy as a preferred treatment method for women from different cultural backgrounds with histories of sexual abuse (Sayin et al., 2013). Tremendous growth can occur when groups address shame, because the group container ideally provides empathic mirroring, understanding, and self-acceptance that may increase a survivor’s self-esteem, acceptance, and forgiveness (Dearing & Tangney, 2011). Survivors need others to assist them in overcoming shame and arriving at a fair assessment of conduct because extremes of harsh criticism or ignorant, blind acceptance exacerbate rather than heal feelings of shame and isolation (Courtois & Ford, 2013; Herman, 1992). For survivors to experience detoxification from their feelings of stigma, shame, and defilement, they must receive supportive responses from those closest to them (Dearing & Tangney, 2011; Herman, 1992; Sayin, Candansayar, & Welkin, 2013).
There are many benefits to addressing underlying trauma and shame in a group setting. Sharing traumatic experiences with others and receiving validation so survivors understand that the traumatic event was not their fault helps survivors repair the injury and even restore their sense of order and justice (Herman, 1992). Hearing others tell their stories increases empathy and decreases feelings of isolation (Courtois & Ford, 2013; Sayin et al., 2013). Practicing skills with others for modulating body arousal helps to develop bodily awareness, understanding that others experience the same or similar symptoms (Courtois & Ford, 2013). Observing others demonstrate resilience may be inspiring and convince survivors that personal effort to achieve a worthwhile and satisfying life can be rewarded by growth and healing (Courtois & Ford, 2013). The success of one can be inspiration for others.

The effectiveness of addressing shame in group therapy was researched with a group of women who were at risk for Human Immunodeficiency Virus (HIV) and who had a history of childhood sexual abuse (Ginzburg et al., 2009). Results showed that the women experienced a reduction in both guilt and shame, and that their PTSD symptoms declined as their shame decreased (Ginzburg et al., 2009). This precedent provides promising data suggesting that women with a history of complex trauma may also benefit from learning about shame with the added component of developing shame resilience tools.

**Specific Interventions**

Specific interventions for maladaptive shame have been largely overlooked in treatment models and manuals for all disorders, including borderline personality disorder (Rizvi et al., 2011). Presently very few shame-focused therapies exist: Pia Mellody’s Shame Reduction treatment approach, Compassion Focused Therapy, Dialectical Behavioral Therapy for borderline personality disorder, Gestalt Therapy, and Brené Brown’s curriculum for shame
resilience are some of the few highlighted in literature (Brown, Hernandez, & Villarreal, 2009; Dearing & Tangney, 2011; Fishkin, 2016; Gilbert & Proctor, 2006; Lee & Wheeler, 1996; Rizvi et al., 2011). More scientifically informed outcome research is needed to demonstrate the efficacy of shame-focused treatments (Dearing & Tangney, 2011). Dr. Brené Brown’s curriculum, *Connections: A 12-Session Psychoeducational Shame-Resilience Curriculum*, incorporates many of the treatment suggestions mentioned above and is designed to be implemented in a group therapy setting. The current study was designed to make use of Dr. Brown’s theory and to apply it toward a population with a history of PTSD or complex PTSD and substance abuse.

**The Curriculum**

According to her book *Daring Greatly* (2012), Brené Brown, Ph.D., LMSW, began work as a social worker and later pursued her doctorate in social work. Her work led her to believe one main thing about people: Connection is what gives people meaning and purpose in life (Brown, 2012). She believes that resilience to shame allows people to successfully connect with others. After researching shame and scarcity, she soon realized the way to best measure what shame did was to see what manifested when it was not present. When talking with people who displayed shame resilience, she noticed patterns and differences between the ways those people approached their lives compared to the approaches of people who regularly experienced shame. Those who demonstrated shame resilience were almost always able to demonstrate vulnerability in their interactions with others, so vulnerability showed up repeatedly in her research as a core category of shame resilience.

Dr. Brown’s research has been largely qualitative, rooted in a Grounded Theory approach. After summarizing her initial research in the book, *I Thought It Was Just Me (but it*
isn’t): *Telling the Truth About Perfectionism, Inadequacy, and Power* (2007), Dr. Brown saw the need to create a curriculum based on her research for professionals to use with their clients. The purpose is to provide clinicians from multiple fields a means of addressing shame and teaching coping skills that clients can use to achieve empowerment in the face of shame (Brown et al., 2009).

The *Connections* curriculum includes 12 sessions, generally held once per week. Each session is largely composed of taught material, an experiential exercise, and a process component during which group facilitators engage participants with the material (Brown et al., 2009). Each session has specific objectives and aims to reach participants on cognitive, behavioral, and interpersonal levels (Brown et al., 2009).

Outside of Dr. Brown’s own authorship, only one journal article has been published on a study using her curriculum and involving quantitative research. The study involved 19 women from predominately Hispanic backgrounds who were affiliated with three different substance abuse programs and who lived in California (Hernandez & Mendoza, 2011). The purpose of the study was to determine whether teaching shame resilience skills to women who struggled with substance abuse would benefit this population. Six standardized psychometric measures were administered to each participant at the beginning of the 12-week group and again at the end. Results indicated that six of the eight assessments showed significant differences between the pre- and post-tests. The authors concluded that addressing shame directly with this population might be a viable way to teach shame resilience. More research was suggested to amass further evidence of the therapeutic potential of the *Connections* curriculum (Hernandez & Mendoza, 2011).
Given the need for such research, this study is designed to investigate whether shame-focused interventions successfully enhance therapeutic outcomes for people with complex PTSD who are in treatment for substance abuse. The relationship between shame and trauma has been well established, and the need for effective treatment strategies has also been documented. Empirically demonstrating the efficacy of directly incorporating shame interventions into standard therapeutic protocols is the goal of this current study.
CHAPTER III: METHODS

The Connections curriculum was used in a group therapy setting in two different recovery programs in Washington and Oklahoma. Participants all identified as women and had received drug related criminal charges that would have resulted in a jail or prison sentence had they not been allowed to participate in a treatment program instead of serving time. The Connections group was included in the curriculum to meet requirements for individuals’ completion of each of these programs. Quantitative data were gathered from subjects before and after the 12-week group to test three null hypotheses about the effects of teaching shame resilience skills to people who have a history of comorbid substance use and complex PTSD. The Connections curriculum was administered according to protocols outlined for each weekly group session (Appendix H).

Theoretical Perspective

Shame Resilience Theory (SRT) was developed by Dr. Brené Brown (2012) through grounded theory methodology, which is a qualitative research framework developed by Glaser and Strauss (Glaser, Strauss, & Strutzel, 1968). Theoretical sampling, the method used in grounded theory methodology, is a process of data collection that allows for the generation of a theory after the researcher has either gathered enough data to reach a saturation point or the researcher begins to see only repeated data. After the data have been coded and analyzed to uncover patterns and findings, a theory is developed to explain the information that has emerged from the research (Brown, 2012). After gathering data by interviewing 1,280 participants consisting of 750 females and 530 males ages 18 to 80 from diverse ethnic backgrounds, Dr. Brown created SRT (Brown, 2012). Through SRT, 12 main theoretical propositions were developed:
(1) Shame is best understood as a psycho-social-cultural construct. It is best defined as the intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging.

(2) Shame often creates feelings of fear, blame, and disconnection.

(3) Shame is organized by gender. The messages and expectations that trigger and fuel shame for women are based on our rigid cultural definitions of women and women’s roles. Likewise, the expectations that fuel shame for men are based on our culture’s perception of masculinity – what a man should be like, look like, and act like.

(4) The opposite of experiencing shame is experiencing empathy.

(5) Empathy is necessary for practicing courage, compassion, and connection – the qualities that increase our shame resilience.

(6) We cannot become resistant to shame; however, we can develop resilience to shame.

Shame resilience is best conceptualized as a continuum, with shame, fear, blame, and disconnection anchoring one end, and empathy, courage, compassion, and connection anchoring the other end.

(7) Our level of shame resilience is determined by our combined ability to recognize (1) shame and our specific triggers, (2) our level of critical awareness, (3) our willingness to reach out to others, and (4) our ability to speak shame. In other words, our position on the shame-resilience continuum is actually the sum of our positions on these other four continua.

(8) We must assess our shame resilience independently for each of the twelve shame categories. A high level of shame resilience in one area does not guarantee high shame resilience in all areas.
(9) Women and men with higher levels of shame resilience recognize shame when they are experiencing it and recognize their shame triggers. Understanding our triggers allows us to better recognize shame and reach out for support. When we don’t know our vulnerabilities, we rely on ineffective methods to protect ourselves from the pain caused by shame. I call these protection methods “shame screens.”

(10) Women and men who practice critical awareness have higher levels of shame resilience. Critical awareness helps us demystify, contextualize, and normalize our shame experiences. A lack of critical awareness can result in our reinforcing, individualizing, and pathologizing our shame experiences.

(11) Women and men who reach out to others experiencing shame have higher levels of shame resilience. Reaching out allows us to share our stories and create change. When we don’t reach out, we often start separating and insulating ourselves from others.

(12) Women and men who “speak shame” have higher levels of shame resilience. Speaking shame gives us the tools we need to express how we feel and to ask for what we need. When we don’t speak shame, we often start to shut down or act out (Brown, 2009, p. 4–5).

Dr. Brown employed qualitative research methods to develop her theory. In this dissertation, quantitative analysis was used to determine if using material developed based on SRT would support specific research hypotheses. Three conceptual hypotheses were developed, along with their corresponding null hypotheses, which are used to determine if the implemented procedures produce outcomes significantly different from those expected by the null hypotheses. The hypotheses were formed using the theoretical propositions posited by SRT.
Conceptual Hypotheses

Using the Connections curriculum in a group therapy setting was hypothesized to have three outcomes. First, participants would experience a reduction in shame-proneness or self-identification with shame. This would occur after participants learned to identify the feeling of shame, rather than automatically identifying with the shame-based thought. Dr. Brown (2007) refers to this awareness as recognizing shame and the associated shame triggers. Second, participants would experience a decrease in trauma-related symptoms. Existing research demonstrates the role shame plays in fueling traumatic symptomology (Bennett, Sullivan, & Lewis, 2010; Bryan, Morrow, Etienne, & Ray-Sannerud, 2013; Dyer et al., 2009; Gaudet, Sowers, Nugent, & Boriskin, 2016; Held, Owens & Anderson, 2015; Platt & Freyd, 2011; Whiffen & MacIntosh, 2005). After participants gained conscious cognition of the fact that they are not inherently “bad” and that shame is merely a feeling that can be questioned, they would experience decreased physical manifestations of trauma such as anxiety, headaches, or depressive symptoms. The third outcome is that after recognizing shame as a feeling rather than an automatic truth, participants would be more likely to address underlying trauma. In other words, by learning to verbalize shame, which involves discussing the events that evoked the feeling, the desire to hide or cover the shameful event(s) would lessen. This would enhance the willingness to initiate or proceed more deeply with clinical treatment of trauma.

Two null hypotheses were tested. The first was: participants will not differ in shame-proneness or self-identification with shame before and after the intervention. The second was: participants will not differ in trauma related symptoms before and after the intervention. The third hypothesis is an inference based on prior research and is contingent on the rejection of the
first two null hypotheses, but is not directly measured in this study. Therefore, there is not a null hypothesis directly associated with research question three.

**Measures**

Four questionnaires were given to participants before the *Connections* group began. Three of the initial four measures were given again after the group was completed. Two of these four measurements were used as screening tools. These measures are described below.

**Screening Tools**

To assess whether participants met criteria for the proposed complex PTSD diagnosis as well as internalized shame, two screening measures were administered prior to subjects’ participation in the *Connections* group.

*Adverse Childhood Experiences International Questionnaire.* The Adverse Childhood Experiences International Questionnaire (ACE-IQ) was developed by the World Health Organization (WHO) and is intended to measure the number of different kinds and frequency of adverse childhood experiences a person from any country has endured (World Health Organization, 2011). The assessment includes 44 questions that assess family dysfunction; physical, sexual, and emotional abuse and neglect by parents or caregivers; peer violence; witnessing community violence; and exposure to collective violence (World Health Organization, 2011). The ACE-IQ also has questions about basic demographic information such as gender, race, age, education level, current work status, and marital status. Because complex PTSD is not an official diagnosis in the DSM-5, an ACE-IQ score above zero was used to infer that the criteria for complex PTSD were met and a participant was qualified for this study. This measure was given to participants in the beginning of the study as a screening tool. This is the only measure not given to participants after the group was completed.
The ACE-IQ was chosen for this study instead of duplicating the exact measurement used by Felitti and Anda (2000) for three reasons. The first is due to the international application of this version of assessing ACEs. For cultural competency reasons, this researcher believes using a tool designed for use in multiple cultures will increase its efficacy among diverse populations such as those who may be present at the community health center in Seattle, WA. The WHO’s measurement tool was also created in more recent years suggesting that knowledge gained since the original ACE studies were conducted would be incorporated into this version of the assessment tool. Lastly, the World Health Organization is a well-known international agency seeking to find a measurement tool applicable to humans in many places around the world. Selecting a measurement tool that is designed to accommodate diversity and universality appealed to this researcher.

**Internalized Shame Scale.** The Internalized Shame Scale (ISS) is a 30-item self-report questionnaire designed to measure a person’s feelings of shame and the negative response patterns that result from internalized shame (Multi-Health Systems, Inc., 2003). David Cook, Ed.D (1988), created the ISS and originally formulated this scale for use with individuals who struggled with alcohol problems. Originally developed in 1988, the ISS has undergone a series of five intensive revisions that have rendered it the efficient and effective assessment tool it is today (Multi-Health Systems, Inc., 2003). The ISS measures the single factor of internalized shame as a mean of the scores from items determined to represent internalized shame on the scale. Participants are asked to rate each of the 30 items on a five-point Likert scale (Multi-Health Systems, Inc., 2003).

On the ISS, there are 24 negatively worded questions that measure shame and six positively worded questions that measure self-esteem that lessen the tendency for a response set
to develop when all items are worded in the same direction (Multi-Health Systems, Inc., 2003). These six self-esteem items were taken from the Rosenberg Self-Esteem Scale that has been widely used in research for many years (Multi-Health Systems, Inc., 2003). It is important to note the Self-Esteem subscale is not intended to be used as an independent measure of self-esteem (Multi-Health Systems, Inc., 2003).

Research on the ISS found it to be a valid and reliable measure of internalized shame, with specific applications for the treatment of shame in drug-dependent populations (Rybak & Brown, 1996). One of the main strengths of the ISS is the centralized focus upon shame as an internalized and stable way of viewing oneself, rather than as a fleeting emotional state (Rybak & Brown, 1996). This supports the literature reviewed in this dissertation on the development of a shame-prone sense of self, making this assessment tool compatible with what the current research was designed to study. Construct validity was assessed for clinical populations by using the Multiple Affect Adjective Checklist-Revised (MAACL-R), with alpha reliabilities all above .90, suggesting high reliability in the measure (Rybak & Brown, 1996). Validity studies previously conducted by Cook (1987) found the ISS to also be a valid measurement in nonclinical populations.

A subsequent study conducted to assess the temporal stability, internal consistency, and underlying factor structure of the ISS supported results found by Rybak and Brown (1996) supporting its validity (del Rosario & White, 2005). This study also found the ISS demonstrated high temporal stability and high internal consistency (del Rosario & White, 2005). In a book chapter focusing on effective assessment tools for shame, the ISS was noted as valid, reliable, and frequently used in both research and clinical contexts (Robins, Noftle, & Tracy, 2007). For use in the current research, a score of zero on the ISS questions that measured shame would
disqualify a participant from participating in the study. Although the ISS was administered as a screening tool, it was also re-administered post-group to measure whether significant changes between pre- and post-test measures occurred.

**Assessment Tools**

After participants took the screening measures, they began attending the *Connections* group. In order to measure outcomes and assess the previously asserted null hypotheses, three assessment measures were used. One measure is the ISS addressed in the previous section. The additional two measures, to be described below, were administered at the first session of the *Connections* group and again at the last session, after the group work had been completed.

**Test of Self-Conscious Affect.** The Test of Self-Conscious Affect, Version 3 (TOSCA-3S), is a standardized measure composed of 11 different scenarios so participants can respond to potentially shaming scenarios, offering a valid and reliable measure of shame and guilt responses (Tangney, Dearing, Wagner, & Gramzow, 2000). Each response option is derived from shame self-talk, guilt self-talk, or blame towards others and has a five-point Likert-style scale to assess frequency on a “not likely” to “very likely” spectrum (Brown, 2009). This assessment tool is used as an established measure chosen by Dr. Brown in the *Connections* curriculum. Put simply, when given a hypothetical situation where something negative has occurred (i.e. red wine spilled on white carpet), will the participant be likely to internalize the response (e.g. “I am bad”), externalize the action (e.g. “the action was bad, but I am not”), or blame someone else (e.g. “that happened because someone else caused it to”)?

To test the validity of the TOSCA-3S, a study was conducted on 238 male and female participants to determine if the measure was a valid way of assessing shame and guilt (Woien, Ernst, Patock-Peckham, & Nagoshi, 2002). Results of the study supported the TOSCA-3S as a
valid method of assessing these traits (Woien et al., 2002). According to this study, the TOSCA-3S reproduced most of the results of studies in which different measurements were used to assess shame and guilt (Woien et al., 2002). As predicted in the study, shame was associated with lower levels of self-esteem and higher levels of stress and psychiatric symptomatology, whereas guilt was unrelated to the psychopathology variables and had no impact on self-esteem (Woien et al., 2002). These findings are consistent with the aforementioned literature regarding the relationship between shame and psychopathology. In a book chapter focusing on effective assessment tools for shame, the TOSCA-3S was noted as valid, reliable, and was a frequently used measure to assess shame and guilt proneness (Robins, Noftle, & Tracy, 2007).

The Likert-style scale used in this assessment measure allowed the current researcher to assess if changes occurred between how participants viewed life scenarios before learning about shame resilience and after completing the shame resilience group sessions. This measurement was also chosen because of its inclusion in the Connections curriculum. The TOSCA-3S differs from the ISS in that it measures how participants interpret life events rather than simply assessing views the participants hold about themselves. This researcher hypothesized that participants would be less likely to view the scenarios from a shame-based point of view after completing the Connections group. Because blame is often considered a defensive reaction to feeling shame (Brown, 2009; Dearing & Tangney, 2011), this researcher would also expect to see a decrease in the blame response pattern of participants.

**Trauma Symptom Checklist.** The Trauma Symptom Checklist-40 (TSC-40), created by Elliot and Briere in 1992, is a 40-item self-reported measure of symptomatic distress in adults arising from childhood or adult traumatic experiences (U.S. Dept. of Veterans Affairs, 2016). Participants are asked to report how often they have experienced various symptoms in the past
two months on a four-point Likert scale ranging from “never” to “often” (U.S. Dept. of Veterans Affairs, 2016). The TSC-40 has six subscales: Anxiety, Depression, Dissociation, Sexual Abuse Trauma Index, Sexual Problems, and Sleep Disturbances (U.S. Dept. of Veterans Affairs, 2016). The original version of the Trauma Symptom Checklist, created in 1989 by Briere and Runtz, contained only 33 questions. It has since been expanded to the 40-question measure that was used in this study. Briere is a well-known researcher and clinician who supports the idea of a complex PTSD diagnosis and has created protocols for the treatment of complex PTSD (Briere & Scott, 2006; Briere & Scott, 2015).

In a study conducted by Briere & Elliott (1992) to assess validity and reliability in using the TSC-40 to measure long-term sequelae in 2,963 professional women who had a history of sexual abuse, the TSC-40 was reliable and displayed predictive validity of childhood sexual victimization. In subsequent research, the TSC-40 was a valid predictor of childhood sexual and physical abuse in a sample of non-clinical adults (Neale & Nagle, 2013). In preliminary studies, this measure was proven valid in clinical populations, evincing the accuracy to distinguish between abused and non-abused samples (Neale & Nagle, 2013). Results showed that the TSC-40 was a reliable and internally consistent measure appropriate for assessing the impact of childhood abuse for both men and women (Neale & Nagle, 2013).

Because the TSC-40 provides a measure of frequency of symptoms, in this study it can be used to measure a change or decrease after attending the Connections group. This researcher hypothesizes a decrease in symptom frequency after shame resilience skills have been taught to participants. The next section will describe the composition of individuals in this study.
Programs

The women who completed this study came from two geographical locations with different programs. Some of the participants were from a community health center in Seattle, WA that specializes in substance abuse treatment, including methadone, to help treat opiate addiction. The participants from Seattle were engaged in Washington state’s Drug Court program. These individuals had a criminal charge related to substance use or distribution and were granted permission to receive outpatient treatment through the Drug Court program instead of serving a jail sentence. The other participants were from Women in Recovery (WIR) program in Tulsa, OK that specialized in substance abuse treatment. These individuals also had drug related charges and were given the opportunity to participate in an 18-month program instead of serving time in prison.

Washington Group Descriptions

The Washington treatment center runs groups affiliated with the Drug Court program, and also runs groups where participants receive methadone treatment and are not affiliated with the Drug Court program. This researcher started two groups at the community health center. One was composed of 11 participants enrolled in the Drug Court program. The other group was composed of 10 participants who receive methadone treatment and were not part of the Drug Court program.

The Drug Court program is composed of substance abuse treatment groups, combined with helping participants find employment and housing. The program does not require mental health treatment, although access to mental health services is available if participants are interested. Participants must complete all required classes and other requirements in order to graduate from the program, including not using substances while in the program.
Of the 21 original participants, only six completed the research study. Group members were not allowed to miss more than two groups without making up a session. The members of the group not in the Drug Court program all missed more than two group sessions, so this entire group did not complete the course. Five members of the Drug Court group either completed the program or left the program before the group ended. Therefore, only six participants in the Drug Court program successfully met attendance requirements and were included in the research data.

**Washington Participant Referral**

To obtain participants for the group not related to Drug Court, an email describing the Connections group was sent to all mental health counselors and chemical dependency professionals at the community health center where the research took place. The email requested interested participants’ information be sent to the researcher for their enrollment. Mental health counselors and chemical dependency professionals were informed in the initial email that a research element was involved in the group activity and asked potential clients whether they would be willing to participate. The clients who were interested in participating in the group were contacted by the researcher to alert them they had been enrolled. They were also informed of the session start date. This group was a closed group meaning that no new members were allowed to join after the second session had completed.

To obtain Drug Court participants, the researcher was allowed to teach the Connections curriculum at an already established class time that members in the Drug Court program attended to meet program requirements. While participants had to attend the class, they were not required to participate in the research. Some participants expressed a desire or need to learn shame resilience, while others would most likely not have chosen to take the class had it not been a requirement.
Research Limitation

Initially, all research was intended to take place at the community health center in Washington. This researcher had planned for 30 participants to complete pre and post questionnaires before the researcher moved to a different state for internship in August of 2017. Due to attendance difficulties, the researcher had to find an additional location after moving to Oklahoma to finish collecting research data. The researcher planned to obtain an additional 24 participants in Oklahoma.

Oklahoma Group Description

Women in Recovery (WIR) agreed to allow the Connections group to be run as part of their curriculum. The WIR program lasts approximately 18 months and has three phases women must complete before they are eligible for graduation. The Connections group was taught to participants who were currently in phase three of the program. Most participants graduated while either participating in the group or within three months afterward. Two thirteen-week groups were run at WIR. These were composed of 23 participants. All participants who started the group successfully completed it.

In the WIR program, participants are required to participate in trauma focused mental health treatment. All participants have a therapist, and they work with this therapist throughout the program. Participants also participate in substance use treatment, parenting classes if needed, learn life skills such as cooking, and self-care activities such as yoga. This program offers additional classes compared to the substance use only focused program in Washington. Like the Washington program, participants cannot use substances while in the program and are assisted in finding housing and employment.

Oklahoma Participant Referral
Participants were selected for the Connections group by therapists who identified individuals they believed would benefit from the course. Some participants agreed with their therapists’ referral and were reportedly excited about the class. Others were referred by their therapist and were required to attend despite not having their own desire to learn about shame resilience.

**Sample Size**

Group therapy was conducted with a maximum of 12 participants per group with goal of 30 total participants completing pre and post-test questionnaires. Groups were initially intended to be closed, meaning new members were not allowed to join the group after it had begun; however, for the Washington participants in the Drug Court group, the group had to be left open for new members beginning the Drug Court program during the 12-week group period. Only the participants who started in the first session and completed the additional 12 sessions were selected for the research. Individuals who joined later were allowed to participate in the groups, but not the research.

The two groups in Oklahoma, and the non-Drug Court group in Washington, were closed groups. As a reminder, the closed group in Washington did not have participants included in this research; only the open group did. Closed groups help create a sense of safety and trust among members (Brown, 2009). Allowing for the group to remain open was deemed an appropriate, although not ideal, option in the Connections curriculum guidelines designed by Brené Brown. If anything, having an open group may have resulted in decreased effects, assuming participants’ safety and trust levels were decreased.

**Inclusion and Exclusion Criteria**
Eligible participants were individuals over the age of 18 currently enrolled for services at the treatment centers where the research took place. Additionally, participants had to have scored higher than zero on both the ACE-IQ and ISS screening measurements to suggest they have at least a minimal history of adverse childhood experiences and have experienced some level of internalized shame. Participants also had to be able to read and speak English in order to effectively complete the group, because sessions were conducted in English. Participants were not allowed to miss more than two groups without meeting with the facilitator to make up for missed material.

Participants

All participants who were screened met requirements to participate in the research study. All participants who were asked to participate in the research study agreed to do so and willingly signed the informed consent. All participants were given a copy of the informed consent to keep.

A total of 44 participants began one of the twelve-week groups. Twenty-nine women successfully completed the groups without missing more than two sessions. The other fifteen participants were disqualified from participating in the research due to attendance issues. The Washington group began April 13, 2017 and ended July 27, 2017. The first Oklahoma group began January 12, 2018 and ended April 6, 2018. The second Oklahoma group began April 20, 2018 and ended July 13, 2018.

Participant Demographics

For this research, only people identifying as female were chosen to participate. Gender was defined based on the sex with which a person currently identified, which was not necessarily the sex with which that person was born. Groups of the same gender were selected for multiple reasons. Many people who have experienced complex PTSD also have sexual trauma and find
groups of the same sex safer than mixed gender process groups (Brown, 2009). Dr. Brown’s (2012) research has shown that both men and women experience shame in their lives, although the reasons may differ. Keeping groups gender-specific allowed facilitators to focus the group discussion on issues most relevant for members and to help them feel safe.

The youngest participant was 20 years old and the oldest participant was 50 years old. Of this sample, 48.1% of participants were between the ages of 20 and 29, 37.8% of participants were between the ages of 30 and 39, and 13.7% of participants were between the ages of 40 and 50.

African-American participants composed 13.7%, Caucasian participants composed 55.2%, Caucasian/Native Americans (participants in this category selected a bi-racial status) composed 6.9%, Hispanic participants composed 3.4%, Native American participants composed 13.8%, and those choosing not to disclose their ethnicity composed 6.9%. Participants in Washington and Oklahoma had a similar ethnic composition.

Most participants were of low socio-economic status. Many participants at both programs received Social Security benefits or state funded health insurance. Both programs provided housing, or helped the women find housing while they were in the programs. Many did not have housing prior to beginning treatment. Participants who were unemployed at the start of the programs were assisted in finding employment as a program requirement.

Procedures

Although the Connections curriculum is a 12-week course, participants in this study were asked to attend 13 sessions. The additional session was added to allow time for the research component of this study, and to identify which members were eligible to participate in the research. In the first session, participants were introduced to the facilitators and fellow group
members. They were also given an informed consent form to participate in this study, the two screening assessments, the TOSCA-3S, and the TSC-40. The Connections curriculum was not initiated until session two. Only those participants who met eligibility requirements of the screenings were included in the research study, although all participants were allowed to participate in the group sessions regardless of screening results.

Group sessions lasted for a minimum of 90 minutes, which is the recommended time allotment to cover all material (Brown, 2009). The group sessions in Washington all lasted 90 minutes. The group sessions at the Oklahoma locations were 120 minutes and included a 15-minute break. The Oklahoma groups were scheduled in a larger time slot that fit the pre-established class schedule at WIR.

In the second group session, the Connections curriculum was started. Each session featured a similar format, beginning with a check-in, review of homework (starting in session three), a lesson that included new psychoeducational information, a process activity, assignment of new homework, and a checkout to close the group session. During session two, participants were also asked to complete a Coping Agreement included in the Connections curriculum, specifying strategies they would employ if they became emotionally overwhelmed by the session content or group process. The researcher kept these Coping Agreements and brought them to each session in case a particular member became distressed during the group.

Subsequent sessions followed the Connections curriculum, including a 10-minute DVD segment narrated by Dr. Brown. At the end of the curriculum, during session 13, participants were given the ISS, TOSCA-3S, and TSC-40 to collect post-test information. They were given a gift card after completion of the post-tests to thank them for participating in the research.
All data collected by the researcher was scored using an Excel spreadsheet and imported into IBM SPSS Statistics. Each questionnaire was scored according to the measure’s instructions for calculating results. Categorical data obtained from the participants was also imported into SPSS including group location, age, and race.

**Compensation**

Participants who completed the group were given a $10 gift card for a local grocery store to thank them for their participation and to encourage completion of the study. It is believed the gift cards were not of high enough value to persuade participants who did not anticipate emotional benefit to join the study. Participants were given the gift card upon completion of post-test assessments at the end of the last group session.

**Participant Confidentiality**

All programs that participated in the current research study already employed an established system of confidentiality that assigned each participant a number upon admission. The number is used to reference the client in interoffice communications or on documents meant to maintain confidentiality. This study made use of those same numbers to track obtained assessment information while continuing to protect the participant’s identity. The researcher kept one key that associated the number with the participant’s name that was stored in a double-locked environment in the researcher’s office along with signed consent forms. The research documents only used the assigned numbers to distinguish participants’ scores.

**Emotional Support for Participants**
Due to the nature of group activities that address feelings of shame and involve participants identifying their own shame triggers, it is likely that negative or emotionally upsetting experiences arose for participants. The assessment tool ACE-IQ does not ask for specific information about a person’s past experiences, but does ask questions that may elicit uncomfortable memories. Researchers Felitti and Anda (2000) discovered in their ACE study that participants sometimes thanked them for asking questions about their trauma and that of 17,000 participants, not one used the emergency phone number given to them in case additional support was needed. Although this data indicates that most participants who take assessments like the ACE-IQ will not experience extreme distress, this study offered two measures to help participants feel supported if they did experience distress. The first was administering the Coping Agreement during session one as described previously in this dissertation. The second was a provision in the informed consent form, whereby participants were advised that they may discontinue the study at any time, that they need share only information they feel comfortable sharing, and that they would be provided with resources in case an emotional crisis occurs. Participants were given time to review the informed consent form, ask any questions, and sign the form before the Connections curriculum began the following week.

Oklahoma participants all had a therapist before the Connections groups began and whom they continued to see during the course of the group sessions. Washington participants had access to therapists at the community health center, which held the groups. Some already had a therapist and all had the ability to request one.

**The Researcher and Group Facilitators**

At the time this study began, the researcher was a 35-year-old Caucasian female Psy.D. student living and attending school in Seattle, Washington. The researcher moved to Oklahoma
after the data collection phase began to complete an internship for her Clinical Psychology program. The researcher served as a co-facilitator in each of the groups studied.

The researcher is familiar with Dr. Brené Brown’s work on shame, both personally and professionally, as she has found the information helpful for herself and in clinical settings. The researcher was first introduced to Dr. Brown’s ideas in 2013 and has studied her work via three of her books and two TED.com talks. The researcher also previously co-facilitated a *Connections* curriculum with a group of 10 women at the same location where the research study took place in Seattle. This first group was a “practice” group to make sure the curriculum would work in this population.

In each of the groups, the researcher had a co-facilitator. The co-facilitator was the same for both Oklahoma groups, but each Washington group had a different person. All co-facilitators were female, Caucasian, worked at the location where the group was being held, and did not take on a direct teaching role. Rather, the co-facilitator served a supporting role to the researcher. These supporting roles included taking attendance, helping the facilitator monitor participants for signs of distress, and ensuring all group rules were followed.
CHAPTER IV: RESULTS

The researcher used three measures on 29 participants before and after facilitating the Connections group to test three hypotheses: (a) participants would experience a reduction in shame-proneness or self-identification with shame, (b) participants would experience a decrease in trauma-related symptoms, and (c) after recognizing shame as a feeling rather than automatic truth, participants would be more likely to therapeutically address underlying trauma. Two screeners were used to establish eligibility for research participation. Two of the hypotheses asserted were directly tested using the chosen measures, and the third hypothesis is inferred if the other two null hypotheses are rejected. Subsequent sections will describe participant scores, the analyses conducted, and examine other potential relationships or confounding factors gleaned from the data.

Descriptives of Measures

The ACE-IQ has a possible range from zero to 13, and in this study was used as a screening tool. All potential participants met the eligibility criterion of a score of at least one on this measure. In the sample, the 29 participants had a mean ACE score of 6.90 (SD = 3.09) with a minimum score of two and a maximum score of 12.

The primary scales of interest for pre and post-test data were the ISS, TSC-40, and TOSCA-3S. Table 1 shows the means, standard deviation, and Cronbach’s alpha measure of reliability for each pre and post-test measure. As shown, reliabilities were at least acceptable (α ≥ .70) on all scales except for the pre measure of TOSCA guilt. Each of the given measures had a single participant (and it was a different participant for each measure) who did not fill out the form in its entirety on the pre-test. Those participants could not receive a score on the TSC-40 and the TOSCA-3S, creating a sample size of 28 on each of those two measures. The person
who did not complete the back page of the ISS was allowed to remain in the sample because the researcher used the average scores and not the sum of scores for data analysis; this inclusion did not change any of the hypothesis testing results for this measure.

Table 1.
*Pre and Post Intervention Scores*

<table>
<thead>
<tr>
<th>Measure</th>
<th>n</th>
<th>M (SD)</th>
<th>Min-Max</th>
<th>M (SD)</th>
<th>Min-Max</th>
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</thead>
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<tr>
<td>ISS Shame</td>
<td>29</td>
<td>1.22 (.68)</td>
<td>.07-2.73</td>
<td>.65 (.48)</td>
<td>0-1.53</td>
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<tr>
<td>ISS Self Esteem</td>
<td>29</td>
<td>.50 (.16)</td>
<td>.18-.80</td>
<td>.63 (.15)</td>
<td>.27-.80</td>
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<tr>
<td>TSC-40</td>
<td>28</td>
<td>24.14 (17.36)</td>
<td>0-60</td>
<td>16.46 (16.28)</td>
<td>0-68</td>
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<tr>
<td>TOSCA Shame</td>
<td>28</td>
<td>29.25 (9.90)</td>
<td>12-47</td>
<td>25.43 (10.90)</td>
<td>7-51</td>
</tr>
<tr>
<td>TOSCA Guilt</td>
<td>28</td>
<td>45.29 (6.02)</td>
<td>29-54</td>
<td>46.25 (6.25)</td>
<td>31-55</td>
</tr>
<tr>
<td>TOSCA Blame</td>
<td>28</td>
<td>22.64 (7.62)</td>
<td>11-34</td>
<td>22.07 (7.87)</td>
<td>11-38</td>
</tr>
</tbody>
</table>

**Trauma Symptom Checklist**

The TSC-40 is composed of 40 questions scored on a four-point Likert scale ranging from zero (the person never feeling the symptom) to three (the person often feeling the symptom). Scores are summed and can range from zero to 120.

**Internalized Shame Scale**

The ISS is composed of 30 questions with two subscales: 24 items measuring a person’s internalized shame and six items measuring self-esteem. Although this subscale assesses self-esteem, the original authors note it should not be used as a stand-alone measure for self-esteem. Items use a five-point Likert scale where zero means the participant Never feels or experiences the statement given, and four means the person Almost always feels or experiences the statement given, and as noted a mean was taken of the items.
Test of Self Conscious Affect

The TOSCA-3S measures the likelihood that a person will respond to a described situation with an attitude of shame, guilt, and blame, with each of these represented by a separate subscale. Using a five-point Likert scale where one means “not likely” and five means “very likely,” the participant receives an overall score on each of the three categories on all 11 of the situations described on the TOSCA-3S. This measure was included in the Connections curriculum so the participant would have awareness of their most common response style. This researcher decided to include the measure in the research to determine if the same scenario might be responded to differently after completing the Connections group. Although this measure does not directly address a hypothesis, a significant decrease in the shame responses could help support the hypothesis that internalized shame decreases after participants completed the Connections group.

Assumptions

The assumptions of the paired sample t-tests used for the hypothesis testing include normality of the difference scores from pre to post, as well as no outliers on the difference scores. Difference scores were computed and histograms were visually inspected for normality and outliers, as well as skewness scores. The assumption of normality was met for all pre and post difference scores with two exceptions on skew and an outlier addressed further below. Difference scores on TSC Total and ISS Shame both had moderate negative skews, with skewness of -.847 (SE = .441) and -.879 (SE = .434), respectively. These skews are significant using z score testing (-1.98 and -2.03, respectively, p’s < .05) so in the hypothesis testing section below, these two measures will also be tested using non-parametric Wilcoxon rank sum tests which are appropriate for non-normal data.
Based on the visual inspections of the histograms, there may have been one extreme outlier on TOSCA blame with an increase of 20 points from pre to post (with the next increased value at 9). Following up with a box plot, this point and the lowest value of a -14 indicating a decrease from pre to post (with the next reduced value being a -12) were identified as being more than 1.5 interquartile ranges from the quartiles. Excluding these points and re-running the paired sample t-tests (that will be presented below) did not meaningfully change the conceptual conclusion and thus will not be presented. Based on the histograms there did not appear to be any outliers on other difference scores.

Pre Intervention Demographic Differences

Before examining changes from pre to post-test, the researcher wanted to analyze if pre scores differed by any demographic factors. There were a number of differences between the two programs, including geographical location, plus open and closed group status. However, there were no significant differences on mean scores on any of the pre measures between the two program sites of Washington ($n = 6$) and Oklahoma ($n = 23$; all independent samples t-test $p’s > .23$).

In assessing any difference by age on the pre measures (TSC-40, ISS shame, ISS self-esteem, TOSCA shame, TOSCA guilt, and TOSCA blame), the largest correlations were for age with ISS self-esteem ($r = -.31, p = .097$) and with TOSCA shame ($r = -.25, p = .209$), but these were not significant, nor were any of the other correlations (all other $p’s > .39$).

Due to small sample size and particularly very small numbers of people in each of the race and ethnic minority groups, the researcher decided to categorize race into binary categories: Caucasian only ($n = 16$) and any race or ethnic minority ($n = 11$; two participants refused to list their race and were thus excluded from analyses about race and ethnicity). There were also no
differences on mean scores on any of the pre measures when comparing participants who were Caucasian only to those who identified as any race or ethnic minority (all independent samples t-test \( p \)'s > .25).

**Hypothesis Testing**

To determine if significant changes occurred among participants before and after completing the group sessions, the pre- and post-test scores on the ISS, TOSCA-3S, and TSC-40 were compared using paired t-tests. Although all the research questions predicted particular directions of effects, all the hypothesis testing was done using two-tailed tests to be open to the possibility that the results could actually be in the opposite direction than predicted.

Table 2.

*Paired sample t-tests*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean Difference</th>
<th>SD of Difference</th>
<th>( t )</th>
<th>95% CI of difference</th>
<th>( p )</th>
<th>Cohen’s ( d )</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISS Shame(^a)</td>
<td>0.58</td>
<td>0.69</td>
<td>4.55</td>
<td>0.32</td>
<td>0.84</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>ISS Self Esteem</td>
<td>-0.13</td>
<td>0.13</td>
<td>-5.71</td>
<td>-0.18</td>
<td>-0.09</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>TSC-40(^a)</td>
<td>7.68</td>
<td>15.75</td>
<td>2.58</td>
<td>1.57</td>
<td>13.79</td>
<td>.016</td>
</tr>
<tr>
<td>TOSCA Shame</td>
<td>3.82</td>
<td>11.67</td>
<td>1.73</td>
<td>-0.7</td>
<td>8.34</td>
<td>.094</td>
</tr>
<tr>
<td>TOSCA Guilt</td>
<td>-0.96</td>
<td>5.45</td>
<td>-0.94</td>
<td>-3.08</td>
<td>1.15</td>
<td>.358</td>
</tr>
<tr>
<td>TOSCA Blame</td>
<td>0.57</td>
<td>7.07</td>
<td>0.43</td>
<td>-2.17</td>
<td>3.31</td>
<td>.672</td>
</tr>
</tbody>
</table>

\(^a\)See section on this hypothesis for non-parametric Wilcoxon rank sum exact test results due to non-normality of the difference scores.

**Research Question One**

It was hypothesized that participants would experience a reduction in shame-proneness or self-identification with shame. This was tested by comparing results to a null hypothesis that
participants will not differ in shame-proneness or self-identification with shame before and after the intervention.

As seen in Table 2, the measure of shame-proneness and self-identification with shame significantly decreased from before to after the participants completed the group with a large effect size (as measured by Cohen’s $d$). However, as previously noted in assumption checks, differences scores on ISS shame were negatively skewed and thus did not fully meet the assumption of normality of difference scores needed for a paired sample t-test. It is noted that results from a non-parametric Wilcoxon rank sum exact test were consistent in also confirming a significant and large effect decrease size in shame from pre to post test ($Z = -3.95$, $p < .001$, effect size $r = .73$). Thus, the null hypothesis of no difference in shame-proneness before and after the intervention was thus rejected. See Figure 1 for a visual representation of the change.

Although there were no specific hypotheses about it, the ISS also included a subscale of self-esteem. As shown in Table 2, self-esteem significantly increased from pre to post intervention with a large effect. See Figure 2 for a visual representation of this change.

In addition, although the TOSCA score was not directly a part of the hypotheses, the TOSCA measure includes a subscale of shame, and this measure did not significantly change from pre to post intervention but the results are consistent with a small effect size of decreasing shame. There were also subscales of blame and guilt on the TOSCA measure, but these did not significantly change from pre to post test and their effect sizes indicate there may not have been any meaningful effect.
Figure 1. ISS Shame Comparisons

Figure 2. ISS Self Esteem Comparisons

Research Question Two
It was hypothesized that participants would experience a decrease in trauma-related symptoms from before to after the group. This was tested by comparing results to a null hypothesis that participants will not differ in trauma related symptoms before and after.

As also seen in Table 2, TSC-40 scores significantly decreased with a small and almost medium effect size, indicating trauma-related symptoms were lower after participants completed the group. A visual representation of this can be seen in Figure 3. However, as previously noted in assumption checks, differences scores on TSC-40 were negatively skewed and thus did not fully meet the assumption of normality of difference scores needed for a paired sample t-test. A non-parametric Wilcoxon rank sum exact test showed a marginally significant decrease in TSC-40 from pre to post test ($Z = -1.95$, $p = .051$, effect size $r = .37$). Although not significant, the results from this more robust test are broadly consistent with the paired sample t-test findings of the possibility of a decrease in trauma symptoms from before to after the intervention with a medium effect size. Thus, the null hypothesis of no difference in trauma symptoms before and after the intervention is, with slight caveats, rejected.
Figure 3. TSC-40 Comparisons.

Research Question Three

It was hypothesized that after recognizing shame as a feeling rather than automatic truth, participants would be more likely to therapeutically address underlying trauma. Although there was no direct test of this process or addressing trauma, its possibility can be assessed by noting whether or not shame decreased. The results of research question one showed that shame did significantly decrease, thus the results are at least consistent with the possibility of this inferred research question three that people can change in their shame and can recognize shame as a feeling rather than automatic truth. Perhaps consistent with prior research, this would make participants more likely to address underlying trauma.

Exploring Possible Intervention Changes By Location

Exploratory analyses were conducted to examine if there were differences in pre to post score changes based on location. Oklahoma and Washington were quite different programs
serving different populations of women, and thus it was of interest to see if the programs differed in their change. Mixed model ANOVAs were conducted to examine if there were any time by location interactions. Although none of the interactions was significant, it is noted that there were only six women in the Washington location and a small overall sample size, and there was an interesting overall pattern that may be worth future attention. Specifically, the locations by time interaction were always at least in the direction of the Oklahoma group showing more improvement than the Washington group. The three strongest effects are noted below with additional exploratory follow-ups.

For TSC-40 there was a marginally significant interaction of time by location (F(1, 26) = 3.62, \( p = .068 \), \( \eta^2_p = .122 \)). Follow up analyses splitting by location showed a non-significant 2.7 point increase or worsening in TSC-40 from pre to post in Washington (\( t(5) = -.81, \ p = .455 \)) while Oklahoma showed a significant 10.5 point decrease in TSC-40 scores from pre to post (\( t(21) = 3.03, \ p = .006 \)). Given the skewed distribution of TSC-40 change scores, it is also noted that similar conceptual results were found when using the Wilcoxon rank sum test to follow up on the location differences.

For both measures of shame (ISS shame and TOSCA shame), there were weaker but similar patterns of results. Specifically, for ISS shame, the interaction was not significant (F(1, 27) = 2.53, \( p = .123 \), \( \eta^2_p = .086 \)), but splitting by location showed a non-significant decrease of only .19 for Washington (\( t(5) = 1.22, \ p = .278 \)) and a significant decrease of .68 for Oklahoma (\( t(22) = 4.55, \ p < .001 \)). For TOSCA shame there was also not a significant interaction (F(1, 26) = 1.85, \( p = .185 \), \( \eta^2_p = .066 \)), but the pattern of results splitting by location showed a non-
significant increase or worsening of 1.8 points in Washington ($t(5) = -.35, p = .741$) and a significant decrease or improvement of 5.4 points in Oklahoma ($t(22) = 2.26, p = .035$).

**Exploring Possible Intervention Changes By Race**

Exploratory analyses were also conducted to examine if there were differences in pre to post score changes based on race (Caucasian compared to those of any racial or ethnic minority). It is noted that there were not differences in this binary race classification by location (Oklahoma was 57.1% Caucasian and 42.9% racial and ethnic minorities, while Washington was 66.7% Caucasian and 33.3% racial and ethnic minorities, chi square test of independent $\chi^2(1) = .17, p = .675$). Mixed model ANOVAs were conducted to examine if there were any time by race classification interactions. There were no significant nor even marginally significant interactions.

**Exploratory Analyses of Differences by ACE**

Due to prior research denoting the relationship between adverse childhood experiences and both mental and physical illness, this researcher wanted to examine whether participant scores differed based on the amount of adverse childhood experiences reported on the ACE-IQ. Exploratory analyses were conducted to see if there were any pre score differences by ACE-IQ and if the intervention was any more or less effective based on the amount of reported trauma experienced.

It was assessed if any of the pre intervention measures differed depending on women’s scores of adverse childhood experiences. There was a significantly positive correlation such that higher adverse childhood experiences are associated with higher pre intervention trauma symptoms scores on the TSC ($r = .504, p = .006$). There was a marginal but not significant negative correlation such that adverse childhood experiences are marginally associated with
lower self-esteem on the ISS \((r = -0.342, p = 0.070)\). No other pre scores were significantly correlated with ACE, indicating that they did not differ as a function of the number of adverse childhood experience.

In looking at mixed model ANOVAs of pre to post scores with ACE, it was tested if change over time was moderated by someone’s level of adverse childhood experiences, specifically by testing for an interaction of ACE scores by the time of measurement. There were no significant interactions, indicating that lower and higher ACE scores were not associated with greater or lesser change in scores from pre to post intervention measures, nor were there any consistent patterns. Thus, the differences reported previously in the hypothesis testing and Table 2 do not differ depending on one’s amount of adverse childhood experiences.
CHAPTER V: DISCUSSION

Experiencing trauma that leads to a diagnosis of PTSD or complex PTSD can have devastating effects on both the mental and physical health of people. Child abuse may be the costliest public health issue in the United States (Felitti & Anda, 2000). Without treatment, the effects of trauma can negatively impact people not only for the span of their lifetime, but also can negatively impact their children, leading to a pattern of intergenerational consequences. Research has linked experiencing childhood trauma to medical illness, mental health illness, and substance abuse, some of which can be fatal (Brier & Scott, 2006; Courtois & Ford, 2013; Felitti & Anda, 2000; Herman, 1992; Rizvi, Brown, Bohus & Linehan, 2011). This research sample specifically all had substance use in addition to experiencing childhood trauma.

Given the seriousness of the impact of trauma on individuals’ lives, we must look at what keeps people from seeking the treatment they need. One of the major barriers to treatment is the feeling of shame that often accompanies trauma (Bennett, Sullivan, & Lewis, 2010; Bryan, Morrow, Etienne, & Ray-Sannerud, 2103; Dyer et al., 2009; Gaudet, Sowers, Nugent, & Boriskin, 2016; Held, Owens & Anderson, 2015; Platt & Freyd, 2011; Whiffen & Macintosh, 2005). Over time, people can internalize feelings of shame, experiencing what is called internalized shame. If people have internalized shame, they may believe they are deeply broken, flawed, or defective rather than realizing the feeling of shame is not truth, but rather a common side effect of experiencing a traumatic event (Bockers et al., 2015; Chan, Hess, Whelton, & Yonge, 2005; Courtois & Ford, 2013; Harvey, Dorahy, & Vertue, 2011). The problem is if people believe they are broken or deeply flawed, they may see no point in treatment or hope in recovery. They may also believe they are the only ones who feel this way, wanting to hide their experiences further.
Although there are many successful therapeutic interventions for addressing trauma, directly addressing the shame that often prevents people from seeking treatment is not currently included as a standard protocol when working with those who have an underlying trauma history (Beck et al., 2013; Dearing & Tangney, 2011; Gaudet et al., 2016; Holl et al., 2016; Talbot, Talbot, & Tu, 2004). This research supports not only including a protocol to directly address shame, but a protocol that teaches people how to become resilient against shame. It appears to be possible that this addition to current treatment standards is a necessity for maximum treatment effectiveness.

**Current Study**

The intervention chosen for this research was the twelve-week group curriculum entitled *Connections* created by shame researcher Brené Brown, Ph.D. This curriculum was given to a population of women with a history of complex trauma and substance abuse who had all committed a drug related crime and who had chosen treatment instead of serving a jail or prison sentence. The curriculum was conducted at two different programs in two different states, Washington and Oklahoma.

This researcher hypothesized that introducing an intervention, which directly addressed shame, could potentially lead to three outcomes: a reduction in shame-proneness, a decrease in trauma-related symptoms, and a greater willingness to address underlying traumatic experiences when participants are able to separate the traumatic incident(s) from the shame they have associated with those incidents. Empirically supporting these hypotheses are important steps in showing how the shame often associated with trauma can be lessened with an appropriate intervention, and how this intervention could also help reverse the damaging effects internalized shame can have on the individual—namely the belief that he or she is broken or deeply flawed.
and not worthy of love and belonging. It is the reduction of this belief that may then allow people to feel worthy enough to continue to seek the treatment they need.

**Review of Results**

After implementing the *Connections* curriculum with the chosen sample, results from the research supported the assertion that this intervention would be successful in creating several positive outcomes. Supporting the first hypothesis, there was a significant reduction in participants’ reported level of internalized shame after completing the group sessions. This indicated that the protocol may have been an effective intervention for reducing internalized shame and helping individuals decipher the difference between “I am feeling shame now” versus “I am bad.” Interestingly, there was also a significant increase in reported self-esteem from before to after the intervention. Although self-esteem was not directly assessed in this research and it was only measured with a subscale on one of the scales used, effects on self-esteem and the role of self-esteem in overall treatment outcomes would benefit from further exploration. This could include directly assessing the relationship between internalized shame and low self-esteem and linking it with established research on the topic of self-esteem and how increased levels positively affect people’s lives. If the *Connections* curriculum not only increases the likelihood of people addressing underlying issues stemming from trauma, but also increases their self-esteem in the process, this further supports the benefit of including shame resilience protocols in treatment.

Shame has been known to exacerbate psychopathology and fuel its symptoms. This researcher wanted to see if physical trauma symptoms were reduced after participants learned shame resilience skills. Results tentatively supported the second hypothesis because symptoms did decrease by a marginally significant amount. Although this assertion needs to be tested with
a larger sample size in future research, results indicated that teaching shame resilience skills may also reduce physical symptoms of trauma.

If people believe they are broken or deeply flawed, it follows there would be symptoms of anxiety or depression in certain situations such as forming relationships or trying to learn new skills. If people can learn they are not broken, but rather survivors, it follows that they may not be as scared or as hopeless when engaging with others, or when trying to make positive changes to their lives. After skills are learned to counter the “I am bad” internal messages, possibilities and outlooks can change in a dramatic way. Seeing physical symptoms possibly decrease indicates that change in this regard is possible.

Based on research supporting shame as a barrier to receiving treatment (Bennett, Sullivan, & Lewis, 2010; Brown, 2007; Bryan, Morrow, Etienne, & Ray-Sannerud, 2103; Dyer et al., 2009; Gaudet, Sowers, Nugent, & Boriskin, 2016; Held, Owens & Anderson, 2015; Platt & Freyd, 2011; Whiffen & MacIntosh, 2005), it is then inferred that there is support for the third hypothesis that participants might be more likely to seek further support to address underlying trauma because of having decreased internalized shame. Therefore, research indicated support for all three hypotheses stated at the onset of the study.

Shame is like a silent poison that slowly erodes people’s belief that they are worthy of love and belonging. The effects of this are devastating. As we see by physical symptoms of trauma reducing after shame resilience is taught, the research finding shame as a catalyst to mental health symptoms is further supported. As we also see how the Connections intervention can be effective in reducing internalized shame, there is hope for changing this vicious cycle.

Unless we give people the tools to identify and reject the messages they give themselves when they are shame-based, the underlying mental health issues will remain hard to treat and
often hidden. Helping people to resolve their shame, or to change the belief that the messages they have learned to give themselves because of their shame are true, perhaps can help them develop a more solid view of their self-esteem and sense of wholeness than they had prior to working through their trauma. If people move forward in their recovery and can eliminate some of the emotional pain that, unresolved, could contribute to self-medication, such as substance use. If we address shame early in treatment, people may be more likely to remain in treatment, might learn to resolve symptoms associated with having experienced trauma, have a decreased need to self-medicate and gain self-esteem.

**Differences by Location**

There were no significant differences between scores on the participants by location, nor were there any significant interactions of pre- to post-score changes by location. Nonetheless, there were patterns that could lead to further research. The two geographic locations differed in their overall programs.

Although there were no significant differences by location, there are some suggestions that the Oklahoma program was more effective for participant improvement than the Washington program. Specifically, on the TSC-40, the ISS shame, and TOSCA shame, all Oklahoma participants changed as would be expected, decreasing in shame and trauma after the intervention. In contrast, Washington participants’ trauma symptoms (as measured on the TSC-40) increased, and their TOSCA shame scores slightly increased. Although their ISS shame scores did decrease, the change was only slight and was less of a change than for participants in Oklahoma. Both groups tended towards improvement in ISS self-esteem, but the Oklahoma group had higher scores after the intervention than the Washington group.
Although the interpretation of these findings is limited because of the small sample size used (n=6 for Washington; n=23 for Oklahoma), it is possible to consider any differences in the programs themselves. Oklahoma’s Women in Recovery program had more diversity in the types of classes participants in the program were required to take at the time this research was conducted. Their classes included trauma-focused therapy to address underlying mental health and trauma related issues that often co-occur with substance use. The Washington Drug Court program did not require these classes for its participants at the time of this research. Also, members of the Washington group were often newly entering the program when they began the Connections group, whereas Oklahoma members were in phase three of the program and nearing graduation when the group began. It is difficult to say if the duration of time in the program contributed to the greater improvement for the Oklahoma group. Because shame can be a difficult topic for some people to discuss, establishing a prior foundation in treatment before introducing the group might enhance treatment outcomes.

Research supports the belief closed groups help create a sense of safety among participants. Safety increases the likelihood of participants’ willingness to be vulnerable and discuss sensitive topics. Because shame is often a difficult topic to discuss, having a closed group would be helpful in creating an environment for maximum effectiveness. Unfortunately, due to the nature of the program in Washington, the Drug Court group there was not closed, although the groups in Oklahoma were closed. This could have affected treatment outcomes in favor of Oklahoma participants.

Finally, not all of the participants of the Oklahoma group chose the group themselves, but they were individually referred based on therapist recommendation. This means that their therapist either consulted with the participant about joining the group, or decided based on
clinical evaluation that the group would be likely to be helpful for the participant. For Washington participants, the group replaced a previous group and no one was referred by a therapist. Groups that are created intentionally might be more effective than groups that are created randomly based on someone’s need to be in a group to meet program criteria. If participants wanted or needed the intervention, they may have responded better than those who did not.

It is difficult to say if some aspect other than the Connections group contributed to better outcomes between the Oklahoma group than the Washington group. The Connections group appeared to be effective in both groups, but other program additions or the match of the program to the needs of particular people may increase its overall efficacy. However, addressing underlying trauma in addition to directly addressing substance use might improve outcomes for participants.

**Other Potential Change Variables**

To see if any other variables may have affected changes observed after the intervention, this researcher assessed if participant’s age, ethnicity, or ACE-IQ scores significantly moderated any change. There were no significant moderations of change for any of these variables. This suggests the Connections curriculum was equally effective no matter the individual’s age, ethnicity, or amount of experienced childhood trauma.

**Limitations**

This research was focused on introducing an intervention that taught participants shame resilience skills. The single biggest limitation to this research was the other confounding variables that may have contributed to change among participants. For example, differences between programs, closed versus open groups, intrinsic motivation, length of time in program,
and other factors that may have been occurring while participants were involved in the group. Although it is likely the *Connections* curriculum was a factor in the effective outcomes of the study, it is difficult to determine if it was the only factor. To demonstrate that changes are caused specifically by the intervention, future research would need to test the *Connections* curriculum while also using a therapy group that did not use the curriculum to allow a comparison of outcomes between the groups. This would help eliminate some of the confounding factors that were present during the current study, particularly the other aspects of treatment that all participants were receiving.

Other limitations include the small size of the sample, as well as having such a small number in the Washington group compared to the Oklahoma groups. It was difficult to accurately assess potential differences based on program, ethnicity, and age when comparing such small numbers of people. Results would have been more generalizable if both locations had equal and larger numbers of participants.

Regarding a limitation in using the TSC-40 to measure trauma symptoms specifically, participant medication consumption was not inquired about before, during, or after the study. Medication usage may have affected symptoms measured on the TSC-40 during this study, because medications often affect physical symptoms. How medications changed during the course of the group and other treatment during this time may have affected outcomes on this questionnaire, either negatively or positively.

**Future Research Directions**

Further research to explore whether participants were more likely to address underlying trauma after developing shame resilience skills is needed. This research included an inferred hypothesis based on prior research, but it would be necessary to have additional studies to see if
this inference was accurate. After learning about shame and its effects, were participants more likely to seek continued treatment for underlying issues?

Additional future research possibilities include assessing other changes that may have occurred after the participants completed the group. For example, did participants have higher self-esteem, or possibly fewer symptoms of anxiety or depression? A long-term study to collect follow-up data to see how mental and physical illness were affected after including both a direct shame intervention and a trauma focused treatment intervention would be beneficial. This data would help support the claim that adding a direct shame intervention is a necessary component for the most effective treatment of complex PTSD and trauma.

In prior research, shame has been associated with relapse in those who use substances to help manage their symptoms of trauma (Held et al., 2015; Potter-Efron, 2011). Teaching shame resilience skills may help participants offset the shame that often arises when people have completed treatment and then use substances again. In programs, such as the ones which this research was conducted, using shame resilience skills might help participants either relapse less, or seek help from treatment resources sooner if relapse occurs. Future studies may benefit from following up on participants to assess relapse outcomes after completing the shame resilience curriculum.

In addition to isolating the specific effects of the curriculum compared to other aspects of treatment, future research recommendations include using the Connections curriculum with men, transgender, or non-binary participants to assess the benefits of shame resilience skills in groups other than women only. Research has been done on the Connections curriculum itself to support differences in the way males and females report what triggers shame for them. There are also cultural expectations that contribute to feelings of shame. Although the antecedents may differ,
shame affects everyone. Further empirical support to help all people who struggle with internalized shame is needed.

**Conclusion**

This research was designed to add empirical support to understanding what increases the effectiveness of treatment modalities when working with people who have experienced trauma. Although we cannot prevent trauma from occurring, we can learn to help people heal in the most effective ways possible. Addressing deeply held beliefs of being unworthy and flawed, otherwise known as internalized shame, is a necessary component of trauma-focused treatment.

Not only does the inclusion of shame resilience training help survivors heal and find peace within themselves, it can also prevent the damages of internalized shame and trauma from being passed down generationally. This treatment addition not only positively impacts survivors’ quality of life; it also addresses a major health issue in our country. Benefits can include a decreased need to use substances, decreased continuation of further traumatic experiences, decreased health issues both mental and physical, and decreased attachment issues in offspring. If child abuse is the costliest issue in the United States due to the long-term effects of the trauma, the sooner we can help individuals recover and reduce the symptoms of trauma, the better.

This research supports the use of the *Connections* curriculum, which includes the use of empathy and compassion for self and others in the treatment process to reduce shame. In a world where so many traumatic experiences exist, finding the best possible treatment approaches that can effect lasting change is essential. Change in the larger system often begins on the individual level. It is asserted that incorporating tools to help an individual become resilient against shame when addressing underlying trauma is an important addition to the healing process for self that
can extend interpersonally and eventually systemically. As an added bonus, a treatment modality that fosters empathy and compassion in the self and toward others may also be a worthy contribution to further systemic change in general, and eventually reduce the amount of traumas that lead to these devastating issues in the first place.
References


Appendix A

ICD-11 Definition of complex PTSD
Complex post-traumatic stress disorder (complex PTSD) is a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). The disorder is characterized by the core symptoms of PTSD; that is, all diagnostic requirements for PTSD have been met at some point during the course of the disorder. In addition, complex PTSD is characterized by 1) severe and pervasive problems in affect regulation; 2) persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the traumatic event; and 3) persistent difficulties in sustaining relationships and in feeling close to others. The disturbance causes significant impairment in personal, family, social, educational, occupational or other important areas of functioning.
Appendix B

Internalized Shame Scale
APPENDIX D

ISS
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NAME: ___________________________ DATE: _______________________

DIRECTIONS: Below is a list of statements describing feelings or experiences that you may have from time to time or that are familiar to you because you have had these feelings and experiences for a long time. Most of these statements describe feelings and experiences that are generally painful or negative in some way. Some people will seldom or never have had many of these feelings. Everyone has had some of these feelings at some time, but if you find that these statements describe the way you feel a good deal of the time, it can be painful just reading them. Try to be as honest as you can in responding.

Read each statement carefully and circle the number to the left of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below. **DO NOT OMIT AN ITEM.**

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale</td>
<td>NEVER</td>
<td>SELDOM</td>
<td>SOMETIMES</td>
<td>OFTEN</td>
<td>ALMOST ALWAYS</td>
</tr>
</tbody>
</table>

**SCALE**

0 1 2 3 4 1. I feel like I am never quite good enough.
0 1 2 3 4 2. I feel somehow left out.
0 1 2 3 4 3. I think that people look down on me.
0 1 2 3 4 4. All in all, I am inclined to feel that I am a success.
0 1 2 3 4 5. I scold myself and put myself down.
0 1 2 3 4 6. I feel insecure about others' opinions of me.
0 1 2 3 4 7. Compared to other people, I feel like I somehow never measure up.
0 1 2 3 4 8. I see myself as being very small and insignificant.
0 1 2 3 4 9. I feel I have much to be proud of.
0 1 2 3 4 10. I feel intensely inadequate and full of self doubt.
0 1 2 3 4 11. I feel as if I am somehow defective as a person, like there is something basically wrong with me.
<table>
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<th></th>
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<th>1</th>
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<tbody>
<tr>
<td></td>
<td>NEVER</td>
<td>SELDOM</td>
<td>SOMETIMES</td>
<td>OFTEN</td>
<td>ALMOST ALWAYS</td>
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<td>12.</td>
<td>When I compare myself to others I am just not as important.</td>
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<td>13.</td>
<td>I have an over powering dread that my faults will be revealed in front of others.</td>
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<tr>
<td>14.</td>
<td>I feel I have a number of good qualities.</td>
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<td>15.</td>
<td>I see myself striving for perfection only to continually fall short.</td>
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<td>16.</td>
<td>I think others are able to see my defects.</td>
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<td>17.</td>
<td>I could beat myself over the head with a club when I make a mistake.</td>
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<td>18.</td>
<td>On the whole, I am satisfied with myself.</td>
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<td>19.</td>
<td>I would like to shrink away when I make a mistake.</td>
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<td>20.</td>
<td>I replay painful events over and over in my mind until I am overwhelmed.</td>
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<td>21.</td>
<td>I feel I am a person of worth at least on an equal plane with others.</td>
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<td>22.</td>
<td>At times I feel like I will break into a thousand pieces.</td>
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<td>23.</td>
<td>I feel as if I have lost control over my body functions and my feelings.</td>
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<td>24.</td>
<td>Sometimes I feel no bigger than a pea.</td>
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<td>25.</td>
<td>At times I feel so exposed that I wish the earth would open up and swallow me.</td>
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<tr>
<td>26.</td>
<td>I have this painful gap within me that I have not been able to fill.</td>
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<tr>
<td>27.</td>
<td>I feel empty and unfulfilled.</td>
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<td>28.</td>
<td>I take a positive attitude toward myself.</td>
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<td>29.</td>
<td>My loneliness is more like emptiness.</td>
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<tr>
<td>30.</td>
<td>I feel like there is something missing.</td>
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</table>
Appendix C

Trauma Symptom Checklist -40
### Trauma Symptom Checklist – 40
(Briere & Runtz, 1989)

How often have you experienced each of the following in the last month? Please circle one number, 0-3.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Never</th>
<th>1</th>
<th>2</th>
<th>3</th>
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</thead>
<tbody>
<tr>
<td>1. Headaches</td>
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<td>2. Insomnia</td>
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<td>3. Weight loss (without dieting)</td>
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<td>4. Stomach problems</td>
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<td>5. Sexual problems</td>
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<tr>
<td>6. Feeling isolated from others</td>
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<tr>
<td>7. “Flashbacks” (sudden, vivid, distracting memories)</td>
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<td>8. Restless sleep</td>
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<td>9. Low sex drive</td>
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<tr>
<td>10. Anxiety attacks</td>
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<td>11. Sexual overactivity</td>
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<tr>
<td>12. Loneliness</td>
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<tr>
<td>13. Nightmares</td>
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<tr>
<td>14. “Spacing out” (going away in your mind)</td>
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<tr>
<td>15. Sadness</td>
<td></td>
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<tr>
<td>16. Dizziness</td>
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<tr>
<td>17. Not feeling satisfied with your sex life</td>
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<td>18. Trouble controlling your temper</td>
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<td>19. Waking up early in the morning</td>
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<td>20. Uncontrollable crying</td>
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<tr>
<td>21. Fear of men</td>
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<td>22. Not feeling rested in the morning</td>
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<td>23. Having sex that you didn’t enjoy</td>
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<td>24. Trouble getting along with others</td>
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<td>25. Memory problems</td>
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<tr>
<td>26. Desire to physically hurt yourself</td>
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<tr>
<td>27. Fear of women</td>
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<td>28. Waking up in the middle of the night</td>
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<td>29. Bad thoughts or feelings during sex</td>
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<td>30. Passing out</td>
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<td>31. Feeling that things are “unreal”</td>
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<td>32. Unnecessary or over-frequent washing</td>
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<td>33. Feelings of inferiority</td>
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<td>34. Feeling tense all the time</td>
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<td>35. Being confused about your sexual feelings</td>
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<tr>
<td>36. Desire to physically hurt others</td>
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<td>37. Feelings of guilt</td>
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<tr>
<td>38. Feeling that you are not always in your body</td>
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<tr>
<td>39. Having trouble breathing</td>
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<tr>
<td>40. Sexual feelings when you shouldn’t have them</td>
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</tbody>
</table>
Trauma Symptom Checklist – 40
(Briere & Runtz, 1989)

Subscale composition and scoring for the TSC-40: The score for each subscale is the sum of the relevant items.

Dissociation – 7, 14, 16, 25, 31, 38
Anxiety – 1, 4, 10, 16, 21, 27, 32, 34, 39
Depression – 2, 3, 9, 15, 19, 20, 26, 33, 37
SATI (Sexual Abuse Trauma Index) – 5, 7, 13, 21, 25, 29, 31
Sleep Disturbance – 2, 8, 13, 19, 22, 28
Sexual Problems – 5, 9, 11, 17, 23, 29, 35, 40

TSC Total Score: 1-40

Important Note: This measure assesses trauma-related problems in several categories. According to John Briere, PhD “The TSC-40 is a research instrument only. Use of this scale is limited to professional researchers. It is not intended as, nor should it be used as, a self-test under any circumstances.” For a more current version of the measure, which can be used for clinical purposes (and for which there is a fee), consider the Trauma Symptom Inventory – contact Psychological Assessment Resources at 800-331-8378. The TSC-40 is freely available to researchers. No additional permission is required for use or reproduction of this measure, although the following citation is needed: Briere, J.N. & Runtz, M.G. (1989). The Trauma Symptom Checklist (TSC-33): Early data on a new scale. Journal of Interpersonal Violence, 4, 151-163. For further information on the measure, go to www.johnbriere.com.
Appendix D

Coping Agreement
Coping Agreement*

This agreement should be distributed before or during the first session.

I agree to take care of myself while I participate in this group. If I am feeling overwhelmed, I will slow down. I will not push myself to do things that I am not comfortable doing or sharing.

If I need to take a break and stop thinking about this work, I will

If I need to process through my feelings, I will

If I need to reach out, I will call

_____ I do not have a therapist or counselor right now, but I will ask for a referral from my group facilitator if I think that will be helpful.
_____ I have a therapist/counselor whom I can call and meet with when I need to.

Signature ___________________________ Date ________________

*Adapted from an agreement used by the Houston Area Women’s Center.
Appendix E

Informed Consent
Project: Introducing Shame Resilience to Those Who Struggle with Complex Trauma and Substance Abuse
Researcher: Kirsten Robertson, Psy.D. Student in Clinical Psychology

You are invited to participate in a research study. The purpose of this research study is to analyze the effects teaching shame resilience skills have on those who have experienced adverse childhood experiences and struggled with substance abuse. You are being asked to participate because you are a person over the age of 18 who meets criteria for having endured adverse childhood experiences, and struggled with substance abuse.

If you participate in this research, you will be asked to partake in completing four questionnaires at the start of this study, participate in a 12-week group designed to identify shame and teach shame resilience skills, and complete three additional questionnaires after the group is over. The content of these questionnaires will consist of assessing the number of adverse childhood experiences you endured, and the amount of internalized shame, traumatic symptoms, and differences in perceptions of events you experience. You will also be asked basic demographic questions such as your date of birth, ethnicity, marital status, and current employment status.

The risk inherent in this study is the potential stress of emotional topics coming up while completing the questionnaires, or during group. Although you will not be asked to share specific personal experiences unless you choose to, simply recalling the event may cause unpleasant memories that can be uncomfortable or overwhelming for some people.

If, while answering the questionnaires or participating in the group, you become overwhelmed by these feelings you are encouraged to: reach out to a psychotherapist, call the National Suicide Hotline at 1-800-273-8255, call your local crisis hotline, and/or access online crisis chat at http://crisisclinic.org/find-help/crisis-chat/. A potential benefit of participation in this study may include the personal satisfaction of developing shame resilience skills and viewing yourself and your experiences in a way that may be different than before you began. Sharing personal experiences with others in a safe and trusted environment has also had a positive affect in some people.

Your participation will take 90 minutes each meeting and last for thirteen weeks. You will be provided with a $10 gift card as a small token of appreciation for your time, which will be given on week thirteen.

Your participation in this research is strictly voluntary. You may refuse to participate at all, or choose to stop your participation at any point in the research, without fear of penalty or negative consequences of any kind.

The information you provide for this research will be treated confidentially, and all raw data will be kept in a secured file by the principal investigator. Results of the research will be reported without the inclusion of any individually identifiable information.

You also have the right to review the results of the research if you wish to do so. A copy of the
results may be obtained by contacting the principal investigator at the address below:

Kirsten Robertson  
(XXX) XXX-XXXX  
krobertson2@antioch.edu

There will be no direct or immediate personal benefits from your participation in this research, outside of potentially finding the education you receive during group helpful.

I understand that this research study has been reviewed and Certified by the Institutional Review Board, Antioch University, Seattle. For research-related problems or questions regarding participants’ rights, I can contact Antioch University’s Institutional Board Chair, Mark Russell, Ph.D. at mrussell@antioch.edu.

The primary researcher conducting this dissertation study is Kirsten Robertson, Psy.D Student. The supervising dissertation chair is Dana Waters, Psy.D, who can be contacted at dwaters@antioch.edu. If you have questions later, you may contact Kirsten Robertson at (XXX) XXX-XXXX or krobertson2@antioch.edu.

I have read and understand the information explaining the purpose of this research and my rights and responsibilities as a participant. My signature below designates my consent to participate in this research study, according to the terms and conditions outlined above.

Participant Name (printed): __________________________________________________________

Participant Signature: ___________________________ Date: ___________________

Participant Phone Number: __________________________________________________________

Is it OK to leave you a voicemail message on this phone? Yes ☐ No ☐
Appendix F

Method of Proposed Study Diagram
Where?  
THS groups were in Washington  
WIR groups were in Oklahoma

When?  
THS groups January 2017 - July 2017  
WIR groups January 2018 - July 2018

Who?  
Original goal of 30 women currently receiving treatment at Therapeutic Health Services (THS) or Women In Recovery (WIR). Actual N=29  
THS= 6  
WIR= 23

Method of Study

Week 1: What?  
Informed consent  
ACE-IQ  
ISS  
TOSCA-3  
TSC-40

Weeks 2-12: What?  
Begin the 12-session Connections group curriculum administered according to manual guidelines

Week 13: What?  
ISS  
TOSCA-3  
TSC-40  
Give $10 gift cards for participation
Appendix G

Permissions
Taylor and Francis granted permission for the Internalized Shame Scale to be reused in the present dissertation manuscript.
Dr. Brené Brown’s team has given permission for the Coping Agreement to be reused in the present dissertation manuscript.

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Hi Kirsten,

Thanks for connecting. Congratulations on all your hard work and dedication to your dissertation. We are ok with you using the Coping Agreement in your appendix. We just ask for appropriate attribution and that there is no implication of endorsement by Brené.

We really appreciate you reaching out to ask permission. We wish you wholehearted success on your studies!

Warm regards,
Cookie

Brené Brown Team