

Effects of Verbal Responses to Shame Disclosures on State Shame and Dissociation:

An Experimental Investigation

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Table of Contents

Acknowledgements..... i

Table of Contents ..... ii

List of Tables ..... v

List of Figures ..... vi

Abstract..... 1

**Introduction..... 2**

    Overview ..... 2

    Shame Defined..... 3

    Shame as a Barrier to Treatment..... 8

    Dissociation..... 13

    Relationship Between Shame and Dissociation..... 16

    Review of Shame Induction Methods..... 19

    The Present Study ..... 21

**Method ..... 24**

    Participants..... 24

    Design ..... 24

    Shame Induction ..... 26

    Shame Reduction ..... 27

    Pilot Test ..... 29

    Measures ..... 29

    Procedure ..... 34

    Data Analysis ..... 36

<b>Results</b> .....	37
Demographics and Trait Measures .....	37
Manipulation Check and Test of Assumption 1 .....	37
Test of Hypotheses 1 and 2: Effect of Verbal Responses on State Shame .....	40
Experimental Checks .....	41
Test of Hypotheses 3 and 4: Relationship Between State Shame and Dissociation ....	43
Test of Hypothesis 5: Ratings of Helpfulness.....	45
<b>Discussion</b> .....	48
Overview.....	48
Effects of Verbal Responses .....	49
Relationship Between State Shame and Dissociation.....	55
Ratings of Helpfulness.....	56
Limitations and Directions for Future Research.....	59
Theoretical and Practical Implications.....	63
Summary and Conclusion .....	65
References.....	66
Appendices.....	81
Appendix A: Advertising Poster .....	81
Appendix B: Ethics Approval Letter .....	82
Appendix C: Procedure Script .....	83
Appendix D: Shame Induction Written Instructions .....	87
Appendix E: Experimental Checks .....	88
Appendix F: Demographic Questions.....	89
Appendix G: ESS .....	90
Appendix H: DES .....	92

Appendix I: SSGS.....94

Appendix J: PDEQ-M.....95

Appendix K: Single-Item Emotion Ratings .....96

Appendix L: Ratings of Helpfulness.....97

Appendix M: Information Sheet .....99

Appendix N: Consent Form ..... 101

Appendix O: Debriefing Sheet..... 102

List of Tables

Table 1 .....25  
*Descriptive Statistics for Demographic Variables Showing Numbers (n) and Percentages (%) Across Conditions and the Overall Sample (N = 85)*

Table 2 .....35  
*Procedure Summary*

Table 3 .....38  
*Descriptive Statistics for Trait and State Measures Across Conditions*

Table 4 .....39  
*Descriptive Statistics for Single-Item Emotion Ratings Across Time by Condition*

Table 5 .....43  
*Descriptive Statistics for Experimental Checks Across Conditions*

Table 6 .....45  
*Descriptive Statistics for Ratings of Helpfulness Across Conditions*

List of Figures

*Figure 1*.....40  
 Mean SSGS Scores Across Time by Condition.

*Figure 2*.....42  
 Mean Single-Item Emotion Ratings at Post-Induction and Post-Reduction.

*Figure 3*.....44  
 Mean PDEQ-M Scores Across Time by Condition.

*Figure 4*.....46  
 Mean Ratings of Helpfulness as a Function of Response Type.

## Abstract

Shame is pervasive across psychological disorders, particularly those associated with complex trauma (Dorahy et al., 2017; Miller, 1996). Despite evidence suggesting that shame may pose barriers to psychological treatment (Lee, Scragg, & Turner, 2001), scarce empirical literature exists to guide clinicians' approaches to patients' acute shame feelings. Thus, the primary goal of the present study was to experimentally evaluate effectiveness of verbal responses to shame disclosures on reducing state shame. Further, a growing body of research points towards a bi-directional relationship between state shame and dissociation. Given the potential for these phenomena to perpetuate one another in therapeutic settings, the second aim of current research was to further examine their relationship. Following the shame induction (i.e., writing about a personal shame experience) and subsequent verbal shame disclosures, 85 university students were randomly assigned to receive one of three verbal response interventions intended to reduce state shame, before completing subjective ratings of state shame and dissociation, as well as ratings of helpfulness of imagined therapist responses. Contrary to Hypotheses 1 and 2, none of the intervention conditions demonstrated a capacity to reduce state shame. Consistent with Hypothesis 3, a positive relationship between state shame and dissociation was evident at post-induction and post-reduction phases. Yet, contrary to Hypothesis 4, verbal response interventions did not appear capable of reducing state dissociation. Consistent with Hypothesis 5, the Withdrawal response, which facilitated avoidance of shame in therapy, was rated as less helpful than all other therapist responses. While utility of specific verbal responses remains inconclusive, the present findings tentatively suggest that therapeutic prompts that encourage exploration of shame material may be more beneficial than those enabling its avoidance. These preliminary insights may be relevant for clinicians across patient groups, and particularly therapists working with trauma patients.

## Introduction

### Overview

Shame is a highly aversive self-conscious emotion associated with various psychological presentations, particularly, trauma-based disorders such as posttraumatic stress disorder (PTSD; Miller, 1996; Miller & Resick, 2007). Due to its painful affect and the heightened vulnerability associated with disclosing shame-laden experiences, shame may form a barrier to psychotherapeutic interventions by inhibiting exploration and emotional processing of shame-laden content (Lee et al., 2001). Scarce empirical evidence is available to guide clinicians' immediate responses to in-session elevations in patients' state shame (Dorahy, Gorgas, Hanna, & Wiingaard, 2014). Thus, the overarching goal of the present study was to explore the effectiveness of immediate responses to initial shame disclosures by examining the capacity of verbal responses to reduce participants' feelings of shame following a shame induction (i.e., recalling shame-laden experiences), as well as exploring participants' subjective perceptions of helpfulness of various verbal approaches to shame.

Furthermore, a large body of research indicates that both shame and dissociation constitute common responses to traumatic experiences (Carlson, Dalenberg, & McDade-Montez, 2012; Platt & Freyd, 2015; Platt, Luoma, & Freyd, 2017; Thomson & Jaque, 2013). Additionally, growing empirical evidence points towards a bi-directional relationship between shame and dissociation (Dorahy et al., 2017; McKeogh, Dorahy, & Yogeeswaran, 2018). Given their potential to perpetuate one another as barriers to effective treatment, the second aim of the present study was to further examine the relationship between shame and dissociation by measuring changes in state dissociation following the experimental shame induction and subsequently the shame reduction interventions, to test whether acute dissociative experiences increase in response to heightened shame and/or decrease in response to verbal response interventions targeting state shame.

The ensuing literature review will first outline existing definitions and conceptualisations of shame, differentiating it from other self-conscious emotions. Second, ways in which shame may present barriers to psychological treatment will be outlined, formulating an argument for empirical investigations within the field of clinical approaches to shame disclosures. Third, existing studies exploring approaches to shame in therapeutic contexts will be outlined as the basis of the present study. Fourth, phenomena encompassed by the construct of dissociation will be defined and conceptualised. Fifth, existing theoretical and empirical literature examining the relationship between shame and dissociation in the context of trauma will be reviewed. Sixth, experimental shame induction methods will be reviewed to identify the most appropriate methodology for the goals of the present study, before presenting its objectives and corresponding hypotheses.

### **Shame Defined**

Shame is a painful, intense, and potentially destructive self-conscious emotion in which one's core sense of self is devalued and perceived as inferior, defective, worthless, and powerless (La Bash & Papa, 2014; Gilbert, 1997; H. B. Lewis, 1971; Schoenleber, Sippel, Jakupcak, & Tull, 2015; Tangney, 1999). Shame may arise in response to a wide range of idiosyncratic experiences, particularly those characterised by perceived moral transgressions, failure, and/or rejection. It is most evident following failure to achieve a desired goal or exclusion from a desired group (DeYoung, 2015; Gilbert, 1998; Tangney, 1999). Within self-discrepancy theory, shame may be conceptualised as arising from the discrepancy between the *actual* self (i.e., one's perception of attributes they actually possess) and the *ought* self (i.e., attributes one believes they should possess based upon internalised responsibilities and others' expectations; Higgins, 1987). Gilbert (1997, 2000, 2003, 2011) distinguishes between internal and external components of shame, arguing that internal shame is generated through negative evaluations of the self *by the self* (i.e., negative self-evaluations such as "I am a bad

person”), while external shame stems from one’s perception of negative evaluations and rejection of the self *by others* (e.g., perception of public disapproval, criticism, and/or rejection linked to one’s personal shortcomings). According to Gilbert (1998, p. 22) “the sense of personal unattractiveness” and “being in the social world as an undesired self” are central to the shame experience.

**Cognitive aspects of shame.** Shame is an inherently self-conscious and self-focused experience, characterised by self-criticism and self-devaluation (Gilbert, Clarke, Hempel, Miles, & Irons, 2004). Cognitive aspects of shame may manifest as negative thoughts about the self, perceptions of the self as exposed and vulnerable, as well as more enduring negative beliefs about the self (e.g., as defective, flawed, and inadequate; Gilbert, 1998; Gilbert et al., 2004; Herman, 2011; Kaufman, 2004; H. B. Lewis, 1971; Schoenleber et al., 2015; Tangney, 1996). Drawing upon attribution theory, M. Lewis’s (1995) model posits that shame is activated when one perceives that they have failed to meet internalised standards and subsequently attributes this perceived failure to internal and global causes (i.e., attributing responsibility for negative events to personal shortcomings and viewing their entire self as inherently flawed and inadequate; Platt & Freyd, 2012). Consistently, shame is associated with negative attributions that are internal, global, and stable, as opposed to external, situation-specific, and transient (Tangney, 1990; Tangney & Dearing, 2002).

**Behavioural aspects of shame.** Acute experiences of shame are associated with distinct observable non-verbal behaviours (e.g., eye gaze aversion, downward head tilt, collapsed posture, and postural avoidance [e.g., turning away]; Lewis, Alessandri, & Sullivan, 1992; Tracy & Matsumoto, 2008; Tracy & Robins, 2007). These behaviours are hypothesised to make the individual appear smaller, with the overwhelming discomfort of shame prompting a desire to hide and disappear to minimise further disgrace and scrutiny associated with exposure of the self as inferior and weak (Herman 2011; Kaufman, 2004;

Nathanson, 1992). Empirical research has yielded support for M. Lewis's (1995) arguments that behavioural expressions of shame involve collapsed posture and a downcast eye gaze (Keltner, 1995), which may be reflective of internal states of inferiority and withdrawal (Gilbert & Andrews, 1998).

Nathanson's (1992) Compass of Shame model postulates four key behavioural coping strategies and responses to shame: (1) withdrawal (e.g., hiding and isolating self, active attempts to escape stimuli associated with shame), (2) avoidance (e.g., attempts to minimise the activation of shame via distraction, denial, suppression, substance abuse, overeating), (3) attacking self (e.g., self-disparaging thoughts, self-harm), and (4) attacking others (e.g., lashing out, blaming others, attempts to transfer the shame onto another by making them feel inferior; Dorahy, Gorgas, Seager, & Middleton, 2017; Kluft, 2007; Van Vliet, 2008, 2009).

**Shame and related self-conscious emotions.** In contrast to basic or primary emotions (e.g., sadness, happiness, fear, anger), which are believed to constitute hard-wired and universal experiences from infancy (M. Lewis, 1995), the ability to experience self-conscious emotions (e.g., shame, guilt, embarrassment, pride) requires capacities for self-awareness, self-reflection, and self-evaluation (Dyer et al., 2016; M. Lewis, 1995; Nathanson, 1992), as these socio-cognitive processes enable one to internalise and compare one's overall self and/or specific behaviours against external standards or expectations (M. Lewis, 1995; 2003). These capacities develop at age 14-16 months through interpersonal interactions with close figures, particularly, the mother-infant dyad, within which the earliest experiences of shame are typically thought to occur when the mother's response (e.g., eye gaze, affect) does not reciprocally reflect one expected by the infant (Gilbert & Andrews, 1998).

Despite growing clinical and empirical interest in shame, particularly as it relates to trauma, there is limited consistency within emotion literature with respect to how shame may

be defined and differentiated from related self-conscious emotions (e.g., guilt, embarrassment, humiliation; Tangney, Miller, Flicker, & Barlow, 1996).

***Shame and guilt.*** Some theorists argue that it is the self-devaluation and reprehension of the *entire* self that differentiates shame from guilt (H. B. Lewis, 1971). In guilt, which likewise follows a perceived moral transgression, one negatively evaluates their specific behaviour that contravened some internalised standard, rather than their entire self (H. B. Lewis, 1971; Tangney, 1991). Subsequently, in contrast to shame, attributional patterns in guilt tend to be situation-specific and relatively transient (e.g., negative self-perceptions of “I have *done* something wrong” in guilt vs. “I *am* a bad person” in shame; Tangney, 1991). The separation of the reprehended behaviour from one’s identity in guilt is thought to preserve the overall self, thereby leading to an arguably less painful and destructive affective experience than shame (Gramzow & Tangney, 1992). Distinctions have also been identified between the behavioural consequences of guilt and shame. Perhaps as one’s self-concept remains intact in the former (Tangney, 1990), guilt appears to motivate approach behaviours ‘to repair the damage’ (e.g., apologising, confessing; Lindsay-Hartz, 1984; Roseman, Wiest, & Swartz, 1994), while shame more prominently drives avoidance behaviours (e.g., desire to hide, appeasement; Keltner, 1995).

***Shame and embarrassment.*** There is little consensus in the emotion literature with respect to whether shame and embarrassment represent distinct emotions (Crozier, 2014). While some theorists do not draw distinctions (Darwin, 1872; Izard, 1977; Roseman et al., 1994), pointing out shared characteristics of these affective experiences (e.g., heightened self-awareness, feelings of exposure and inadequacy, accompanying distress; Andrews, 1995), others argue that embarrassment may be “a mild form of shame” (Borg, Staufenbiel, & Scherer, 1988, p. 82; Crozier, 2014; M. Lewis, 1990). Some authors posit that patterns of negative attributions associated with embarrassment are more situation-specific and transient

(vs. global and enduring in shame; Klass, 1990). Subsequently, some argue that, in contrast to embarrassment, the experience of shame is more intense, global, and enduring, as embarrassment is believed to reflect a perceived deficiency of the *presented* (i.e., more superficial) rather than the *core* (i.e., deeper) self (Klass, 1990). Further, relative to shame, embarrassment is thought to stem from events or transgressions that are relatively trivial, rather than those perceived to entail serious moral implications, and to result in transient, rather than enduring, loss of self-esteem (Tangney et al., 1996).

***Shame and humiliation.*** While conceptual confusion pervades the emotion literature, some key distinctions have been identified between shame and humiliation (Gilbert, 1997). In contrast to humiliation, in which an external party lowers the individual to an inferior position through a humiliating act (e.g., degrading treatment, contempt, ridicule; Klein, 1991), in shame, it is the individual themselves who negatively evaluates their own self as inferior and deficient (Miller, 1996). Subsequently, humiliated individuals do not believe that they deserve the humiliation, and tend to feel a sense of injustice as they view the external party as responsible for inflicting this aversive experience (i.e., external rather than internal attribution of blame), while ashamed individuals view themselves as responsible, accepting that they deserve the shame (Gilbert, 1997; Klein, 1991). Thus, instead of the high *self*-focus characteristic of shame, the humiliated individual is more likely to focus on the harm caused by *others* (Gilbert, 1997; H. B. Lewis, 1987).

***Shame and psychopathology.*** Given the pervasive and debilitating impact of shame on the core sense of self, Miller (1996) argues that shame lies at the core of psychopathology. Indeed, frequent, sustained, or chronic shame is associated with various clinical presentations, including depression (Andrews, 1995; Andrews, Qian, & Valentine, 2002; Matos & Pinto-Gouveia, 2010), social anxiety (Cox et al., 2000), alcohol abuse (Brown, 1991), eating disorders (Goss & Allan, 2009), borderline personality disorder (Lieb, Zanarini,

Schmahl, Linehan, & Bohus, 2004), and suicidality (Wilson, Droždek, & Turkovic, 2006).

Shame appears to be particularly pervasive in trauma-based disorders, such as PTSD (Feiring, Taska, & Chen, 2002; Leskela, Dieperink, & Thuras, 2002; Miller & Resick, 2007) and dissociative disorders (Dorahy et al., 2015).

***Shame and trauma.*** Some authors argue that unresolved or chronic shame may mediate the relationship between trauma and PTSD (Gilbert, 1998), and that shame may be central in the development and maintenance of posttraumatic symptoms (Amstadter & Vernon, 2008). Further, Herman (2011) conceptualises PTSD as a “shame disorder”, as shame frequently appears to be the core issue among patients with moderate to severe PTSD in her clinical practice. Given that shame inherently influences self-perception and that alterations in self-perception are a hallmark of complex trauma, shame and trauma appear to be closely linked (Platt et al., 2017). From a theoretical standpoint, shame may arise in response to trauma, as traumatic experiences (particularly, relational trauma, such as physical or sexual abuse), likely pose a threat to one’s core self, giving rise to enduring and pervasive alterations in self-perception (Platt et al., 2017; Thomson & Jaque, 2013). Empirical findings of associations between shame and posttraumatic symptoms provide support for these arguments. For example, Feiring and Taska’s (2005) longitudinal study of sexually abused children and adolescents found that those with higher self-reported shame at 1 and 6 years post-disclosure were more likely to have persisting clinically significant levels of intrusive PTSD symptoms at the 6-year follow-up. Moreover, Andrews, Brewin, Rose, and Kirk’s (2000) study of violent crime survivors found that persistent feelings of shame were the solo independent predictor of PTSD symptomatology six months following the traumatic event.

### **Shame as a Barrier to Treatment**

Empirical evidence of posttraumatic shame and conceptualisations of the function of shame in trauma suggest that the experience, the meaning, and the memories of trauma may

become associated with shame (Freyd, 1996), which may ultimately form barriers to psychological treatment (Lee et al., 2001). By its very nature, shame causes one to feel vulnerable and exposed (Kaufman, 2004; H. B. Lewis, 1971); an experience that is likely amplified in the context of revealing intimate details of trauma (e.g., as in shame disclosures in therapy). Lee and colleagues (2001) argue that disclosures of shame-laden trauma likely re-activate intense acute feelings of shame, which may inhibit discussions of shame-laden content, as intense experiences of shame are thought to lead to safety behaviours of hiding, escaping, or concealing the shame (Gilbert, 2000; H. B. Lewis, 1971). Furthermore, Herman (2011) discusses the self-perpetuating nature of shame in which patients may feel ashamed of being ashamed (i.e., the “feeling trap”), and, thus, reluctant to reveal shameful experiences, attempting to conceal shameful self-perceptions due to fear of being negatively evaluated by the therapist (Pineles, Street, & Koenen, 2006). Indeed, shame-prone individuals tend to be guarded and actively attempt to defend against others’ discovery of their shame, rendering them challenging to treat with traditional therapeutic interventions (Gilbert, 2003).

Despite substantial empirical support for the effectiveness of exposure-based interventions (Foa, Keane, Friedman, & Cohen, 2008), empirical evidence suggests that their effectiveness appears to be significantly lower among individuals with histories of childhood trauma, emotion dysregulation, and high levels of trauma-related shame (Feeny, Zoellner, & Foa, 2002; Hembree, Street, Riggs, & Foa, 2004). Accordingly, shame has been shown to undermine psychological treatment response (Platt et al., 2017; Simeon, Greenberg, Nelson, Schmeidler, & Hollander, 2005).

Taken together, literature suggests that shame may create several barriers to treatment. First, the debilitating experience of shame and the associated fear of negative evaluation may impede help-seeking altogether and may contribute to early treatment drop-out (Lee et al., 2001). Second, among patients presenting for therapy, shame may impede the

emotional processing of shame-laden trauma, which forms a fundamental barrier to exposure-based therapeutic interventions that require revisiting trauma content (e.g., via imaginal exposure; Brewin, Dalgleish, & Joseph, 1996; Joseph et al., 1997) and facing and processing feelings of shame (Van Vliet, 2008; Wagner, Rizvi, & Harned, 2007), thereby ultimately perpetuating trauma-related symptomatology (Lee et al., 2001). Additionally, Lee and colleagues (2001) caution that, due to the heightened vulnerability of patients with shame, the therapeutic context (e.g., therapist's responses) has the potential to re-shame the patient, and induce concealment of shame and/or withdrawal from therapy altogether. Correspondingly, Herman (2011) argues from clinical experience with trauma patients that even using the word "shame" (by patient or therapist) may be too confronting for initial shame disclosures, as merely acknowledging the feeling of shame may in itself be a shaming experience (DeYoung, 2015). However, these postulations have not yet been verified through empirical investigations.

Notably, De Hooge, Zeelenberg, and Breugelmans (2010) posited the possibility of distinct behavioural responses to chronic shame (i.e., dispositional tendency to experience shame, referred to as "shame proneness" or "trait shame" in empirical literature) versus acute shame feelings (referred to as "state shame" within literature; Platt & Freyd, 2012). They argue that experiences of chronic shame are likely to induce withdrawal or avoidance behaviours (e.g., withdrawing from discussion of shame-laden content) due to high motivation to protect the self from further scrutiny or injury, perhaps relating to perception that the damaged view of the self is irreparable (De Hooge et al., 2010). In contrast, elevations in acute shame may activate approach behaviours (e.g., confronting shame, approaching discussion of shame-laden material) if one feels capable of restoring their damaged view of the self (Dorahy et al., 2014), which could be facilitated by conditions within the therapeutic environment (e.g., installation of hope that such changes are possible;

Dorahy et al., 2014). Critically, possible conditions that may facilitate approach, rather than withdrawal from, shame have not yet been empirically investigated (Dorahy et al., 2014).

**Approaches to shame in therapeutic settings.** A growing body of empirical evaluations has shown support for the effectiveness of Compassion-Focused Therapy (CFT), which aims to generate self-compassion in place of self-criticism (Gilbert, 2000), in reducing individuals' general proneness to shame (i.e., trait shame; Gilbert & Procter, 2006; Judge, Cleghorn, McEwan, & Gilbert, 2012). However, no specific approaches have been identified for in-the-moment elevations in shame (i.e., state shame), despite consensus within literature that shame disclosures are challenging to effectively address in therapeutic settings (Dorahy et al., 2014; Herman, 2011). Given the additional vulnerability of ashamed patients, therapists' responses to shame disclosures ought to be carefully considered to safely and effectively validate patients' experiences without re-shaming in order to facilitate exploration of disclosed material and, ultimately, engagement with therapeutic interventions (Herman, 2011). Yet, despite the apparent need for additional considerations, a paucity of empirical evidence exists to inform clinicians' approaches to patients' in-session shame elevations, particularly, their immediate responses to initial shame disclosures (Dorahy et al., 2014).

**Existing empirical studies.** Promisingly, two studies have initiated this empirical enquiry through experimental simulations of therapists' immediate interventions for shame disclosures. Dorahy and colleagues (2014) investigated undergraduate students' perceptions of helpfulness of therapists' responses to patients' initial shame disclosures. Participants viewed video clips of mock therapy excerpts while placing themselves in the position of the patient who disclosed a shame or a shock experience to a therapist, and subsequently rated the extent to which they would find helpful each of the five possible therapist responses. Responses ranged from directly addressing shame (i.e., Non-Withdrawal or Approach) to avoiding it completely (i.e., Withdrawal; offering the patient to change the subject away from

shame). Both extremes (i.e., completely avoiding shame and directly approaching it) were rated as less helpful than the intermediary responses that encouraged exploration of the shame experience without direct confrontation of shame feelings (i.e., responses that prompted further discussion of thoughts, coping strategies, and past experiences relating to the shame experience, rather than the shame emotion itself). These findings suggest that a delicate balance between withdrawal from and approach of shame may be optimal.

Dorahy, Gorgas, and colleagues (2017) built upon Dorahy and colleagues' (2014) methodology, utilising ratings of helpfulness with a clinical sample of adults with dissociative disorders, who listened to audio clips of the mock therapy sessions. Consistent with Dorahy and colleagues (2014), the Withdrawal response was rated as the least helpful. Taken together, these studies provide insight into participants' perceived utility of therapists' immediate reactions to shame disclosures they *observed*. However, it is possible that their true effectiveness may differ when intervention responses are personally *experienced*. Thus, the current study aimed to investigate the effectiveness of immediate interventions for personally-experienced shame disclosures, which were simulated through a shame induction and subsequent verbal response interventions.

Notably, beyond the association between trauma and shame and the need for evidence-informed interventions for effectively responding to acute shame in therapy, clinicians also need to be aware of the close link between shame and dissociation, as this latter construct is related to both trauma and shame (Carlson et al., 2012). Further, compromised treatment outcomes of, and universally high drop-out rates among, trauma-focused treatment seekers (Hembree, Street, Riggs, & Foa, 2003) urge the need for further clinical research to explore both shame and dissociation as potential barriers to effective psychological treatment of trauma and ways in which they may be addressed (Platt & Freyd, 2015). Thus, conceptual definitions of dissociation, as well as theoretical and empirical

literature connecting dissociation and shame will now be reviewed, as a foundation for the second aim of the present study to experimentally examine their relationship.

### **Dissociation**

The construct of dissociation encompasses a broad range of psychological phenomena, such as absorption (i.e., being fully immersed in mental imagery, including daydreaming, fantasising, and absorbed attention in a task with minimal awareness of external events and passage of time; Roche & McConkey, 1990), depersonalisation (i.e., subjective sense of disconnection from the self, which may encompass “out-of-body experiences” such as watching oneself from a distance; American Psychiatric Association [APA], 2013; Coons, 1996; Simeon, 2009), derealisation (i.e., alterations in subjective perception of the world as unreal or dreamlike; Sierra & Berrios, 2000), emotional numbing (i.e., inability to connect to and process emotional aspects of experience; Holmes et al., 2005), dissociative amnesia (i.e., inability to recall autobiographical information that is not accounted for by normal forgetfulness), and the presence of and alterations between two or more distinct identities (as in dissociative identity disorder [DID]; APA, 2013; Brown, 2006).

Definitions and conceptualisations of dissociation, as well as its underlying mechanisms and functions, are widely debated (DePrince & Freyd, 2007; Platt & Freyd, 2015). However, fundamentally, dissociation is characterised by alterations in consciousness (Holmes et al., 2005) and dis-integration of cognitive, affective, physiological, and/or behavioural aspects of experience (Dalenberg & Carlson, 2012; Stein, 2009). The Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> Edition (APA, 2013) defines dissociation as disruptions in typically integrated mental processes (e.g., perception, emotion, behaviour, memory, identity), though some argue that this definition may be insufficiently nuanced to capture the complexity of the multifaceted phenomena comprising dissociation (Dell, 2009). From Dell’s viewpoint, dissociation may be conceptualised as “involuntary intrusions into

executive functioning and sense of self' where volitional control over cognition, behaviour, and emotion may become temporarily disrupted (Brown, 2006; Dell, 2009, p. 226).

**Detachment and compartmentalisation.** Dissociative phenomena occur with varying degrees of frequency, intensity, and subjective distress across both general and clinical populations (Ross, Joshi, & Currie, 1990). A number of theorists classify dissociative phenomena into two qualitatively distinct categories of "detachment" and "compartmentalisation" (Brown, 2006; Holmes et al., 2005), which are thought to entail distinct underlying mechanisms and continua of distress and functional impairment (ranging from relatively mild and non-pathological experiences to severe and chronic conditions), and subsequently different treatment implications (Brown, 2006; Holmes et al., 2005).

Detachment-type symptoms are thought to encompass more common dissociative phenomena that are characterised by detachment from different aspects of experience (i.e., subjective sense of separation or disconnection). Examples include detachment from the external world and/or reality (e.g., derealisation; Sierra & Berrios, 2000); detachment from the body and/or sense of self (e.g., depersonalisation; Coons, 1996; Simeon, 2009), and detachment from emotions (e.g., emotional numbing; Brown, 2006; Coons, 1996; Holmes et al., 2005; Simeon, 2009). Dissociative phenomena classified under compartmentalisation involve disruptions in deliberate control over typically controllable psychological functions (e.g., emotion, memory; Brown, 2006; Holmes et al., 2005). The disrupted functions are 'compartmentalised' (i.e., divided or separated off, subsequently lacking continuity and integration), operating in the absence of volitional control and accessibility, which may account for phenomena such as memory lapses in dissociative amnesia and fugue states, and separation or 'compartmentalisation' of knowledge and memories as belonging to separate identities in DID (Brown, 2006; Holmes et al., 2005).

**Function of dissociation.** While specific functions of dissociation have not been isolated, a substantial body of research spanning over a century has discussed dissociation as a response to psychological trauma, positing that it may arise in response to, and serve to distance from, negative emotions evoked by trauma (Dalenberg & Carlson, 2012; Otis, Marchand & Courtois, 2012; Platt & Freyd, 2015). Consistent with this view, DeYoung (2015) conceptualised dissociation as a “shield” from emotional pain inflicted by the trauma, which may remove the individual from fully experiencing painful affective states associated with traumatic experiences (e.g., perception that “It is not me that this is happening to, it is someone else” facilitated by depersonalisation; M. Lewis, 1995, p. 11). Similarly, Putnam (1997, p. 75) conceptualised dissociation as a “defence mechanism” that facilitates coping in the face of “psychologically overwhelming” traumatic experiences through detachment from and compartmentalisation of painful emotions and trauma-related memories, estrangement from the self, and automatising of behaviour. In a similar vein, Stein (2009, p. 324) termed dissociation an “adaptive disengagement” which protects the brain from becoming overwhelmed during severe and protracted childhood trauma, as fully experiencing and processing the trauma in its absence would otherwise “overwhelm the brain”.

**Trait and state dissociation.** With respect to measurement of dissociation in empirical research, general tendency to experience dissociative symptomatology on a day-to-day basis is referred to as “trait dissociation” (Hagenaars & Krans, 2011). Acute or in-the-moment experiences of dissociation are termed “state dissociation”, and when these experiences occur during or immediately following a traumatic event, they are referred to as “peri-traumatic dissociation” (Dorahy et al., 2017). The measurement of dissociation during experimental procedures is sometimes referred to as “peri-experimental dissociation” (Marshall, Orlando, Jaycox, Foy, & Belzberg, 2002). Peri-traumatic or peri-experimental dissociation may manifest as altered perceptions and/or reduced or absent awareness of time,

the environment, and the self (e.g., time slowing, derealisation, depersonalisation), which are considered to be common responses during traumatic experiences (Huntjens et al., 2013).

### **Relationship Between Shame and Dissociation**

A large body of empirical and treatment literature discusses both shame and dissociation as common responses to psychological trauma (La Bash & Papa, 2014; Platt et al., 2017; Thomson & Jaque, 2013), prompting empirical enquiries into the shame-dissociation relationship (Dorahy et al., 2017). Evidence suggests that trait shame and trait dissociation are elevated in individuals with trauma histories (Dutra, Bureau, Holmes, Lyubchik, & Lyons-Ruth, 2009; Kluft, 2016; Platt & Freyd, 2015), with some authors proposing that shame proneness may constitute a diathesis of dissociation, in particular among those with histories of childhood sexual abuse (Talbot, Talbot, & Tu, 2004; Thomson & Jaque 2013).

**Theoretical conceptualisations.** While conceptual understanding of the relationship between shame and dissociation remains subject to debate, existing theoretical accounts have attempted to explicate their functions in the context of trauma (Platt et al., 2017). While these conceptualisations are somewhat conflicting, they appear to converge on the notion that both shame and dissociation may serve as adaptive or protective responses during the course of chronic and inescapable trauma (e.g., childhood abuse), but become maladaptive when they persist once abuse has ceased (Freyd, 1994; Platt & Freyd, 2015).

Notably, shame proneness (i.e., chronic feelings of shame) appears to be higher among survivors of interpersonal or relational trauma (i.e., intentionally inflicted by a human perpetrator) compared to non-interpersonal trauma (e.g., natural disasters or accidents; Amstadter & Vernon, 2008; Platt & Freyd, 2015). In the context of relational trauma, such as sexual abuse perpetrated by a close figure, the role of shame may be explained as a means of preserving the relationship, particularly, if the victim depends upon the perpetrator for fulfilment of needs (e.g., child abuse perpetrated by an attachment figure; Dorahy, 2017; H.

B. Lewis, 1987). In shame, the blame and responsibility of abuse is attributed to the self, amplifying the focus on one's personal deficiency and making the self, rather than the perpetrator, the target of rage in response to the abuse (Dorahy, 2017; Platt et al., 2017).

Freyd (1996) conceptualised these processes within the Betrayal Trauma Theory (BTT). BTT posits that both shame and dissociation act to preserve the needed relationship when abuse is perpetrated by a trusted person. BTT proposes that shame may prevent the recognition of harm inflicted by a trusted abuser by leading the victim to attribute aversive feelings associated with the abuse to their own perceived defectiveness (Platt et al., 2017). Concomitantly, dissociation may minimise the victim's awareness of emotionally distressing aspects of the abusive experience (Stein, 2009), thereby allowing them to selectively attend to positive aspects of the relationship, protecting the perception of the abuser, and preserving the relationship while they depend upon the abuser for survival and/or attachment (Freyd, 1996). According to BTT, both shame and dissociation act as mechanisms of "betrayal blindness" (Platt et al., 2017), which may be adaptive in the short-term (i.e., during the course of abuse), but entail maladaptive long-term psychological consequences (Covert, Tangney, Maddux, & Heleno, 2003; Leskela et al., 2002).

BTT's notion that shame and dissociation co-occur has been supported by a growing body of research. Positive correlations between shame and dissociation have been found in non-clinical (Irwin 1998; Thomson & Jaque, 2013) and clinical (Talbot et al., 2004) samples. Further, Platt and colleagues (2017) found that state shame increased following an experimental induction of dissociative experiences among trauma survivors, providing support for BTT. Critically, this finding was interpreted as inconsistent with an alternative, albeit well-established, theory connecting shame and dissociation: the Bypassed Shame Theory (BST; H. B. Lewis, 1971). BST posits that dissociation serves as a "defence mechanism" or a means of reducing or "bypassing" the highly aversive experience of shame

associated with severe trauma (M. Lewis, 1995). Thus, from this perspective, shame should reduce, rather than increase, in the presence of dissociation.

This view is consistent with other conceptualisations of dissociation as an avoidance strategy for the painfully intolerable shame associated with overwhelming experiences of trauma. For example, within his Compass of Shame model, Nathanson (1992, p. 341) conceptualised the function of shame (i.e., view of the self as defective) in the face of ongoing childhood abuse as an “adaptive trade-off” from the risk of “abandonment and/or death” by an abusive and/or neglectful caregiver while the child depends upon them for survival. In turn, dissociation is thought to represent an avoidance coping response, by enabling avoidance and/or escape from the overwhelming experiences of shame and trauma. Similarly, Bose (2016) argues that shame may give rise to dissociation to alleviate the otherwise intolerably painful shame experiences in the context of severe relational childhood trauma. Empirical research with survivors of childhood trauma provides support for this proposed role of shame as an activator of dissociation. For example, Irwin (1998) found that shame proneness mediated the relationship between childhood trauma and dissociation (Bose, 2016; Talbot et al., 2004). However, Platt and colleagues (2017) argue that the role of dissociation as an alleviator of shame entails an assumption that increases in dissociation should produce decreases in shame, which appears to have been unsupported by growing empirical evidence suggesting that increases in dissociation are followed by increases, rather than decreases, in acute levels of shame.

**Empirical evidence.** A small but growing number of empirical studies point to a bi-directional relationship between shame and dissociation, wherein dissociation appears to increase during and/or following acute experiences of shame, and shame appears to increase with acute dissociative experiences (Dorahy, et al., 2017; McKeogh et al., 2018; Platt et al., 2017). For example, Dorahy and colleagues (2017) found that state dissociation increased

following experimental shame inductions in non-clinical and clinical samples. Although less robust, empirical findings in the opposite direction have also emerged. For example, Schultz (2018) found that acute dissociative experiences were associated with increased state shame among adults with childhood sexual abuse histories. Furthermore, McKeogh and colleagues' (2018) vignette study found that state shame increased to a greater extent following imagined dissociation in the presence of a close friend compared to when with an acquaintance or alone. In reconciling these findings, the authors hypothesised that the threat of rejection and/or relationship breakdown associated with dissociating in the context of a close relationship may have activated shame (McKeogh et al., 2018). McKeogh (2019) also found greater elevations in state shame following exposure to dissociation scripts in the presence of a significant other than alone, further pointing to possible significance of interpersonal context in the shame-dissociation relationship.

Taken together, the possibility of a bi-directional relationship between shame and dissociation suggests that dissociation may perpetuate, rather than reduce, feelings of shame, underscoring the need to consider both variables in empirical investigations seeking to minimise shame as a barrier to therapeutic interventions.

### **Review of Shame Induction Methods**

Experimental investigation of shame reduction approaches in the laboratory, which formed the central aim of the present study, requires the foundation of an effective shame induction, prompting review of shame induction methods. Previous experimental studies successfully induced shame using paradigms involving imagined shame (i.e., reading or listening to shame scenarios; e.g., De Hooge et al., 2010; Dorahy et al., 2017), experiential failure on a task (e.g., Thomaes, Bushman, Stegge, & Olthof, 2008), and recall of personally-experienced shame events (e.g., Tangney et al., 1996). For example, in De Hooge, Breugelmans, and Zeelenberg's (2008) Experiments 1 and 4, undergraduate students in the

shame condition imagined giving an oral presentation that went remarkably poorly, exposing them as incompetent, while imagined presentations of their control group counterparts went unremarkably. Those in the shame group reported significantly higher shame than control group participants, and significantly more shame than any other emotion, indicating that the induction was successful. Chao, Yang, and Chiou's (2012) Experiment 1 successfully induced shame using an easy-task failure paradigm. In the shame condition, undergraduate students were given bogus feedback advising that they had failed a reaction time task against a slow opponent, with their name displayed at the bottom of the ranking list, while those in the control condition did not receive any feedback. The vast majority of participants in the shame condition identified experiencing shame to a greater extent than any other emotion.

By contrast, De Hooge and colleagues' (2008) shame induction in Experiment 2 involved half of the participating undergraduate students writing about a personal experience of shame, while the other half wrote about a neutral event. Participants in the shame condition reported significantly higher shame than those in the neutral control group, and more shame than any other emotion. Chao and colleagues' (2012) Experiment 2 also successfully utilised the recalled induction paradigm, with participants in the shame condition (who wrote about a personally-experienced shame event), reporting significantly higher shame than those in the guilt and neutral induction conditions (who wrote about guilt or neutral events, respectively). Although imagined and failure paradigm inductions have experimental value (e.g., an identical and, thus standardised, shame induction script or failure experience across all participants), the personal experience recall induction method was deemed to better simulate real-world in-session shame disclosures, making it the most appropriate and ecologically valid induction method for the purposes of the present study.

### **The Present Study**

In light of the highlighted gap within the shame literature underscoring the need for empirical investigations into approaches to acute shame in therapeutic settings, the primary aim of the current study was to explore effective responses to shame disclosures, by experimentally investigating whether certain verbal response interventions are experienced and perceived as more helpful than others. Two fundamental assumptions underpinned and were tested by the present study: (1) that approaching shame (e.g., by thinking and writing about shame experiences) evokes in-the-moment feelings of shame; and (2) that verbal responses of individuals to whom shame experiences are disclosed (e.g., therapist, researcher) are capable of reducing state shame. Thus, different verbal responses to shame disclosures were assessed on their capability of reducing in-the-moment shame feelings assumed to accompany disclosures of shame experiences.

In light of growing empirical evidence pointing to a bi-directional relationship between shame and dissociation, suggesting that state dissociation may increase state shame, thereby perpetuating it as a barrier in therapy (Dorahy et al., 2017; McKeogh et al., 2018), the second aim of the current study was to further examine the relationship between shame and dissociation, given the therapeutic relevance of this connection. Thus, the present study sought to replicate previous findings and explore whether verbal response interventions intended to reduce state shame were capable of concurrently reducing state dissociation, by measuring effects of a shame induction and, consequently, shame reduction strategies on both state shame and state dissociation.

An experimental design was used employing the recalled shame induction paradigm that required participants to write about their own experiences of shame, followed by an experimental shame reduction intervention that intended to reduce shame through one of three verbal response types (i.e., experimental conditions; Ashamed vs. Bad vs. Tough). The

wording within these interventions was manipulated in order to test the clinically-derived hypothesis that using the word “shame” in response to shame disclosures may in itself be shame-inducing and that its synonyms may be more beneficial (Herman, 2011). More specifically, the study sought to explore whether a reflective verbal response that uses wording which labels the shame emotion (e.g., “[*feeling*] *ashamed*”) would be less likely to reduce acute feelings of shame than one that does not explicitly identify shame but captures its affective experience through a descriptive synonym (e.g., “[*feeling*] *really bad about oneself*”). These responses were further compared to a more generic reflective statement with wording that captures negative experiences more generally (e.g., “[*feeling*] *tough*”), which was intended to act as an active control condition. Additionally, the present study built upon Dorahy and colleagues’ (2014, 2017) designs with participants rating the extent to which they found helpful therapist responses they imagined in response to their *own* (versus observed) shame disclosures, which was intended to enhance the ecological validity of the ratings. Thus, the present study sought to explore possible interventions to shame through both an experiential measure of effectiveness (i.e., effect on state shame) and a subjective measure of response utility (i.e., ratings of helpfulness).

The following research questions and corresponding hypotheses were generated in light of the aforementioned goals. Hypotheses 1 and 2 were designed to evaluate the effect of verbal responses on state shame, while Hypotheses 3 and 4 aimed to test the relationship between state shame and dissociation, to address the study’s first and second aims, respectively. Hypothesis 5 was developed to generate further insights towards the first aim by exploring participants’ subjective perceptions of utility of different verbal responses.

(1) Are different verbal responses capable of reducing state shame? (i.e., Assumption 2)

*Hypothesis 1:* It was predicted that at least one of the shame reduction interventions would serve to reduce state shame (i.e., that shame would be lower post-reduction

relative to post-induction).

(2) Is using the word “shame” in response to shame disclosures less effective than using alternative responses?

*Hypothesis 2:* As per Herman’s (2011) predictions that the word “shame” may be shame-inducing and less effective than its synonyms, it was predicted that post-reduction state shame would be significantly higher in the Ashamed condition compared to the synonym and active control conditions (i.e., Bad and Tough conditions would be more effective than Ashamed condition at reducing state shame).

(3) Does increasing state shame increase state dissociation?

*Hypothesis 3:* On the basis of previous findings pointing to a causal relationship between shame and dissociation (Dorahy et al., 2017), it was predicted that higher state shame scores would predict higher state dissociation scores post-induction (i.e., a significant positive relationship between state shame and state dissociation).

(4) Are verbal responses designed to reduce state shame capable of reducing dissociation?

*Hypothesis 4:* Given the proposed bi-directional relationship between shame and dissociation, it was predicted that an intervention condition that effectively reduces state shame would concurrently reduce state dissociation (i.e., state dissociation would be significantly lower post-reduction compared to post-induction for participants in the synonym [Bad] and/or active control [Tough] conditions).

(5) Is avoiding shame in therapy perceived as less helpful than approaching shame?

*Hypothesis 5:* On the basis of Dorahy and colleagues’ (2014, 2017) findings that the Withdrawal therapist response, which enabled patients’ avoidance of shame, was the least effective response option across both non-clinical and clinical samples, it was predicted that ratings of helpfulness for the Withdrawal response would be significantly lower than those for the other response options.

## Method

### Participants

Participants were 90 university students, recruited through a student participant pool ( $n = 72$ ) and advertising posters placed on noticeboards around the university campus ( $n = 18$ ; see Appendix A), in exchange for course credit or a \$10 shopping voucher, respectively. Ethics approval was obtained from the University of Canterbury Human Ethics Committee (Appendix B) prior to commencing data collection, which was completed over a five-month period. Inclusion criteria comprised having age over 18 years, having proficiency in English, and the provision of informed consent. The final sample included 85 participants as five were excluded due to insufficient English proficiency. Participants' age ranged from 18 to 61 years ( $M = 22.71$ ,  $SD = 7.02$ ), with 61 (71.8%) participants identifying as female, and 24 (28.2%) as male. Table 1 summarises participants' demographic information.

### Design

The present study used an experimental procedure, with a 3 (Condition: Ashamed vs. Bad vs. Tough; between-subjects) x 3 (Time: Baseline vs. Post-Induction vs. Post-Reduction; within-subjects) mixed design. The main dependent variables were state shame, state dissociation, and ratings of helpfulness, while single-item emotion ratings and trait shame and trait dissociation were secondary. All dependent variables were continuous.

**Study phases.** The present study comprised four phases: (1) demographics, trait measures, and baseline state measures, (2) shame induction and post-induction state measures, (3) shame reduction and post-reduction state measures, (4) ratings of helpfulness. The Information Sheet, Consent Form, all questionnaires and rating scales, and the shame induction were completed on the Qualtrics software on a desktop computer at the research laboratory, within one experimental session. All questionnaires were counterbalanced. The primary researcher provided all verbal instructions and verbal responses across all conditions.

**Table 1**

*Descriptive Statistics for Demographic Variables Showing Numbers (n) and Percentages (%)*

*Across Conditions and the Overall Sample (N = 85)*

Demographic Characteristic	Shame (n = 27)	Bad (n = 29)	Tough (n = 29)	TOTAL (N = 85)
Mean Age (SD)	21.11 (4.05)	22.90 (8.49)	24.00 (7.51)	22.71 (7.02)
Gender				
Male	10 (37.0%)	7 (24.1%)	7 (24.1%)	24 (28.2%)
Female	17 (63.0%)	22 (75.9%)	22 (75.9%)	61 (71.8%)
Ethnicity				
NZ European	14 (51.9%)	18 (62.1%)	20 (69.0%)	52 (61.2%)
Māori	3 (11.1%)	0 (0.0%)	3 (10.3%)	6 (7.1%)
Pasifika	2 (7.4%)	5 (17.2%)	2 (6.9%)	9 (10.6%)
Asian	4 (14.8%)	1 (3.4%)	3 (10.3%)	8 (9.4%)
Other European	4 (14.8%)	5 (17.2%)	1 (3.4%)	10 (11.8%)
Education Level				
NCEA Level 3 or UE	18 (66.7%)	17 (58.6%)	19 (65.5%)	54 (63.5%)
Nat Cert/Diploma	5 (18.5%)	2 (6.9%)	7 (24.1%)	14 (16.5%)
Undergraduate Degree	2 (7.4%)	6 (20.7%)	1 (3.4%)	9 (10.6%)
Postgraduate Degree	2 (7.4%)	4 (13.8%)	2 (6.9%)	8 (9.4%)
Relationship Status				
Single	14 (51.9%)	16 (55.2%)	16 (55.2%)	46 (54.1)
In a Relationship	12 (44.4%)	10 (34.5%)	10 (34.5%)	32 (37.6%)
Engaged	0 (0.0%)	1 (3.4%)	0 (0.0%)	1 (1.2%)
Married	1 (3.7%)	2 (6.9%)	3 (10.3%)	6 (7.1%)
Mental Health Diagnosis				
Yes	9 (33.3%)	6 (20.7%)	10 (34.5%)	25 (29.4%)
No	18 (66.7%)	23 (79.3%)	19 (65.5%)	60 (70.6%)
Diagnosis Endorsed				
Anxiety disorder	7 (25.9%)	3 (10.4%)	9 (31.0%)	19 (22.4%)
Major depressive disorder	3 (11.1%)	5 (17.2%)	6 (20.7%)	14 (16.5%)
PTSD	1 (3.7%)	0 (0%)	1 (3.5%)	2 (2.4%)
Eating disorder	1 (3.7%)	0 (0%)	0 (0%)	1 (1.2%)
ADHD	1 (3.7%)	0 (0%)	0 (0%)	1 (1.2%)
Autism spectrum disorder	1 (3.7%)	0 (0%)	0 (0%)	1 (1.2%)
Conduct disorder	0 (0%)	0 (0%)	1 (3.5%)	1 (1.2%)

*Note.* SD = Standard Deviation; UE = University Entrance. Nat Cert/Diploma = National Certificate or Diploma. ADHD = Attention-deficit/hyperactivity disorder.

### **Shame Induction**

All participants underwent the shame induction procedure. The recall induction paradigm was employed as it had been successfully used to induce state shame in previous experimental studies (e.g., De Hooge et al., 2008), and was selected for two key reasons. First, it has greater ecological validity than other shame induction paradigms (e.g., imagined shame, experiential task failure), as it simulates a face-to-face therapeutic interaction; and maximising ecological validity was viewed as critical given the study's overarching aim of informing clinicians' approaches to shame in therapeutic settings. Second, it allowed the present study to test the assumption that approaching feelings of shame by thinking and writing about personal shame experiences increases in-the-moment shame feelings.

**Induction instructions.** Participants were given verbal instructions asking them to write about a time when they experienced a strong sense of shame (see Appendix C for complete verbal instructions within a detailed Procedure Script). Identical written instructions (Appendix D) were displayed on the computer throughout the induction. In order to maximise the likelihood of eliciting experiences that predominantly tapped shame (versus another self-conscious emotion; e.g., guilt, humiliation), both verbal and written instructions specified the definition of shame (i.e., *“People tend to experience shame when they have failed to achieve something they really wanted to or felt excluded from something they wanted to be a part of. For example, people describe feeling ashamed when they have failed to reach their own goals or standards or the expectations of someone else.”*). Consistent with instructions of previous studies' shame inductions (e.g., De Hooge et al., 2008, 2010; Tangney et al., 1996), participants were asked to write for approximately 10 minutes and to describe their experiences in detail.

### Shame Reduction

**Experimental conditions.** To investigate the primary aim of the present study, participants were randomly assigned to receive one of three verbal responses, which were tested as possible interventions for state shame. In Condition 1 (Ashamed), the researcher used a verbal response containing a derivative of the word “shame”, which was intended to represent Dorahy and colleagues’ (2014, 2017) theme of direct approach of shame feelings (i.e., “*It sounds like that experience makes you feel ashamed.*”). In Condition 2 (Bad), the manipulated verbal response contained a synonym that captures shame without labelling the emotion, based on the definition of shame within literature as the whole sense of self being deficient or inferior (i.e., “*It sounds like that experience makes you feel really bad about yourself*”; DeYoung, 2015). The Bad response was intended to approach shame in a less direct manner through an arguably less confronting alternative to Ashamed (Herman, 2011), forming an intermediary response on the Approach-Withdrawal continuum from Dorahy and colleagues’ (2014, 2017) studies. In Condition 3 (Tough; i.e., the active comparison condition), the verbal response did not identify any specific emotion (i.e., “*That sounds tough.*”), which constitutes a further intermediary response on the Approach-Withdrawal continuum, and lies further away from approaching shame than the Bad condition.

**Control condition considerations.** Given that Dorahy and colleagues (2014, 2017) found that the Withdrawal response (which allowed complete withdrawal from shame) was rated as unhelpful, it was not deemed ethical to knowingly subject participants to a potentially unhelpful intervention, particularly given the vulnerability associated with shame disclosures (Kaufman, 2004). Thus, the present study did not include a Withdrawal response as an experimental condition, and instead compared a condition that directly approached shame (i.e., Ashamed) to those that fell between the Approach-Withdrawal poles (i.e., Bad and Tough). In the same vein, it was not deemed ethical to have an experimental condition

that included *no* reflective response at all (i.e., a ‘pure’ control condition to control for extraneous variables). Thus, a generic reflective statement of the Tough condition was selected as an active comparison condition, as it was considered sufficiently reflective to minimise the possibility of causing harm, yet sufficiently generic to serve as an active control.

**Reduction phase instructions.** Immediately following the shame induction and post-induction measures, the researcher followed a standardised script (see Appendix C) to prompt participants to verbally describe their shame experiences. The script differed across the three experimental conditions only on the key manipulated verbal responses (i.e., Ashamed vs. Bad vs. Tough) and was otherwise identical in the effort to maximise the likelihood of equal treatment across conditions. Throughout the reduction phase, the researcher used micro-counselling skills, such as minimal encouragers (e.g., ‘yeah’, ‘uh-huh’, ‘hmm’) and ‘interested’ eye contact and body language to maintain engagement, as these are widely accepted as basic active listening skills used to convey empathy and understanding across therapeutic settings (Shea, 2016). Given that it is reasonable to expect that clinicians employ these skills in routine clinical practice, they were seen as essential components of the verbal shame disclosure interaction between the researcher and participants. Further, given the anticipated discomfort associated with disclosing shame experiences, it was viewed as essential for ethical purposes to create a sufficiently supportive space for participants to discuss their experiences.

**Experimental checks.** At the end of the study, participants were asked to select one of five response options that they believed had been used by the researcher during the reduction phase, to check whether the manipulated wording (i.e., Ashamed vs. Bad vs. Tough) was salient enough to have been noticed and subsequently recalled by participants (i.e., recognition accuracy; see Appendix E). They were also asked to select whether the

response they recalled matched how they felt, to explore whether participants perceived a match between their affect and the verbal responses (i.e., affect match).

### **Pilot Test**

Eight postgraduate psychology students participated in a pilot test, intended to explore the feasibility of the study procedure. Participants' qualitative responses on debrief indicated that the induction procedure (i.e., writing down a shame experience) evoked strong emotional responses and produced increases in subjective feelings of shame. Notably, the initial design that was tested in the pilot had used "mortified" as a synonym to the Ashamed condition (i.e., "*It sounds like that experience makes you feel mortified.*"). However, all of the pilot participants indicated that they found the word "mortified" to be highly unhelpful in response to their shame disclosures (e.g., that it was 'too intense'). Subsequently, upon extensive search through the shame literature and thesaurus for other suitable synonyms of the word "shame", "mortified" was replaced with "really bad about yourself" (i.e., the Bad condition). Instead, the Mortified response was added as a response option under ratings of helpfulness to obtain participants' perceptions of its utility as a possible alternative to the word "shame".

### **Measures**

The present study used self-report measures of trait shame, trait dissociation, state shame, and state dissociation. Additionally, two rating scales were used to measure post-induction and post-reduction state emotions (i.e., single-item emotion ratings) and participants' subjective perceptions of utility of imagined therapist responses to their shame disclosures (i.e., ratings of helpfulness). Validity items were embedded within the trait shame (i.e., "*If you have read this question, please select 'Very Much'.*") and trait dissociation (i.e., "*If you are reading this, please select 20% (third across).*") measures to evaluate whether participants were sufficiently attending to and comprehending the task, and were correctly answered by all participants.

**Demographics.** Participants completed a brief demographic questionnaire on age, gender, ethnicity, education level, relationship status, and mental health status (Appendix F). Age was recorded as a continuous variable, while all the other variables were categorical.

**Trait shame.** The Experience of Shame Scale (ESS; Andrews et al., 2002; Appendix G) is a 25-item self-report questionnaire that measures shame proneness in the domains of Characterological shame (i.e., shame related to self-evaluation, personal ability, and manner with others), Behavioural shame (i.e., shame related to mistakes and failures), and Bodily shame (i.e., shame related to self-evaluation of personal appearance). Participants rated the extent to which each of the 25 statements applied to them during the previous 12 months on a 4-point scale from 1 (*Not At All*) to 4 (*Very Much*). Total scores range from 25 to 100, with higher ratings indicating higher levels of trait shame. The ESS has high internal consistency ( $\alpha = .92$ ) and acceptable 11-week test-retest reliability ( $r = .78$  for Characterological;  $r = .74$  for Behavioural;  $r = .82$  for Bodily shame; Andrews et al., 2002). In the present study, the Cronbach's alpha coefficients were .94 for ESS Total, .91 for ESS Characterological, .88 for ESS Behavioural, and .88 for ESS Bodily.

**Trait dissociation.** The Dissociative Experiences Scale (DES; Carlson & Putnam, 1993; Appendix H) is a 28-item self-report questionnaire that measures the frequency of dissociative experiences in participants' daily life on an 11-point scale from 0% (*Never*) to 100% (*Always*). Total scores are calculated by summing item responses and dividing by the 28 items to obtain the average, with higher scores indicating higher levels of trait dissociation. The DES has high internal consistency ( $\alpha = .95$ ) and test-retest reliability ( $r = .93$ ; Dubester & Braun, 1995; Frischholz et al., 1992). Additionally, the DES also distinguishes between non-pathological and pathological dissociation using an 8-item subscale (i.e., DES-Taxon). In the present study, the Cronbach's alpha coefficients were .91 for DES Total and .71 for DES-Taxon.

**State shame.** The State Shame and Guilt Scale (SSGS; Marschall, Sanftner, & Tangney, 1994; Appendix I) is a 15-item self-report questionnaire comprising three 5-item subscales (Shame, Guilt, and Pride). The SSGS Shame subscale measures in-the-moment feelings of shame on a 5-point scale, ranging from 0 (*Not Feeling This Way At All*) to 4 (*Feeling This Way Very Strongly*), and was the only SSGS subscale utilised in the present study. Total scores range from 5 to 25, with higher scores indicating higher levels of state shame. The SSGS Shame subscale was selected as the primary measure for the state shame dependent variable for two key reasons. First, the SSGS was originally designed and validated as a manipulation check for shame inductions in experimental research, making it appropriate to administer immediately following the shame induction, and thus suitable for the current design (Marschall et al., 1994). Second, the SSGS Shame subscale items describe operationalisations of shame (i.e., affective [e.g., item 5 "*I feel worthless, powerless.*"] and behavioural [e.g., item 1 "*I want to sink into the floor and disappear.*"] experiences associated with shame), rather than explicitly including the word "shame". This covert or 'opaque' manner of measuring state shame may reduce the likelihood of participants identifying shame as the intended measured variable, which may minimise the likelihood of response bias (Turner, 2014). Its brevity also provided utility within the present experimental design, in which the SSGS state shame measure was administered at three time points. The SSGS has good internal consistency ( $\alpha = .89$ ) and good reliability for the Shame subscale ( $\alpha = .90$ ; Platt et al., 2017; Tangney & Dearing, 2002). In the present study, the Cronbach's alpha coefficients were .70 at baseline, .90 at post-induction, and .89 at post-reduction.

**State dissociation.** The Modified Peri-Traumatic Dissociative Experiences Questionnaire (PDEQ-M; Marshall et al., 2002; Appendix J) is an 8-item self-report questionnaire that measures levels of dissociation during or immediately following a specific event (e.g., state dissociation during a traumatic event or an experimental induction). Given

that the modified version of the original 10-item PDEQ had been successfully utilised in previous experimental research (Dorahy et al., 2017; Marshall et al., 2002), the PDEQ-M was selected as an appropriate measure for the state dissociation dependent variable in the present study. Participants rated the extent to which each item applied to them on a 5-point Likert scale, ranging from 1 (*Not At All True*) to 5 (*Very Much True*). Total scores range from 8-40, with higher scores indicating higher levels of peri-experimental dissociation. Marshall and colleagues' (2002) original development and validation study estimated PDEQ-M to have good internal consistency ( $\alpha = .83$ ), strong convergent validity with the original 10-item PDEQ ( $r = .89$ ), and good test-retest reliability ( $\alpha = .85$ ). In the present study, the Cronbach's alpha coefficients were .79 at baseline, .85 at post-induction, and .89 at post-reduction.

**Single-item emotion ratings.** To further explore which emotions were evoked by the shame induction, participants rated the extent to which they experienced each of the six emotions (Angry, Ashamed, Sad, Anxious, Guilty, Calm) on a 5-point scale from 0 (*Not At All*) to 4 (*Extremely*) following the shame induction and the shame reduction phases. Total scores for each emotion range from 0 to 4, with higher scores indicating higher levels of in-the-moment feelings of that emotion (see Appendix K).

**Ratings of helpfulness.** To measure subjective perceptions of response effectiveness, participants were asked to rate ten responses on a scale from 1 (*Very Unhelpful*) to 10 (*Very Helpful*), with higher scores indicating higher levels of helpfulness. Immediately prior to this, participants were verbally instructed to imagine having just shared a personal shame experience with a therapist and as though each response was said to them by their therapist in response to their own shame disclosure (see Appendix C, Phase 4 for verbal instructions).

**Approach-withdrawal responses.** Of the ten responses, five were directly taken from Dorahy and colleagues' (2014, 2017) studies (Appendix L). These responses included a 'passive' intervention component (i.e., a reflection designed to validate emotions; e.g., "*This*

*must be a very tough experience for you...*”) and an ‘active’ component (i.e., a prompt that allowed participants different degrees of withdrawal from their expressed feelings; e.g., “*Could you tell me more about what this feeling is like for you?*”). The Withdrawal response enabled complete withdrawal from shame (i.e., “*This sounds very distressing for you to discuss. Perhaps it might be best if we spoke about it when you are feeling better?*”). On the opposing end of the Approach-Withdrawal continuum, the Feeling-focused response encouraged participants to approach shame by speaking more about their immediate feelings (i.e., “*It must be very hard to feel this way about yourself. I know this may be difficult, but can you try staying with these feelings and tell me what this is like for you?*”). The three remaining responses fell between these two poles. The Cognitive-focused response asked participants to share their thoughts relating to their emotional experiences (i.e., “*It must be so difficult to think this way about yourself. I’m wondering if you can tell me more about the thoughts you have about yourself when you feel like this?*”). The Management-focused response prompted participants to discuss their strategies for managing shame states (i.e., “*This must be difficult. Perhaps you can tell me some of the things you do to try and keep these feelings and thoughts at bay?*”). The History-focused response enquired about participants’ similar past experiences (i.e., “*This must be such a tough experience for you. Does it trigger any memories of similar past experiences?*”).

**Shame alternative responses.** The other five response options aimed to compare participants’ perceived utility of responses containing synonyms of the word “shame” (Appendix L). They included the three experimental conditions (i.e., Ashamed: “*It sounds like that experience makes you feel ashamed.*”; Bad: “*It sounds like that experience makes you feel really bad about yourself.*” which was re-labelled as “Bad Self” to distinguish it from the Bad response option described below; Tough: “*That sounds tough.*”), as well as the Mortified response (i.e., “*It sounds like that experience makes you feel mortified.*”) that had

been excluded as an experimental condition following pilot testing. The final response was included to compare the utility of commenting on the core self (i.e., as in Bad Self described above) to capturing unspecified negative affect more generally (i.e., Bad: "*It sounds like that experience makes you feel really bad.*").

### **Procedure**

Table 2 depicts a summary of the study procedure, while Appendix C outlines a detailed Procedure Script. On arrival at the research laboratory, participants were given a verbal overview of the study procedure and seated at a desktop computer, on which they read the Information Sheet and Consent Form (Appendix M and N). Participants then completed the demographic questionnaire (Appendix F), the trait shame and dissociation measures (Appendix G and H), and the baseline state shame and dissociation measures (Appendix I and J). Next, following verbal instructions explaining the shame induction task, all participants wrote a detailed description of a personal shame experience for 10 minutes and completed the post-induction state shame and dissociation measures and single-item emotion ratings (Appendix K). Subsequently, all participants verbally described their shame experiences to the researcher, to which the researcher responded with a standardised response reflecting the experimental condition to which each participant was randomly assigned ( $n = 27$  in Ashamed;  $n = 29$  in Bad;  $n = 29$  in Tough). All participants subsequently completed the post-reduction state shame and dissociation measures and single-item emotion ratings. Next, all participants were verbally instructed to imagine having shared a shame experience with a therapist, before completing ratings of helpfulness (Appendix L) and the experimental checks (Appendix E). Finally, participants were verbally debriefed and provided with a Debriefing Sheet (Appendix O) outlining contact details of support services. To counter any residual negative effects of the shame induction, participants were encouraged to incorporate self-care activities in the remainder of the day and to contact support services and/or the researchers if

they required a further debrief upon the conclusion of the study. Participants were thanked for their time and given a \$10 Westfield voucher or course credit for their participation.

**Table 2**

*Procedure Summary*

Step	Procedure Component
<b>PHASE 1</b>	
1	On arrival, participant reads the Information Sheet on a desktop computer and completes an electronic Consent Form. Participant is prompted to ask questions and offered assistance with the forms.
2	Participant completes demographic questions and trait shame and dissociation measures. BASELINE MEASURES: Participant completes state shame and dissociation measures (randomised).
<b>PHASE 2</b>	
3	SHAME INDUCTION: Participant writes a detailed description of a personal experience of shame for 10 minutes following verbal instructions.
4	POST-INDUCTION MEASURES: Participant completes state shame and dissociation measures (randomised) and single-item emotion ratings.
<b>PHASE 3</b>	
5	SHAME REDUCTION: Participant describes their shame experience to the researcher. The researcher responds with standardised prompts, comprising one of the three manipulated verbal responses which reflect the participant's experimental condition (i.e., Ashamed, Bad, or Tough).
6	POST-REDUCTION MEASURES: Participant completes state shame and dissociation measures (randomised) and single-item emotion ratings.
<b>PHASE 4</b>	
7	RATINGS OF HELPFULNESS: Participant is given verbal instructions to imagine having shared a shame experience with a therapist. Participant completes ratings of helpfulness and experimental checks.
<b>DEBRIEF</b>	
8	Participant is verbally debriefed and provided with a Debriefing Sheet.
9	Participant is thanked for their time and given a \$10 voucher or course credit.

### Data Analysis

Data were analysed using the Statistical Package for Social Sciences (IBM® SPSS® Statistics Version 25). Threshold for statistical significance was set at the  $p = < .05$  level, and Pillai's Trace was used as the test statistic for Multivariate Analysis of Variance (MANOVA) tests. The Bonferroni test was used for all post-hoc comparisons. Differences across the three experimental conditions (i.e., Ashamed, Bad, Tough) for demographic and trait variables were examined using Pearson Chi-Square, analysis of variance (ANOVA), and MANOVA analyses. The experimental induction manipulation check was conducted by examining the capacity of the shame induction to induce state shame, using a 3 (Condition: Ashamed, Bad, Tough) by 2 (Time: Baseline, Post-Induction) mixed ANOVA. To evaluate effects of the three shame reduction interventions on state shame and dissociation, two separate 3 (Condition: Ashamed, Bad, Tough) by 2 (Time: Post-Induction, Post-Reduction) mixed ANOVA analyses were performed on SSGS and PDEQ-M scores, respectively. Pearson correlations between SSGS and PDEQ-M scores were computed at post-induction and post-reduction. Effects of the shame induction and shame reduction interventions on single-item emotion ratings were examined using mixed MANOVA analyses and (two-tailed) paired samples  $t$ -tests. Ratings of helpfulness were analysed using repeated measures MANOVA analyses and (two-tailed) paired samples  $t$ -tests.

## Results

### Demographics and Trait Measures

A univariate between-subjects ANOVA showed that there were no significant differences in age across the three experimental conditions (i.e., Ashamed, Bad, Tough),  $F(2, 84) = 1.21, p = .31, \eta_p^2 = .03$ . Pearson Chi-Square analyses yielded no significant differences between groups in gender,  $\chi^2(2, N = 85) = 1.51, p = .47$ , or mental health status,  $\chi^2(2, N = 85) = 1.62, p = .44$ . Due to low cell count in several cells, ethnicity, relationship status, and education level were not subjected to Chi-Square analyses, but were generally similar across conditions (see Table 1). A one-way between-subjects ANOVA and a one-way between-subjects MANOVA showed that there were no significant differences in ESS Total scores,  $F(2, 82) = 1.85, p = .16, \eta_p^2 = .04$ , and ESS subscale scores (i.e., characterological, behavioural, and bodily shame),  $F(6, 162) = 1.15, p = .34, \eta_p^2 = .04$ , between the three conditions (see Table 3 for descriptive statistics for all trait and state measures). Similarly, a one-way between-subjects MANOVA showed that there were no significant differences between groups in DES Total and DES-Taxon scores,  $F(4, 164) = 0.74, p = .57, \eta_p^2 = .02$ . Taken together, results of these analyses suggest that the three experimental conditions were equal with respect to demographic characteristics and trait shame and trait dissociation.

### Manipulation Check and Test of Assumption 1

**Post-induction ANOVA on SSGS.** To evaluate whether the shame induction was capable of inducing state shame and thereby test Assumption 1 (i.e., that recalling and writing about a personal shame experience increases state shame), a 3 (Condition: Ashamed, Bad, Tough) by 2 (Time: Baseline, Post-Induction) mixed ANOVA was performed on SSGS scores. This yielded a significant main effect for Time,  $F(1, 82) = 39.46, p < .001, \eta_p^2 = .33$ , indicating that state shame was significantly higher post-induction compared to baseline (see Table 3), and that the shame induction was successful. There was no significant main effect

for Condition,  $F(2, 82) = 0.94, p = .40, \eta_p^2 = .02$ , and no significant Time by Condition interaction,  $F(2, 82) = 1.61, p = .21, \eta_p^2 = .04$ , indicating that levels of induced shame did not differ across the three conditions, which was to be expected given that all three groups underwent the same shame induction procedure.

**Table 3***Descriptive Statistics for Trait and State Measures Across Conditions*

Measure	Ashamed <i>M (SD)</i>	Bad <i>M (SD)</i>	Tough <i>M (SD)</i>	TOTAL <i>M (SD)</i>
ESS Total	62.89 (14.57)	58.31 (14.08)	65.66 (15.35)	62.27 (14.83)
ESS Characterological	29.52 (8.29)	26.07 (6.95)	30.24 (8.07)	28.59 (7.91)
ESS Behavioural	22.85 (4.89)	22.55 (6.17)	24.59 (6.13)	23.34 (5.78)
ESS Bodily	10.52 (3.84)	9.69 (3.53)	10.83 (3.27)	10.34 (3.54)
DES Total	20.71 (14.07)	16.18 (10.25)	20.27 (12.30)	19.02 (12.29)
DES-Taxon	12.78 (13.90)	8.92 (10.20)	11.25 (10.12)	10.94 (11.46)
SSGS Baseline	6.93 (2.45)	6.10 (1.70)	6.28 (2.22)	6.42 (2.14)
SSGS Post-Induction	9.11 (4.49)	8.07 (3.53)	9.90 (5.71)	9.02 (4.68) *
SSGS Post-Reduction	10.22 (5.42)	9.07 (3.58)	10.72 (5.81)	10.00 (5.01) *
PDEQ-M Baseline	11.74 (4.03)	11.97 (4.74)	10.72 (3.27)	11.47 (4.05)
PDEQ-M Post-Induction	13.22 (5.85)	11.93 (4.39)	12.66 (5.47)	12.59 (5.22) *
PDEQ-M Post-Reduction	13.07 (6.23)	10.79 (3.94)	12.62 (5.81)	12.14 (5.42)

*Note.* \* indicates statistically significant changes from Baseline to Post-Induction or Post-Induction to Post-Reduction at  $p < .05$ .

**Post-induction single-item emotion ratings.** As a further test of the shame induction effectiveness, participants' subjective ratings of six emotions were compared following the induction. A 3 (Condition: Ashamed, Bad, Tough) by 6 (Emotion: Angry, Ashamed, Sad, Anxious, Guilty, Calm) mixed MANOVA on post-induction single-item emotion ratings yielded a significant multivariate effect for Emotion,  $F(5, 78) = 17.79, p < .001, \eta_p^2 = .53$ , but a non-significant Emotion by Condition interaction,  $F(5, 158) = 1.42, p = .18, \eta_p^2 = .08$ . The

main effect for Condition was also non-significant,  $F(2, 82) = 1.04, p = .36, \eta^2 = .03$ .

Regarding the Emotion main effect, post-hoc (two-tailed) paired samples  $t$ -tests showed that participants' ratings for Ashamed were significantly higher than those for Guilty,  $t(84) = 6.90, p < .001$ , Anxious,  $t(84) = 5.86, p < .001$ , and Angry,  $t(84) = 6.69, p < .001$ , but not significantly different from ratings for Sad,  $t(84) = 0.11, p = .92$ , or Calm,  $t(84) = 1.70, p = .09$  (see Table 4). Ratings for Sad were significantly higher than those for Angry,  $t(84) = 7.13, p < .001$ , Anxious,  $t(84) = 5.09, p < .001$ , and Guilty,  $t(84) = 5.34, p < .001$ , while ratings for Calm were significantly higher than those for Guilty,  $t(84) = 2.38, p = .02$ , and Angry,  $t(84) = 2.58, p = .01$ . There were no other statistically significant differences between the remaining pairs of emotion ratings (all  $ps > .07$ ). Taken together, these results suggest that, following the shame induction involving recall of a personal shame experience, participants across all three conditions uniformly experienced an increase in state shame, and reported feeling more shame than guilt, anxiety, and anger.

**Table 4**

*Descriptive Statistics for Single-Item Emotion Ratings Across Time by Condition*

Emotion		Ashamed <i>M (SD)</i>	Bad <i>M (SD)</i>	Tough <i>M (SD)</i>	TOTAL <i>M (SD)</i>
Angry	Post-Induction	1.19 (1.21)	1.10 (1.24)	1.14 (1.36)	1.14 (1.26)
	Post-Reduction	0.74 (0.98)	0.62 (0.86)	0.45 (1.06)	0.60 (0.97) *
Ashamed	Post-Induction	2.26 (0.98)	1.83 (1.17)	2.10 (1.24)	2.06 (1.14)
	Post-Reduction	2.00 (1.24)	1.79 (1.18)	2.03 (1.30)	1.94 (1.23)
Sad	Post-Induction	2.00 (1.21)	1.97 (1.32)	2.17 (1.26)	2.05 (1.25)
	Post-Reduction	1.78 (1.22)	1.69 (1.47)	1.90 (1.40)	1.79 (1.36) *
Anxious	Post-Induction	1.44 (1.19)	0.83 (0.97)	1.69 (1.17)	1.32 (1.16)
	Post-Reduction	2.07 (1.47)	1.24 (1.30)	1.86 (1.16)	1.72 (1.34) *
Guilty	Post-Induction	1.30 (1.27)	0.86 (1.25)	1.38 (1.35)	1.18 (1.29)
	Post-Reduction	1.22 (1.48)	0.86 (1.25)	1.21 (1.35)	1.09 (1.35)
Calm	Post-Induction	1.44 (1.19)	2.00 (1.17)	1.62 (1.05)	1.69 (1.15)
	Post-Reduction	1.33 (1.11)	1.76 (0.99)	1.45 (1.09)	1.52 (1.07)

*Note.* \* indicates significant changes from Post-Induction to Post-Reduction at  $p < .05$ .

### Test of Hypotheses 1 and 2: Effect of Verbal Responses on State Shame

**Post-reduction ANOVA on SSGS.** To examine whether verbal responses comprising the shame reduction interventions have the capacity to reduce state shame (i.e., Hypothesis 1 and Assumption 2), and to test whether the verbal response containing the word “shame” was less effective than alternatives (i.e., Hypothesis 2), a 3 (Condition: Ashamed, Bad, Tough) by 2 (Time: Post-Induction, Post-Reduction) mixed ANOVA was performed on SSGS scores. This yielded a significant main effect for Time,  $F(1, 82) = 7.52, p = .008, \eta_p^2 = .08$ , indicating that participants’ state shame scores were significantly higher post-reduction compared to post-induction (see Table 3 and Figure 1). No significant main effect for Condition,  $F(2, 82) = 1.08, p = .34, \eta_p^2 = .03$ , nor Time by Condition interaction,  $F(2, 82) = 0.05, p = .95, \eta_p^2 = .001$ , were evident. Overall, these results suggest that state shame appears to have increased following the shame reduction phase equally across the three conditions. As for Hypothesis 1, none of the three assessed verbal response interventions appeared to demonstrate a capacity to reduce state shame. As for Hypothesis 2, the Ashamed condition appeared to be no better or worse at reducing state shame than the Bad and Tough conditions.

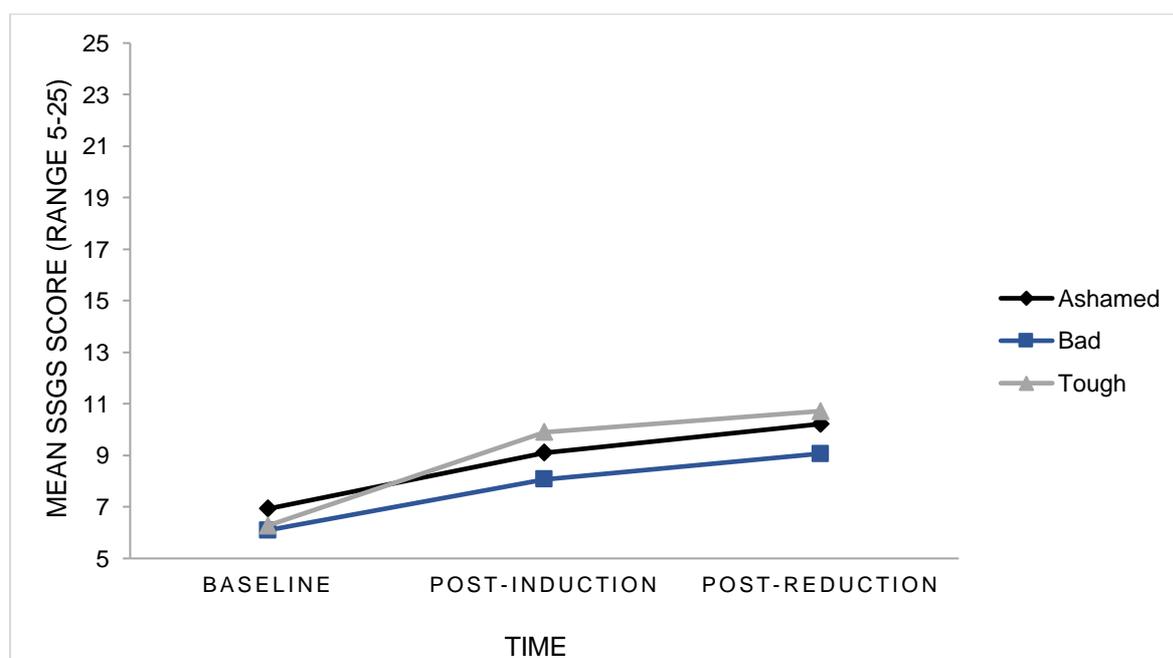


Figure 1. Mean SSGS Scores Across Time by Condition.

**Post-reduction single-item emotion ratings.** To further investigate the effect of the shame reduction interventions on participants' emotional states, the six single-item emotion ratings were compared using a 3 (Condition: Ashamed, Bad, Tough) by 2 (Time: Post-Induction, Post-Reduction) mixed MANOVA. This yielded a statistically significant multivariate effect for Time,  $F(6, 77) = 9.21, p < .001, \eta_p^2 = .42$ , but no significant main effect for Condition,  $F(12, 156) = 1.11, p = .36, \eta_p^2 = .08$ , and no significant Time by Condition interaction,  $F(12, 156) = 0.43, p = .95, \eta_p^2 = .03$ . This indicated that ratings for some emotions changed from post-induction to post-reduction, and that this effect did not differ across the three conditions (see Table 4 and Figure 2). Univariate analyses for Time showed a significant decrease in participants' single-item ratings of Angry,  $F(1, 82) = 22.95, p < .001, \eta_p^2 = .22$ , and Sad,  $F(1, 82) = 5.77, p = .02, \eta_p^2 = .07$ , and a significant increase in ratings of Anxious,  $F(1, 82) = 11.98, p = .001, \eta_p^2 = .13$ , from post-induction to post-reduction. There was no statistically significant change in ratings of Ashamed,  $F(1, 82) = 1.41, p = .24, \eta_p^2 = .02$ , Guilty,  $F(1, 82) = 0.87, p = .35, \eta_p^2 = .01$ , and Calm,  $F(1, 82) = 2.27, p = .14, \eta_p^2 = .03$ . Taken together, these results appear to suggest that all three shame reduction interventions failed to produce reductions in state shame (as measured by the SSGS and the single-item Ashamed rating), but may have had a uniform impact on other emotions (i.e., anger, sadness, anxiety).

### **Experimental Checks**

**Recognition accuracy.** To assess whether the manipulated wording of the three shame reduction interventions (i.e., Ashamed, Bad, Tough) was sufficiently noticeable to be remembered and/or detected by participants, participants' ability to accurately recognise the wording of the researcher's verbal response to their shame disclosure (by selecting it from a list of options) was analysed. Overall, 68.2% ( $n = 58$ ) of the total sample ( $N = 85$ ) correctly recalled the wording that corresponded to their assigned condition (see Table 5). A Pearson

Chi-Square showed a significant difference across the three conditions (i.e., Ashamed, Bad, Tough),  $\chi^2(2, N = 85) = 18.79, p < .001$ , wherein 81.5% of participants in the Ashamed condition correctly recognised having heard the corresponding manipulated response (i.e., “*It sounds like that experience makes you feel ashamed.*”), compared to 86.2% of those in the Tough condition and 37.9% of those in the Bad condition. Seemingly, the wording “really bad about yourself” within the Bad condition (i.e., “*It sounds like that experience makes you feel really bad about yourself.*”) was less memorable than “ashamed” and/or “tough”.

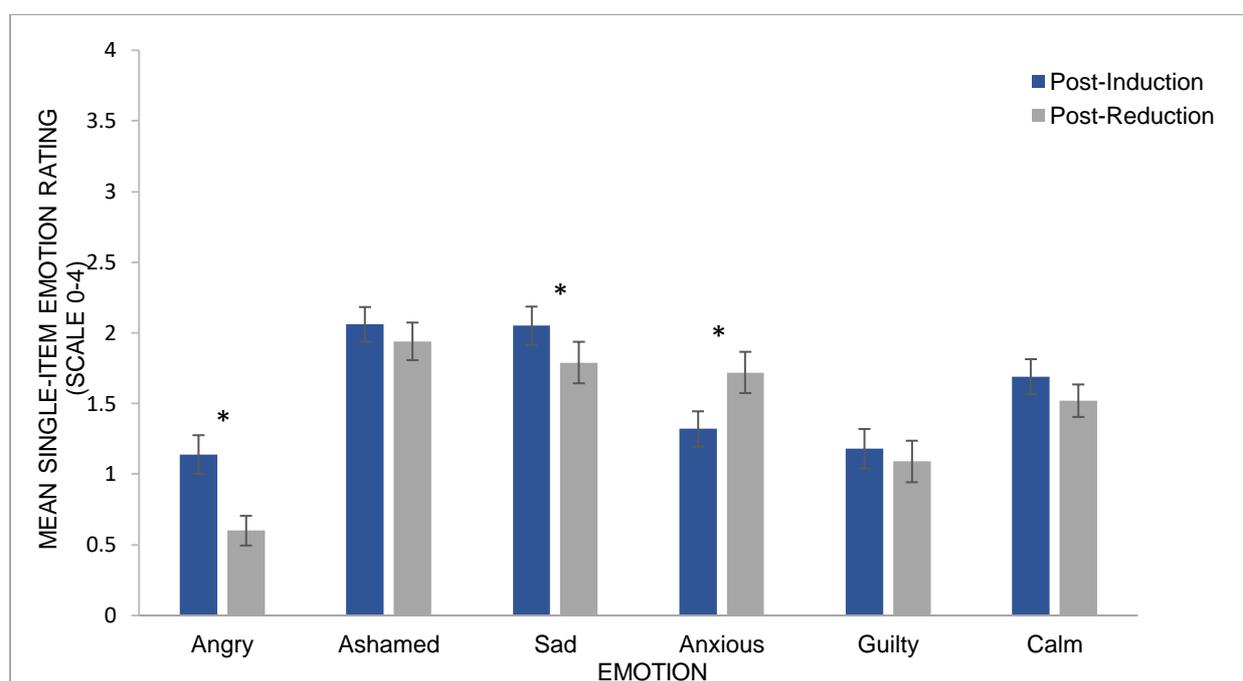


Figure 2. Mean Single-Item Emotion Ratings at Post-Induction and Post-Reduction.

\* indicates that the change across time was statistically significant (all  $p$ s < .05).

**Affect match.** To explore whether the manipulated verbal responses tended to match participants’ experienced affect, proportions of participants who indicated that the wording of their received intervention matched how they felt were examined. Overall, 88.2% ( $n = 75$ ) of the total sample ( $N = 85$ ) endorsed an affect match (see Table 5). A Pearson Chi-Square showed that there were no significant differences across the three conditions,  $\chi^2(2, N = 85) = 0.36, p = .84$ , indicating that, irrespective of the manipulated wording, the vast majority of participants felt that the intervention they received captured their internal experiences.

**Table 5***Descriptive Statistics for Experimental Checks Across Conditions*

Experimental Check	Ashamed <i>n</i> (%)	Bad <i>n</i> (%)	Tough <i>n</i> (%)	TOTAL <i>N</i> (%)
Recognition Accuracy				
Correct	22 (81.5%)	11 (37.9%)	25 (86.2%)	58 (68.2%)
Incorrect	5 (18.5%)	18 (62.1%)	4 (13.8%)	27 (31.8%)
Affect Match				
Yes	23 (85.2%)	26 (89.7%)	26 (89.7%)	75 (88.2%)
No	4 (14.8%)	3 (10.3%)	3 (10.3%)	10 (11.8%)

**Test of Hypotheses 3 and 4: Relationship Between State Shame and Dissociation**

**Post-induction ANOVA on PDEQ-M.** To evaluate the effect of the shame induction on state dissociation and thereby test Hypothesis 3, a 3 (Condition: Ashamed, Bad, Tough) by 2 (Time: Baseline, Post-Induction) mixed ANOVA was performed on PDEQ-M scores (see Table 3). This yielded a significant main effect for Time,  $F(1, 82) = 4.32, p = .04, \eta_p^2 = .05$ , with higher scores post-induction, but no significant main effect for Condition,  $F(2, 82) = 0.29, p = .75, \eta_p^2 = .01$ , or Time by Condition interaction,  $F(2, 82) = 1.23, p = .30, \eta_p^2 = .03$ , indicating that state dissociation was significantly higher post-induction compared to baseline uniformly across conditions (see Figure 3 for graph depicting changes in state dissociation across time by condition). Thus, given that state shame was effectively induced post-induction, state dissociation appeared to elevate in response to state shame. A Pearson correlation analysis found a statistically significant positive correlation between state shame and state dissociation,  $r(85) = .60, p < .001$ , where higher post-induction SSGS scores were associated with higher post-induction PDEQ-M scores. Taken together, these results appear to suggest that state dissociation was elevated in those experiencing higher state shame via a shame induction.

**Post-reduction ANOVA on PDEQ-M.** To examine the effect of the experimental shame reduction interventions (i.e., verbal response conditions) on state dissociation and thereby test Hypothesis 4, a 3 (Condition: Ashamed, Bad, Tough) by 2 (Time: Post-Induction, Post-Reduction) mixed ANOVA was performed on PDEQ-M scores (see Table 3). There was no statistically significant main effect for Time,  $F(1, 82) = 1.07, p = .31, \eta^2 = .01$ , or Condition,  $F(2, 82) = 0.98, p = .38, \eta^2 = .02$ , and no Time by Condition interaction,  $F(2, 82) = 0.69, p = .51, \eta^2 = .02$ . This indicates that participants' levels of state dissociation did not change to a statistically significant degree from post-induction to post-reduction, and that there was no differential impact of the three reduction intervention strategies on state dissociation. Notably, state shame and state dissociation were moderately positively correlated at post-reduction,  $r(85) = .67, p < .001$ , at a similar strength to post-induction. With respect to Hypothesis 4, this may indicate that the three evaluated shame reduction interventions did not demonstrate a capacity to reduce state dissociation, perhaps because they did not reduce state shame. Taken together, results of these analyses point towards a relationship between state shame and dissociation.

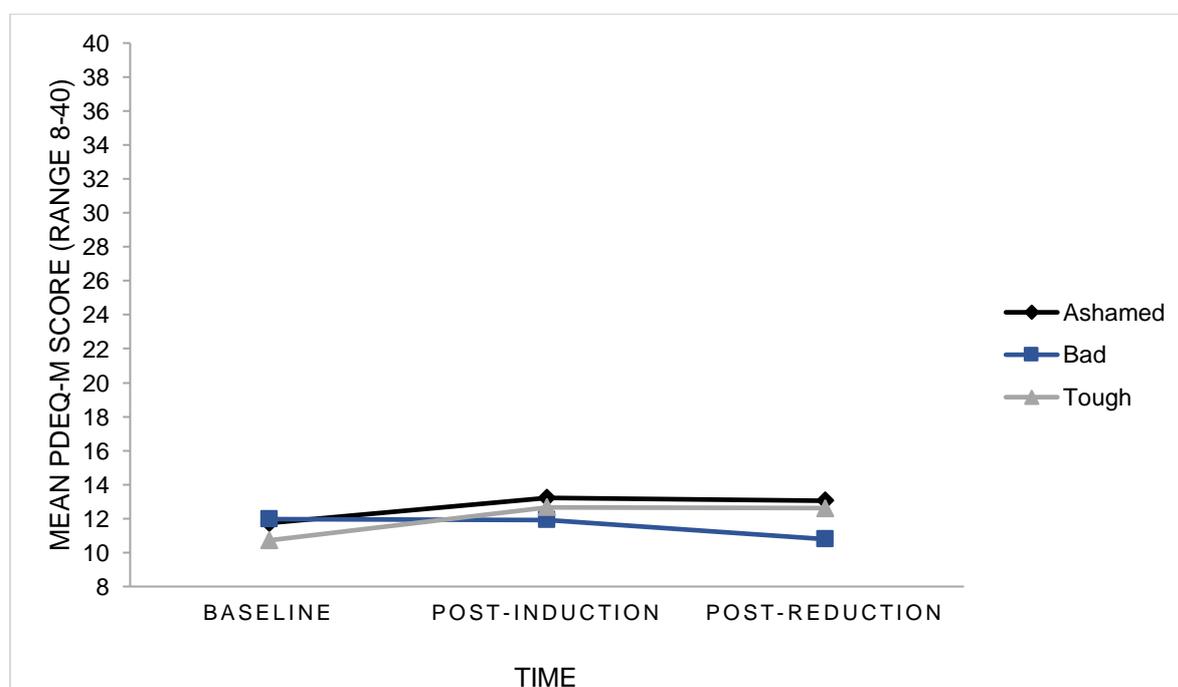


Figure 3. Mean PDEQ-M Scores Across Time by Condition.

**Test of Hypothesis 5: Ratings of Helpfulness**

**Approach-withdrawal responses.** To explore participants’ subjective perceptions of effectiveness of imagined therapist responses to their shame disclosures and to test Hypothesis 5 (i.e., that offering withdrawal from shame would be rated as less helpful), a one-way repeated measures MANOVA was performed on ratings of helpfulness of the five Approach-Withdrawal responses (i.e., Withdrawal, Feeling-focused, Cognitive-focused, Management-focused, History-focused), which yielded a significant main effect for Response Type,  $F(4, 81) = 39.35, p < .001, \eta^2 = .56$ . Post-hoc (two-tailed) paired samples *t*-tests showed that participants’ ratings for Withdrawal were significantly lower than those for all other response options (see Table 6 and Figure 4 for descriptive statistics and graph, respectively). That is, the Withdrawal response was rated as significantly lower than the Feeling-focused,  $t(84) = -7.89, p < .001$ , Cognitive-focused,  $t(84) = -7.88, p < .001$ , Management-focused,  $t(84) = -10.20, p < .001$ , and History-focused,  $t(84) = -7.96, p < .001$ , responses. No other pairs of Approach-Withdrawal responses were significant (all *ps* > .39).

**Table 6**

*Descriptive Statistics for Ratings of Helpfulness Across Conditions*

Therapist Response Type	Ashamed <i>M (SD)</i>	Bad <i>M (SD)</i>	Tough <i>M (SD)</i>	TOTAL <i>M (SD)</i>
<b>Approach-Withdrawal Responses</b>				
Withdrawal	3.81 (2.63)	3.62 (2.65)	3.72 (2.71)	3.72 (2.64)
Feeling-Focused	6.19 (2.04)	6.93 (2.20)	6.62 (2.37)	6.59 (2.21)
Cognitive-Focused	6.00 (2.06)	6.97 (1.86)	6.66 (2.32)	6.55 (2.10)
Management-Focused	6.48 (2.19)	6.90 (2.21)	6.97 (2.37)	6.79 (2.24)
History-Focused	6.37 (2.02)	6.66 (1.93)	6.97 (2.32)	6.67 (2.09)
<b>Shame Alternative Responses</b>				
Ashamed	4.85 (2.20)	4.86 (2.84)	4.41 (2.61)	4.71 (2.55)
Bad Self	4.67 (2.45)	5.21 (2.65)	4.07 (2.73)	4.65 (2.63)
Tough	3.96 (2.68)	5.34 (3.22)	5.00 (3.17)	4.79 (3.06)
Mortified	3.11 (1.89)	3.03 (2.18)	2.55 (1.72)	2.89 (1.93)
Bad	4.37 (2.04)	4.69 (2.21)	4.48 (2.79)	4.52 (2.35)

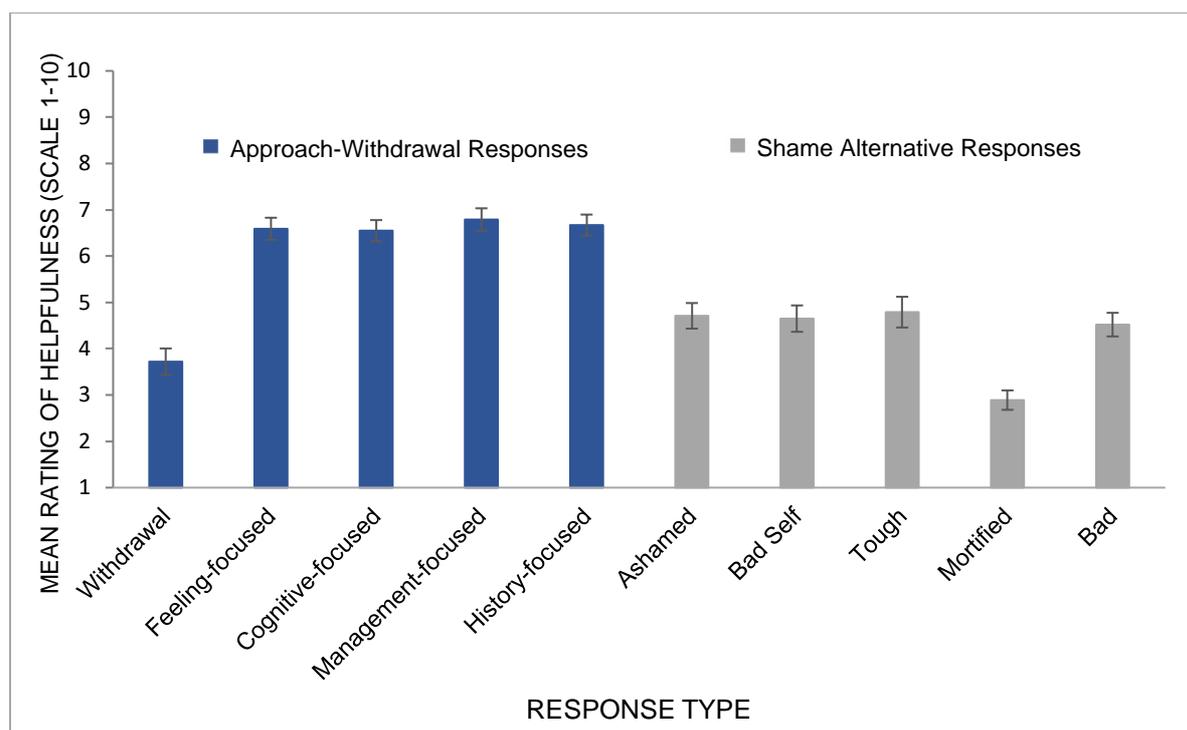


Figure 4. Mean Ratings of Helpfulness as a Function of Response Type.

**Shame alternative responses.** To compare participants' subjective perceptions of the wording within the shame reduction interventions utilised in the present study and to further test Hypothesis 2 (i.e., that using the word "shame" in response to shame disclosures would be less effective than its synonyms), a one-way repeated measures MANOVA was performed on ratings of helpfulness of the five Shame Alternative responses (i.e., Ashamed, Bad Self, Tough, Mortified, Bad). This yielded a statistically significant main effect for Response Type,  $F(4, 81) = 20.39, p < .001, \eta_p^2 = .50$ . Post-hoc (two-tailed) paired samples *t*-tests showed that participants' ratings for Mortified were significantly lower than those for all other response options (see Table 6 and Figure 4). That is, the Mortified response was rated as significantly lower than the Ashamed,  $t(84) = -7.27, p < .001$ , Bad Self,  $t(84) = -6.76, p < .001$ , Tough,  $t(84) = -5.23, p < .001$ , and Bad,  $t(84) = -6.48, p < .001$ , responses. No other pairs of Shame Alternative responses were statistically significant (all  $ps > .47$ ).

**Comparisons across response types.** To explore whether participants' perceived helpfulness of imagined therapist responses differed from that of responses evaluated in the

present shame reduction interventions, a one-way repeated measures MANOVA was performed on ratings of helpfulness of all Approach-Withdrawal responses and Shame Alternative responses excluding Withdrawal and Mortified as both were found to be unhelpful in the previous analyses. This yielded a significant main effect for Response Type,  $F(7, 78) = 15.78, p < .001, \eta_p^2 = .59$ . Post-hoc (two-tailed) paired samples *t*-tests showed that each of the four analysed Shame Alternative responses (i.e., Ashamed, Bad Self, Tough, Bad) was significantly lower than each of the four analysed Approach-Withdrawal responses (i.e., Feeling-focused, Cognitive-focused, Management-focused, History-focused; see Table 6 and Figure 4). That is, participants' ratings for Ashamed were significantly lower than those for Feeling-focused, Cognitive-focused, Management-focused, and History-focused (all  $ps < .001$ ). Ratings for Bad Self were significantly lower than those for Feeling-focused, Cognitive-focused, Management-focused, and History-focused (all  $ps < .001$ ). Ratings for Tough were significantly lower than those for Feeling-focused, Cognitive-focused, Management-focused, and History-Focused (all  $ps < .001$ ). Ratings for Bad were significantly lower than those for Feeling-focused, Cognitive-focused, Management-focused, and History-focused (all  $ps < .001$ ). No other pairs of Approach-Withdrawal responses or Shame Alternative responses subjected to *t*-test analyses were statistically significant (all  $ps > .47$ ).

Taken together, results of these comparisons appear to suggest that Approach-Withdrawal responses, which contained a reflective statement and an 'active' intervention component prompting further discussion in a form of a question, appeared to be rated as more helpful than Shame Alternative responses, which contained a reflective statement only. Critically, with respect to Hypothesis 2, the Ashamed response option was not rated as less or more helpful than any of the alternative responses intended to serve as synonyms of the word "shame".

## Discussion

### Overview

The primary aim of the present study was to evaluate the effect of verbal response interventions on state shame following personal shame disclosures, as well as obtaining subjective ratings of helpfulness of potential therapeutic responses. Additionally, the study's secondary aim sought to examine the relationship between state shame and state dissociation.

Consistent with previous experimental research utilising the recalled shame paradigm (e.g., De Hooge et al., 2008, 2010), the present study's shame induction successfully increased state shame, providing support for the first fundamental assumption that recalling and writing about personal shame experiences increases in-the-moment shame feelings.

Contrary to predictions, none of the three evaluated verbal response interventions appeared to demonstrate a capacity to reduce state shame, thereby failing to provide support for Hypothesis 1 and the study's second assumption that verbal responses to shame disclosures are capable of reducing acute shame feelings. Conversely, state shame appeared to increase, rather than decrease, following the shame reduction phase across all three conditions.

Accordingly, Hypothesis 2 was not supported as the verbal response condition containing the word "shame" (i.e., Ashamed) was no more or less effective than conditions containing related synonyms (i.e., Bad and Tough). As predicted by Hypothesis 3, state dissociation increased following the shame induction. However, contrary to Hypothesis 4, verbal response interventions did not demonstrate a capacity to reduce state dissociation. Interestingly, unlike state shame, state dissociation did not increase from post-induction to post-reduction, despite moderate positive correlations between state shame and dissociation at both post-induction and post-reduction. Finally, as predicted by Hypothesis 5, the Withdrawal response was rated as less helpful than the other therapist responses. The ensuing discussion outlines detailed interpretations of these findings, integrated with existing theoretical and empirical literature.

### Effects of Verbal Responses

**Capacity of verbal responses to reduce state shame.** Two major non-mutually exclusive possibilities may account for the unexpected findings of increased state shame post-reduction relative to post-induction. In the first, verbal responses comprising the shame reduction interventions may have served to heighten, rather than alleviate, acute feelings of shame. In the second, some other factor(s) during the verbal exchange between participants and the researcher may have served to intensify state shame beyond effects of the written shame induction. For example, the process of having to verbally describe their shame experiences to the researcher may have further elevated shame. Critically, as state shame was not measured immediately following the verbal disclosure, the post-reduction state shame measure reflects effects of both verbally expressing shame and receiving verbal responses. Thus, it is not possible to disentangle whether either or both of these processes increased state shame. Yet, the possibility that verbal response interventions may have actually served to *reduce* state shame to some degree (and therefore do possess such capacity) cannot be discounted, as their true effect may have been concealed by possible amplification of shame following participants' verbal disclosures, as illustrated by the following possible scenarios.

First, telling the researcher about one's shame experience may have had no or some impact on further heightening state shame, while the researcher's verbal responses themselves may have increased state shame, leading to increased shame post-reduction. Second, telling the researcher may have intensified state shame over and above acute levels of shame evoked through the process of writing about the shame experience (i.e., the shame induction), while verbal response interventions may have had no influence on (i.e., neither reducing nor further increasing) state shame, leading to increased shame post-reduction relative to post-induction subsequent to the verbal disclosure alone. Third, telling the researcher may have considerably amplified state shame relative to post-induction, and while

verbal response interventions may have had some alleviating impact on state shame, this may have been insufficient to compensate for the post-telling shame elevation, with a net effect of increased shame post-reduction.

The proposed possibility that participants' acute shame feelings may have increased in the process of verbally expressing their shame experiences to the researcher is consistent with theoretical and phenomenological understanding of shame and its disclosures within literature (i.e., that shame elevates when it is shared with another; Herman, 2011, Nathanson, 1992). Accordingly, it would seem plausible that telling another about one's shame experience may produce more potent feelings of shame than merely thinking and writing about that experience on one's own, perhaps due to additional (e.g., interpersonal) factors. Indeed, previous empirical findings suggest that state shame increases to a greater extent in the presence of others than alone in response to dissociation inductions (McKeogh et al., 2018; McKeogh, 2019). In keeping with conceptual definitions of shame, it is possible that individuals may feel vulnerable, exposed, and/or inferior upon revealing their perceived flaws, and/or subsequently fear negative evaluation while verbally disclosing personal shame experiences, which may intensify in-the-moment feelings of shame, as suggested by findings of Schultz's (2018) enquiry into possible reasons for shame during the dissociation induction.

Concurrently, it is also possible that verbal responses themselves may have heightened acute shame feelings. For example, shame may have increased if the specific evaluated responses were insufficiently powerful to reduce state shame and/or perceived as unhelpful due to their content and/or delivery by the researcher. Indeed, given that the same non-blind researcher delivered all responses, researcher characteristics (e.g., tone, demeanour, empathy) may not be ruled out as potential contributing variables. With respect to response content, integrating findings of observed changes in state shame with participants' subjective ratings of helpfulness, tentative conclusions of current findings may

be that more active engagement involving follow-up questions beyond reflective statements alone would have been more beneficial, as all Approach-Withdrawal responses, which contained ‘active’ prompts that encouraged further approach of shame, were rated as more helpful than all Shame Alternative responses, which contained ‘passive’ reflective statements only and constituted the evaluated reduction interventions. Notably, experiential effects of Approach-Withdrawal responses on state shame were not directly tested in the present study.

Critically, further research is needed to disentangle effects of shame reduction interventions from those of verbal disclosures of shame experiences. The present design precluded measurement of state shame immediately following participants’ verbal accounts of shame experiences as this would have disrupted the natural flow of a face-to-face shame disclosure exchange, compromising ecological validity. To address this concern, future studies could include a non-verbal measure of shame, such as eye gaze diversion (e.g., Dorahy et al., 2017), as this would enable measurement of state shame during and following the shame disclosure without requiring disengagement from the task to complete self-report measures. Additionally, inclusion of such observer-rated, and thus arguably more objective, state shame measure would strengthen future experimental designs by minimising response bias and other drawbacks associated with relying on self-report alone in the measurement of shame (Andrews, 1998; Platt et al., 2017). Incidentally, comparing levels of state shame following the written shame induction to those following the verbal shame disclosure would enable future studies to verify the assumption inherent in the literature that talking about shame experiences heightens acute shame feelings.

Notably, as the present design did not have a true control condition, causal influences of verbal responses cannot be inferred, further limiting conclusions concerning their capacity to affect state shame. Although the Tough condition was intended to act as an active comparison condition, it is possible that it did not differ sufficiently from the other

experimental conditions. It could be that relative to saying nothing at all (i.e., a true control), using any of the three evaluated responses would have been significantly more helpful, which may (or may not) have illuminated that they exerted some beneficial effect on state shame. Additionally, common factors (e.g., opportunity to share an adverse experience with someone who was actively listening, passage of time), rather than the experimentally manipulated wording of the verbal responses, may have influenced state shame post-reduction, and could not be controlled for without a true control condition. To address ethical concerns associated with providing *no* response to shame disclosures, future experimental studies could employ a control condition with a minimal acknowledging response (e.g., “*Thank you for sharing.*”).

**Effect of wording.** Findings that the Ashamed condition did not differ from conditions utilising its synonyms (i.e., Bad and Tough) are inconsistent with Herman’s (2011) predictions that using the word “shame” in response to shame disclosures is likely to be more shame-inducing than its alternatives. A possible account of these findings may be that wording of verbal responses may not differentially impact state shame. Within Dorahy and colleagues’ (2014, 2017) Approach-Withdrawal continuum conceptualisation, this could imply that approaching shame directly (e.g., by labelling the shame emotion, as in Ashamed) may not be less effective or more shame-inducing (nor subjectively perceived as less helpful, as indicated by ratings of helpfulness) than intermediary responses that approach shame in a less direct manner (i.e., Bad and Tough). While it is possible that sample sizes within each condition were relatively small and subsequently potentially inadequately powered to detect significant differences between the three conditions, the yielded effect sizes appear to indicate that indeed there may be no detectable effect, though replications with larger samples are needed to verify these tentative conclusions.

Interestingly, the present study’s empirical test of Herman’s (2011) postulation that using a synonym such as “mortified” is more likely to be effective also yielded contrary

results (via ratings of helpfulness), as the Mortified response option was rated as significantly lower than the Ashamed response and all other Shame Alternative responses. Qualitative insights from pilot test participants uniformly suggested that the word “mortified” was perceived as “too intense” and that it did not accurately capture the affective experience of shame, which were indirectly corroborated by subjective ratings of the Mortified response as unhelpful by the present student sample ( $M = 2.89$ ,  $SD = 1.93$  on a scale 1-10). Notably, these findings cannot be generalised to clinical populations, and therefore do not discount Herman’s (2011) arguments that using synonyms (such as “mortified”) may be more helpful than “shame” in response to shame disclosures of highly shame-prone patients, particularly those with histories of relational trauma (i.e., Herman’s patient group) who may be more sensitive or vigilant to “shame” terminology. In a similar vein, it is also possible that “mortified” could more accurately match affective experiences of clinical population groups, who are likely to have more intense and pervasive shame experiences (DeYoung, 2015).

Taken together, the present findings tentatively indicate the possibility that variables other than specific wording of verbal responses may affect in-the-moment shame feelings accompanying shame disclosures, for example, the degree to which responses accurately capture participants’ internal states (i.e., affect match). In the present study, the majority of participants across all conditions felt that the verbal responses they received matched how they felt, which could partially account for the observed absence of difference between the three conditions in their effect on state shame. Furthermore, memorability or salience of the wording (as indicated by recognition accuracy), did not appear to influence state shame, as despite being more memorable than the Bad condition, Ashamed and Tough did not differ from Bad in shame reduction effectiveness.

**Effect on other emotions.** Findings that other emotions (i.e., anger, sadness) increased alongside shame are somewhat unsurprising given the tendency of experimental

inductions to inadvertently evoke multiple emotions (Polivy, 1981). Two main related possibilities may account for the observed decrease in anger and sadness from post-induction to post-reduction, which cannot be disentangled without a true control condition. First, it is possible that verbal response interventions may have exerted an alleviating effect on these emotions, for example, by making participants feel validated through the researcher's active listening. Equally and non-mutually exclusively, anger and sadness may have dissipated naturally with the passage of time, which is plausible given that they may have been relatively less potent and enduring than the induced feelings of shame, having not been targeted by the induction instructions in the first place.

Current findings of increased anxiety post-reduction are consistent with previous experimental studies that found elevations in anxiety to accompany activations of shame in response to shame and dissociation inductions (Dorahy et al., 2017; McKeogh et al., 2018, respectively), as well as with previous findings of associations between anxiety and both shame and dissociation (e.g., Allen, Coyne, & Console, 1996; Tangney, Wagner, Fletcher, & Gramzow, 1992). Reasons for the observed post-reduction increase in anxiety in the present study may parallel those discussed in relation to shame. Namely, it is plausible that telling the researcher about the shame experience and/or the researcher's verbal responses may have been anxiety-provoking (e.g., linked to perceived vulnerability and discomfort). Indeed, shame and anxiety appear to have common features (e.g., heightened arousal, fear of exposure, scrutiny and/or negative evaluation; Gilbert, 2000; Gilbert & Andrews, 1998), and may arise in unison. Accordingly, Gilbert and Andrews (1998) argue that "[a]nxiety appears central to the shame experience, and it is difficult to consider shame without it." (p. 6). Further, recurrent previous findings of anxiety accompanying elevations of shame in response to dissociative experiences suggest that shame may not be a unique emotional response to dissociation (McKeogh et al., 2018), prompting further empirical investigations

to clarify the role of anxiety in the proposed bi-directional relationship between shame and dissociation, as it could have mediating effects.

### **Relationship Between State Shame and Dissociation**

The observed increase in state dissociation following the shame induction, and the moderate positive associations between state shame and dissociation at both post-induction and post-reduction, replicate and strengthen findings of previous experimental studies examining the proposed bi-directional relationship between state shame and dissociation (e.g., Dorahy et al., 2017, McKeogh et al., 2018; McKeogh, 2019; Platt et al., 2017; Schultz, 2018). These authors' theoretical explanations explicating the acute interplay between shame and dissociation may be integrated to provide an account for the current observed findings. It is possible that the shame induction activated in-the-moment feelings of shame, which may have evoked dissociation as a means to deal with (or "bypass") acute shame (H. B. Lewis, 1971; Nathanson, 1992). However, dissociation may have concurrently activated further feelings of shame through appraisals of the accompanying sense of uncontrollability and failure to remain present during the interpersonal exchange as shameful, which have been proposed to constitute shame-inducing elements of dissociation (Platt et al., 2017; Schultz, 2018). Thus, it is possible, albeit not tested by the present study, that dissociation may have served to reduce the initial induced shame, but may have evoked secondary, dissociation-related shame (Platt et al., 2017), resulting in a net effect of increased shame post-reduction.

Critically, as the present design did not have a control induction condition, causal influences of the shame induction on dissociation cannot be inferred, as the observed increase in dissociation post-induction may have been influenced by other variable(s) not accounted for in the study. For example, it is possible that the process of writing detailed descriptions of any personal experience may have evoked acute dissociative experiences (e.g., manifesting as absorption in the task), rather than being specific to shame. Therefore, future designs should

incorporate an emotionally-neutral or another emotional (e.g., anger) induction to test the causal relationship between shame and dissociation.

With respect to Hypothesis 4, the three verbal response interventions (i.e., Ashamed, Bad, Tough) intended to reduce state shame did not appear to demonstrate a capacity to reduce state dissociation, as dissociation did not change from post-induction to post-reduction. This finding is somewhat unsurprising given that their capacity to reduce state shame was also undemonstrated. However, in reconciling seemingly incongruent findings that state dissociation did not increase concurrently with state shame post-reduction, yet the positive association between state shame and dissociation remained significant and moderate, a possible explanation may be that dissociation is not a uniform response to state shame elevations. Accordingly, it would appear that for a subgroup of participants whose shame feelings increased post-induction, dissociation did not increase further upon the shame reduction phase. Current findings do not offer insight into possible reasons for this discrepancy, warranting further experimental investigations to explore factors that may contribute to some individuals dissociating in response to acute shame feelings while others do not, which may further contextualise what appears to be a complex and potentially bi-directional interplay between shame and dissociation (McKeogh et al., 2018).

### **Ratings of Helpfulness**

Findings that the Withdrawal response was rated as significantly less helpful than all other Approach-Withdrawal response options is consistent with previous studies utilising ratings of helpfulness of imagined therapist responses in both student (i.e., Dorahy et al., 2014) and clinical (i.e., Dorahy, Gorgas, et al., 2017) samples. They appear to suggest that, at least subjectively when contemplating hypothetical scenarios of disclosing their own shame experiences to a therapist, participants felt that being offered an opportunity by the therapist to completely withdraw from discussing the subject of shame was viewed as unhelpful.

Notably, this apparent preference against withdrawing from shame in therapeutic settings is at odds with phenomenological understanding of shame and its behavioural coping strategies. As captured by Nathanson's (1992) Compass of Shame, withdrawal and avoidance appear to be dominant responses to shame, at least outside of therapy. Yet, even DID patients, who demonstrated highly elevated levels of trait and state shame and dissociation and a behavioural tendency towards withdrawal and avoidance in response to shame (as measured by the Compass of Shame Scale; Elison, Lennon, & Pulos, 2006), rated the Withdrawal response as the least helpful in Dorahy, Gorgas, and colleagues' (2017) study. In reconciling such discrepancies between theoretical and empirical findings, Dorahy and colleagues (2014) argue that individuals may recognise potential detriments of withdrawing from, and/or benefits of approaching, shame in the context of therapy, despite likely discomfort and desire to avoid talking about shame (DeYoung, 2015; Dorahy, Gorgas, et al., 2017). Indeed, DeYoung (2015) contrasts the healing value of approaching or 'exposing' shame (i.e., the least intuitive response) and the toxic potential of avoiding or 'hiding from' shame (i.e., the most automatic response), arguing that "shame needs light and air" (p. 116). It may be that the safety of, and hope instilled by, the therapeutic environment buffer against withdrawal amid acute shame experiences (Dorahy et al., 2014).

Further, Dorahy and colleagues (2014) argue that the observed preference against withdrawing from shame may be conceptualised as an approach behaviour, which may stem from underlying perceptions that aversive feelings, and/or deficient view of the self, may be healed (De Hooze et al., 2010). Consistently, growing empirical support is emerging for shame approach behaviours, challenging the well-established notion of the dominance of shame avoidance responses. For example, De Hooze, Breugelmans, Wagemans, and Zeelenberg's (2018) findings indicated participants' preference to be in the presence of another (i.e., social approach) versus being alone (i.e., social withdrawal) upon acute shame

experiences. Similarly, McKeogh and colleagues (2018) and McKeogh (2019) found that, following dissociation inductions, participants' imagined behavioural responses indicated a desire to discuss (i.e., approach) their acute feelings with a close friend, yet stronger desire to leave (i.e., withdraw) when with an acquaintance. These findings point to a possible moderating role of relationship context and related constructs (e.g., intimacy, trust, likelihood of negative evaluation) on individuals' inclination to approach or withdraw from discussions of acute shame experiences, which should be explored in further research. Interestingly, McKeogh's (2019) studies found that acute feelings of shame were not elevated in response to dissociation when imagining being in the presence of a therapist, but were activated in the imagined presence of a doctor or a close friend. This could tentatively suggest that therapists may possess some unique attributes that render their presence less shame-inducing (e.g., being perceived as more understanding and accepting of shame-laden experiences than non-mental health professionals). Subsequently, approaching shame in their presence may be perceived as more acceptable.

Taken together, these findings suggest that, within therapeutic settings, despite likely feelings of discomfort, individuals are likely to perceive clinicians' responses that encourage discussions of shame as more beneficial than those that enable their avoidance. Speculatively, individuals may view therapeutic settings as appropriate, or indeed, unique outlets for discussing intimate shame-laden experiences, and may mentally prepare for the possibility of shame disclosures in anticipation of therapy sessions. Subsequently, therapist responses that impede opportunities to talk about shame experiences (as in the Withdrawal response) may be perceived as therapeutically unfulfilling and/or dismissive. Notably, the differential utility of specific responses that approach shame remains inconclusive as there were no differences between Approach responses in the present study. Yet, Dorahy and colleagues (2014) found the Management-focused response, which invited participants to reflect on how they manage

their shame, to be the most helpful with non-clinical participants, while Dorahy, Gorgas, and colleagues (2017) found Feeling-focused, Cognitive-focused, and History-focused responses to be the most helpful in a clinical sample. These findings suggest that, the general theme of approaching shame (e.g., through prompts encouraging patients to stay with and further discuss the emotion, thoughts associated with shame, practical strategies for coping with shame, or similar past experiences) may do less harm therapeutically than its avoidance.

Notably, utility of Approach-Withdrawal responses was based upon ratings of hypothetical interventions rather than retrospective evaluations of personally-experienced shame disclosures, which limits generalisability of current findings, as imagined behavioural responses may differ from actual behaviour under real therapeutic circumstances (e.g., due to underestimation of discomfort during imagined vs. actual shame disclosures). However, the process of having disclosed a shame experience and having received a response immediately prior to completing ratings of helpfulness may have enhanced the realism of the imagined therapy scenario and responses, arguably to a greater extent than reviewing excerpts of someone else's therapy sessions as in Dorahy and colleagues' (2014, 2017) original studies, thereby extending existing evidence base. Future studies could address the present design's limitations through retrospective evaluations of helpfulness of experienced interventions. Rather than seeking to compare differences in wording, as was intended by the present study to test Herman's (2011) predictions, future studies could compare the utility of interventions' broader themes (e.g., Approach vs. Withdrawal) to verify conclusions drawn from subjective Approach-Withdrawal ratings through behavioural measures of experienced effectiveness.

### **Limitations and Directions for Future Research**

In addition to methodological considerations that have been raised as relevant to specific points discussed above, the present study also contained more general limitations that should be addressed in future empirical investigations.

**Sample representativeness and generalisability.** All recruitment materials were required to include specific keywords reflecting the content of the study (e.g., “life experiences, shame, and dissociation”) by the university participant pool and Human Ethics Committee due to the sensitive nature of the investigative enquiry, which may have attracted a subset of students with an interest in the area or self-selected out those with higher (or lower) shame. Thus, the sample may be potentially unrepresentative of the wider student population (e.g., having greater willingness to share their experiences). Given that self-selection bias threatens external validity (Freyd, 2012), caution should be exercised in generalising findings of the present study to the general population, and even more so, to clinical populations, for whom shame disclosures are likely to be more emotionally intense and distressing (DeYoung, 2015; Herman, 2011). Further, as participants were able to self-select which shame experiences to disclose, the current sample may differ from the target clinical population on shame experience intensity and readiness to disclose, as participants may have selected experiences they felt sufficiently comfortable sharing with others. To enhance generalisability of research focused on therapeutic approaches to shame, replications are needed from studies employing experimental designs with community and clinical samples, as well as naturalistic studies with real patients and therapists.

**Priming.** Recurrent appearance of the word “shame” within the Information Sheet and verbal instructions may have primed participants to shame, potentially desensitising them to the word “shame” and normalising shame as a universal human experience (i.e., “*Shame is an emotion that all of us experience at one point or another.*”; Gilbert, 1997). This may have lessened the proposed “jarring” impact of the word “shame” during the reduction intervention (Herman, 2011), concealing differences between conditions. The intention of this elaborate explanation of shame was to elicit shame as the predominant emotion, as research suggests that participants tend to have difficulties distinguishing between shame and related self-

conscious emotions (e.g., guilt, humiliation; Andrews, 1998; Tangney & Dearing, 2002). However, to minimise priming effects without compromising induction potency, future designs could eliminate the word “shame” from induction instructions, while retaining descriptive definitions of the shame construct (e.g., experiences of failure or exclusion).

**Operationalisation of effectiveness.** A fundamental assumption that underpinned, but was not tested by, the present design (i.e., that reducing state shame facilitates shame discussions) concerns the operationalisation of intervention “effectiveness”, which was defined as capability to reduce state shame. However, it is possible that reducing immediate feelings of shame may not be a requisite to achieving the overarching clinical goal of facilitating discussions of shame-laden experiences. In fact, given extensive theoretical discourse on the potency of shame within literature, activations of shame during discussions of shame-related material may be inevitable (DeYoung, 2015; Herman, 2011; Matos & Pinto-Gouveia, 2010) and, hypothetically, may endure no matter how validating the recipient’s responses may be. Thus, it is possible that effective responses could serve to facilitate shame discussions (i.e., make it easier and more likely for individuals to talk about their shame experiences), even if immediate feelings of shame persist, raising the possibility that these may be more useful indicators of intervention effectiveness.

Accordingly, responding effectively to shame disclosures and accompanying acute shame may not necessarily require reducing the immediate feelings of shame, but rather, conveying a more general sense of non-judgement and acceptance to combat the feared external evaluations of the self as flawed and inferior inherent to the experience of shame and instil hope that the damaged view of the self may be restored, as this may facilitate approach of, rather than withdrawal from, shame discussions (Gilbert, 2000; Dorahy et al., 2014). For example, drawing on existing psychotherapy literature on therapeutic process, in the context of psychiatric assessment, Shea (2016) proposes using normalising statements to gently raise

sensitive topics (e.g., *“It’s not unusual for people to...”*; p. 159), which may serve to prompt initial shame disclosures, as well as validation of difficulties as a “shame attenuation” technique (e.g., *“With everything you’ve been going through...”*, p. 160).

Overall, the present findings appear to suggest that offering a simple verbal response intervention to shame disclosures may not reduce feelings of shame in their immediacy. However, it cannot be ruled out that such interventions may have had some knock-on effects, for example, by increasing participants’ likelihood of sharing their shame-laden experiences with others in the future. Anecdotally, a number of participants volunteered that, following participation, they felt encouraged to seek support from others (e.g., mental health services) concerning their shared experiences. Critically, longer-term effects of the present interventions were not assessed, warranting further experimental investigations with follow-ups (e.g., days/months following interventions) and outcome measures beyond state shame reduction capacity (e.g., increase in perceived ease and/or likelihood of discussing the same shame experience in the future) that may signal intervention success in facilitating shame disclosures (i.e., the overarching goal of addressing shame as a barrier to treatment).

**Absence of qualitative insights.** Interpretations of current findings concerning the state shame-dissociation relationship are particularly tentative due to absence of insights into participants’ in-the-moment intrapsychic mental processes during participant-researcher interactions (i.e., verbal shame disclosure and verbal response intervention). Future studies should endeavour to gain more qualitative insights through inclusion of rating scales and qualitative questions tapping participants’ perceived helpfulness of their experienced shame reduction interactions. Such insights could also assist with disentangling effects of other variables (e.g., anxiety, appraisals associated with experiencing shame and/or dissociation in the presence of another) on participants’ willingness to, and comfort associated with, discussing their shame experiences. Further, given clinicians’ inevitability of encountering

shame in clinical practice (Miller, 1996), the field of therapeutic approaches to shame would be enriched by consumer perspectives research. Qualitative designs (e.g., interviews or focus groups) would offer valuable insights into utility of different approaches to shame disclosures through feedback of mental health service users (e.g., trauma survivors) with lived experiences of shame disclosures in therapeutic settings (e.g., helpful and unhelpful strategies used by previous clinicians). Findings of such research may identify other important variables (e.g., role of the therapeutic relationship) to guide further empirical enquiries.

### **Theoretical and Practical Implications**

To the best of the research team's knowledge, the current study was the first to experimentally evaluate the experienced effectiveness of different verbal responses to face-to-face shame disclosures intended to simulate real-life therapeutic settings, contributing to much-needed empirical research towards evidence-based guidelines for therapeutic approaches to disclosures of shame-filled experiences. While the evaluated interventions did not demonstrate differential effects on immediate feelings of shame, conclusions around their capacity to influence acute shame are limited by absence of rigorous experimental controls. Although the present study was not able to identify specific potentially helpful responses, more generally, current findings strengthen existing empirical evidence that facilitating withdrawal from discussions of shame experiences in therapy is perceived as less helpful than encouraging further exploration of shame material. Additionally, the present study strengthens and extends existing empirical literature on the proposed bi-directional relationship between state shame and dissociation, providing novel albeit preliminary insights that dissociation may not be a universal response to acute shame experiences, and thereby inviting further empirical enquiry into mechanisms underlying their acute interplay.

Given that shame is pervasive across clinical presentations (Miller, 1996; Tangney & Dearing, 2002), findings of the current research may be relevant for clinicians in general, and

for those working with individuals with histories of relational trauma and high shame proneness in particular. As shame may play pivotal etiological and/or maintaining roles in psychopathology (Miller, 1996), failing to gain insight into shame-laden experiences may compromise the accuracy and completeness of clinical assessment, formulation, and treatment targets (Lee et al., 2001). Therefore, actively yet gently facilitating opportunities to discuss shame in assessment and therapy may be essential, particularly given patients' high likelihood of concealment (Gilbert, 2000). Current findings suggest that clinicians should not avoid approaching shame discussions as patients are likely to subjectively appreciate therapeutic prompts that encourage exploration of shame experiences, even if emotionally they experience acute shame and discomfort (Dorahy et al., 2014). In contrast, offering to change the subject away from shame may not only be counter-productive to therapeutic progress (Van Vliet, 2009), but could be perceived as unhelpful and/or potentially dismissive or invalidating, which may threaten to disrupt the therapeutic relationship and discourage patients from initiating future disclosures of sensitive material.

In approaching shame, clinicians should be mindful of patients' potential shame-related concerns of being negatively evaluated (Pineles et al., 2006), and thus endeavour to create a containing therapeutic environment characterised by validation, normalisation, and acceptance of their patients' experiences (Dorahy, Gorgas, et al., 2017; Shea, 2016). Further, clinicians should be aware of, and sensitive to, the complex interplay between acute shame feelings and dissociative experiences, particularly as current findings support the notion that these phenomena may perpetuate one another, and subsequently, may interfere with the therapeutic process and progress (Platt & Freyd, 2015). Finally, in the absence of rigorous empirical replications on approaching state shame specifically, clinicians may resort to consulting literature focused on treating trait shame (e.g., CFT; Gilbert, 2000) to inform their evidence-based practice with shame-prone clients.

### **Summary and Conclusion**

In light of the literature conceptualising shame as a barrier to therapeutic interventions, particularly, for trauma-based disorders (Andrews et al., 2000; Dorahy, Gorgas, et al., 2017; Lee et al., 2001), and the concurrent absence of empirically-supported clinical practice guidelines for approaching shame elevations in therapeutic settings, the present study sought to experimentally examine the utility of verbal responses to shame disclosures. The present findings provide preliminary insights into effects of different verbal response interventions through evaluations of both experienced effectiveness and subjective ratings of helpfulness, and strengthen existing evidence of the relationship between acute shame and dissociative experiences.

Current findings suggest that simple verbal response interventions containing predominantly reflective statements may not be sufficient for reducing feelings of shame in their immediacy, however, their longer-term impact ought to be explored in studies with follow-ups. Further, as response wording did not appear to differentially influence acute shame feelings, possible importance of other variables (e.g., affect match) should be further examined. Overall, findings suggest that clinicians should facilitate opportunities to approach shame discussions, rather than enabling their avoidance, though further research is needed to verify these tentative conclusions through evaluations of experienced effectiveness of Approach- and Withdrawal-type therapeutic responses. It is hoped that the present study's preliminary insights, generalisability of which is limited by a number of methodological limitations, will drive further empirical enquiries to continue exploring subjectively and therapeutically beneficial ways of approaching shame disclosures, with the overarching goal of alleviating the burden of patients with shame-laden and/or traumatic exposure, and improving their experiences with clinical services and, ultimately, their therapeutic outcomes.

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Appendix A  
Advertising Poster



RESEARCH  
**PARTICIPANTS  
WANTED**

**"Life Experiences, Shame, and Dissociation"**

We are conducting a study that aims to explore whether describing an emotional life experience increases shame and dissociation (e.g., losing track of time, daydreaming). This research will help us better understand how therapists can improve the way in which they respond to their clients' disclosures of personal experiences.

**PARTICIPATION DETAILS:**

- Age 18+
- One session (approximately 50 minutes)
- Filling out questionnaires
- Writing down and describing an emotional life experience
- **All information will be kept in the strictest confidence**
- Receive:

**\$10 Westfield Voucher**  
or  
**PSYC105/106 Course Credit**

If you are interested in participating or would like more information,  
**please email Maryna at [maryna.verynska@pg.canterbury.ac.nz](mailto:maryna.verynska@pg.canterbury.ac.nz)**

This study is supervised by Professor Martin Dorahy and has been approved by the University of Canterbury Human Ethics Committee (HEC 2018/117).

 Life Experiences Study <a href="mailto:maryna.verynska@pg.canterbury.ac.nz">maryna.verynska@pg.canterbury.ac.nz</a>	 Life Experiences Study <a href="mailto:maryna.verynska@pg.canterbury.ac.nz">maryna.verynska@pg.canterbury.ac.nz</a>	 Life Experiences Study <a href="mailto:maryna.verynska@pg.canterbury.ac.nz">maryna.verynska@pg.canterbury.ac.nz</a>	 Life Experiences Study <a href="mailto:maryna.verynska@pg.canterbury.ac.nz">maryna.verynska@pg.canterbury.ac.nz</a>	 Life Experiences Study <a href="mailto:maryna.verynska@pg.canterbury.ac.nz">maryna.verynska@pg.canterbury.ac.nz</a>	 Life Experiences Study <a href="mailto:maryna.verynska@pg.canterbury.ac.nz">maryna.verynska@pg.canterbury.ac.nz</a>	 Life Experiences Study <a href="mailto:maryna.verynska@pg.canterbury.ac.nz">maryna.verynska@pg.canterbury.ac.nz</a>	 Life Experiences Study <a href="mailto:maryna.verynska@pg.canterbury.ac.nz">maryna.verynska@pg.canterbury.ac.nz</a>	 Life Experiences Study <a href="mailto:maryna.verynska@pg.canterbury.ac.nz">maryna.verynska@pg.canterbury.ac.nz</a>	 Life Experiences Study <a href="mailto:maryna.verynska@pg.canterbury.ac.nz">maryna.verynska@pg.canterbury.ac.nz</a>
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**Appendix B**  
**Ethics Approval Letter**



HUMAN ETHICS COMMITTEE

Secretary, Rebecca Robinson  
Telephone: +64 03 369 4588, Extn 94588  
Email: [human-ethics@canterbury.ac.nz](mailto:human-ethics@canterbury.ac.nz)

Ref: HEC 2018/117

12 December 2018

Maryna Verynska  
Psychology  
UNIVERSITY OF CANTERBURY

Dear Maryna

The Human Ethics Committee advises that your research proposal “Effectiveness of Verbal Statements for Reducing State Shame” has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your email of 29<sup>th</sup> November 2018.

Best wishes for your project.

Yours sincerely

*R. Robinson*  
pp.

Professor Jane Maidment  
**Chair**  
**University of Canterbury Human Ethics Committee**

### Appendix C Procedure Script

*Note.* The researcher's verbal instructions provided to participants are denoted in italics.

#### PHASE 1: Demographics, trait measures, and baseline state measures

(1) Participant arrives and is instructed to take a seat at the desktop computer.

*Thank you so much for coming in today. I'll give you a bit of an overview of what we'll do here today. The study should take between 40-60 minutes, depending on how long we take doing different tasks. If you agree to participate, you will complete some questionnaires on the computer, write about a personal experience and then we'll talk about it as well.*

*How does that sound?*

*The **Information Sheet** about the study is already on the computer screen. Once you've read through it, click 'Next' and it will take you to our electronic **Consent Form**, which means that, when you click 'Next' to that it will give us your consent to participate in the study, so make sure you read through it carefully. I will be here if you have any questions. There will also be a field where you can enter your email address if you'd like a summary of the research results. After the **Consent Form**, just follow instructions on the screen until you get to a screen that says "Please turn to the researcher". Let me know once you've reached this point and I will give you some more instructions.*

*Do you have any questions? Let me know if anything comes up.*

(2) Participant completes demographic questions, trait measures, and baseline state measures on Qualtrics.

1. Information Sheet
2. Consent Form
3. Demographic Questions
4. ESS
5. DES
6. SSGS Baseline
7. PDEQ-M Baseline

#### PHASE 2: Shame induction and post-induction state measures

(3) Participant is asked to turn to the researcher for the **Shame Induction verbal instructions**:

*For this next part, I'll verbally go over the instructions now, but these same instructions will also be written on the next screen while you're completing the task.*

*What we'll do now is, I'll get you to write about a personal experience when you felt ashamed or when you experienced a strong sense of shame. Shame is an emotion that all of us experience at one point or another. People tend to experience shame when they have failed to achieve something they really wanted to or felt excluded from something they wanted to be a part of. For example, people describe feeling ashamed when they have failed to reach their own goals or standards or the expectations of someone else. They might describe "feeling like a failure" or "feeling really crushed".*

*Does that make sense so far? Do you have any questions about that?*

*Please think about an experience when you felt ashamed and write about it in as much detail as possible, so that, in theory, someone who wasn't there could understand what was happening and why you felt the way you did. Your answer doesn't need to be well-written, so don't worry about grammar or spelling.*

*Please give some thought as to what you might write about and spend about 10 minutes thinking and writing about your experience. When you click 'Next', there won't be a 'Next' button for about 10 minutes, to give you the space to be able to think and write. Once 10 minutes have passed, it will re-appear, and if you're ready to move forward then, click 'Next' and continue following on-screen instructions just as you did before.*

*Just a reminder, that everything you write about will be stored as strictly confidential, which means that only myself and my supervisors will have access to the data. Your data will not be linked to your name as we didn't get you to write your name down, but it will be tied to your participant number. Do you have any questions about that?*

(4) Participant writes about a shame experience and completes post-induction state measures and single emotion ratings on Qualtrics:

9. Shame Induction
10. SSGS Post-Induction
11. PDEQ-M Post-Induction
12. Single-item emotion ratings Post-Induction

### **PHASE 3: Shame reduction and post-reduction state measures**

(5) Participant is asked to turn to the researcher for the **Shame Reduction**.

During this interaction, the researcher follows one of the three standardised scripts below, dependent on the condition to which that participant was randomly assigned (i.e., Ashamed vs. Bad vs. Tough). Throughout the interaction, the researcher employs basic active listening skills (i.e., minimal encouragers e.g., “yeah”, “uh-huh”, “hmm”; ‘interested’ eye contact and body language) to convey empathy and understanding across all conditions. The researcher delivers each standardised response once participant’s speech has reached a natural pause.

The manipulated wording that distinguishes the three conditions (which are otherwise identical for standardisation purposes) is underlined>. To maximise the likelihood of equal treatment across conditions, the three conditions were deliberately kept equal with respect to the number of opportunities participants were given to respond to the researcher’s questions and reflections, as denoted in square brackets.

#### **Condition 1 (Ashamed):**

- *You've just finished writing about a personal experience on the computer, could you tell me about this experience in your own words?*  
[Opportunity for participant to respond]
- *Could you describe to me what were the most difficult aspects of that experience for you?*  
[Opportunity for participant to respond]
- *It sounds like that experience makes you feel ashamed.*  
[Opportunity for participant to respond]
- *Can you tell me more about that feeling of shame?*  
[Opportunity for participant to respond]
- *That sounds like a difficult experience, thank you for sharing it with me.*
- *We've got a few more questionnaires to complete on the computer.*

**Condition 2 (Bad):**

- *You've just finished writing about a personal experience on the computer, could you tell me about this experience in your own words?*  
[Opportunity for participant to respond]
- *Could you describe to me what were the most difficult aspects of that experience for you?*  
[Opportunity for P to respond]
- *It sounds like that experience makes you feel really bad about yourself.*  
[Opportunity for participant to respond]
- *Can you tell me more about that feeling?*  
[Opportunity for participant to respond]
- *That sounds like a difficult experience, thank you for sharing it with me.*
- *We've got a few more questionnaires to complete on the computer.*

**Condition 3 (Tough):**

- *You've just finished writing about a personal experience on the computer, could you tell me about this experience in your own words?*  
[Opportunity for participant to respond]
- *Could you describe to me what were the most difficult aspects of that experience for you?*  
[Opportunity for P to respond]
- *That sounds tough.*  
[Opportunity for participant to respond]
- *Can you tell me more about that experience?*  
[Opportunity for participant to respond]
- *That sounds like a difficult experience, thank you for sharing it with me.*
- *We've got a few more questionnaires to complete on the computer.*

(6) Participant completes post-reduction state measures and single-item emotion ratings on Qualtrics:

14. SSGS Post-Reduction
15. PDEQ-M Post-Reduction
16. Single-item emotion ratings Post-Reduction

**PHASE 4: Ratings of Helpfulness**

(7) Participant is asked to turn to the researcher for the **Ratings of Helpfulness verbal instructions**:

*For this next part, I will give you a bit of background to our study, so that it makes sense when you're completing it. One of the aims of our study is to understand how therapists might best respond to their clients' disclosures of personal experiences of shame.*

*Please imagine that you are seeing a therapist, and that you have just shared with them a personal experience of shame. On the next screen, there will be a number of different statements, which are possible responses a therapist could make in response to one's disclosure of a personal experience. Please rate how helpful you would find each one of those statements as though they were said to you by a therapist.*

*Does that make sense? Please let me know if you have any questions.*

(8) Participant completes ratings of helpfulness and experimental checks on Qualtrics.

17. Ratings of helpfulness

18. Experimental checks (i.e., recognition accuracy, affect match)

## **DEBRIEF**

(9) Participant is provided with the **Debriefing Sheet**.

As part of the verbal debrief, the researcher briefly describes the aims of the study, the rationale behind the experimental verbal response manipulation, the key measured variables, and broader implications of this research. The researcher normalises that negative feelings induced by the shame induction may linger, and encourages participant to incorporate self-care activities into the remainder of their day to counter any residual negative effects, and to contact support services and/or the researchers should they wish to discuss any thoughts or feelings related to the study upon its conclusion, with contact details on the **Debriefing Sheet**.

(10) Participant is thanked for their time and given a \$10 Westfield voucher or course credit for their participation.

**Appendix D**  
**Shame Induction Written Instructions**

*Note.* These instructions were displayed on the computer screen above the textbox in which participants typed their responses throughout the shame induction.

Please write about a personal experience that made you feel very ashamed.

For example, think about a time when you failed to achieve something you really wanted to or felt excluded from something you really wanted to be a part of.

- Please think about the experience and describe it in as much detail as possible, so that someone who was not present could understand what was happening and why you felt the way you did.
- Please spend about 10 minutes thinking and writing about your experience. The 'Next' button will appear after 10 minutes and then you will be able to move forward.
- Your response will be stored as strictly confidential and will not be linked to your name or any other information that could identify you.
- Your answer does not need to be well-written.

## **Appendix E**

### **Experimental Checks**

*Note.* Information denoted within square brackets was not displayed to participants.

#### **Recognition Accuracy**

During your interactions with the researcher, which of the following responses do you recall was used by the researcher?

It sounds like that experience makes you feel ashamed. [Ashamed condition]

It sounds like that experience makes you feel mortified. [Mortified response]

It sounds like that experience makes you feel really bad. [Bad response]

That sounds tough. [Tough condition]

It sounds like that experience makes you feel really bad about yourself. [Bad condition]

#### **Affect Match**

Did the researcher's response match how you felt?

Yes

No

## Appendix F Demographic Questions

1. Age \_\_\_\_\_
2. Gender
  - Male
  - Female
  - Other, please state: \_\_\_\_\_
3. Which ethnic groups do you identify with?
  - New Zealand European
  - Māori
  - Australian
  - Aboriginal
  - Cook Island Māori
  - Samoan
  - Tongan
  - Niuean
  - Indian
  - Chinese
  - Japanese
  - Other (e.g., Dutch, Tokelauan). Please state: \_\_\_\_\_
4. What is the highest qualification you have gained to date?
  - NCEA Level 1 or School Certificate
  - NCEA Level 2
  - NCEA Level 3 or Higher School Certificate
  - Trade Certificate
  - University Entrance
  - Foundation or Bridging Course
  - National Certificate or Diploma
  - Undergraduate degree
  - Honours degree
  - Masters degree
  - Doctoral degree
  - Other, please state: \_\_\_\_\_
5. What is your relationship status?
  - Single
  - In a relationship
  - Engaged
  - Married
  - Separated/Divorced
7. Have you ever been diagnosed with any mental health difficulties?
  - Yes
  - No
8. If Yes, and you know which one(s), please select all that apply.
  - Major depressive disorder
  - Bipolar disorder
  - Anxiety disorder (e.g., generalised anxiety disorder, social anxiety disorder)
  - Obsessive Compulsive disorder
  - Post-traumatic Stress disorder
  - Dissociative Identity disorder
  - Eating disorder (e.g., anorexia nervosa, bulimia nervosa, binge eating disorder)
  - Personality disorder (e.g., borderline personality disorder)
  - Substance Use disorder (e.g., alcohol, cannabis)
  - Attention-Deficit/Hyperactivity disorder
  - Autism Spectrum disorder
  - Schizophrenia
  - Other psychotic disorder (e.g., schizoaffective disorder, delusional disorder)
  - Other, please state: \_\_\_\_\_

**Appendix G**  
**ESS**  
(Andrews et al., 2002)

Everybody at times can feel embarrassed, self-conscious or ashamed. These questions are about such feelings if they have occurred *at any time in the past year*. There are no 'right' or 'wrong' answers. Please click on the option that corresponds with how frequently you have experienced the following.

	<b>Not at all</b>	<b>A Little</b>	<b>Moderately</b>	<b>Very Much</b>
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
1. Have you felt ashamed of any of your personal habits?	( )	( )	( )	( )
2. Have you worried about what other people think of any of your personal habits?	( )	( )	( )	( )
3. Have you tried to cover up or conceal any of your personal habits?	( )	( )	( )	( )
4. Have you felt ashamed of your manner with others?	( )	( )	( )	( )
5. Have you worried about what other people think of your manner with others?	( )	( )	( )	( )
6. Have you avoided people because of your manner?	( )	( )	( )	( )
7. Have you felt ashamed of the sort of person you are?	( )	( )	( )	( )
8. Have you worried about what other people think of the sort of person you are?	( )	( )	( )	( )
9. Have you tried to conceal from others the sort of person you are?	( )	( )	( )	( )
10. Have you felt ashamed of your ability to do things?	( )	( )	( )	( )
11. Have you worried about what other people think of your ability to do things?	( )	( )	( )	( )
12. Have you avoided people because of your inability to do things?	( )	( )	( )	( )
13. Do you feel ashamed when you do something wrong?	( )	( )	( )	( )

14. Have you worried about what other people think of you when you do something wrong? ( ) ( ) ( ) ( )
15. Have you tried to cover up or conceal things you felt ashamed of having done? ( ) ( ) ( ) ( )
16. Have you felt ashamed when you said something stupid? ( ) ( ) ( ) ( )
- [Validity Item]. If you have read this question, please select 'Very Much'. ( ) ( ) ( ) ( )
17. Have you worried about what other people think of you when you said something stupid? ( ) ( ) ( ) ( )
18. Have you avoided contact with anyone who knew you said something stupid? ( ) ( ) ( ) ( )
19. Have you felt ashamed when you failed in a competitive situation? ( ) ( ) ( ) ( )
20. Have you worried about what other people think of you when you failed in a competitive situation? ( ) ( ) ( ) ( )
21. Have you avoided people who have seen you fail? ( ) ( ) ( ) ( )
22. Have you felt ashamed of your body or any part of it? ( ) ( ) ( ) ( )
23. Have you worried about what other people think of your appearance? ( ) ( ) ( ) ( )
24. Have you avoided looking at yourself in the mirror? ( ) ( ) ( ) ( )
25. Have you wanted to hide or conceal your body or any part of it? ( ) ( ) ( ) ( )

**Appendix H**  
**DES**  
(Carlson & Putnam, 1993)

These questions describe experiences that you may have in your daily life. Your answer should show how often these experiences happen to you when you ARE NOT under the influence of alcohol or drugs. Please select a number from 0% to 100% to show what percentage of the time these experiences have happened to you.

(NEVER) 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% (ALWAYS)

1. Some people have the experience of driving or riding in a car or bus or subway and suddenly realising that they don't remember what has happened during all or part of the trip.
  2. Some people find that sometimes they are listening to someone talk and they suddenly realise that they did not hear part or all of what was said.
  3. Some people have the experience of finding themselves in a place and having no idea how they got there.
  4. Some people have the experience of finding themselves dressed in clothes that they don't remember putting on.
  5. Some people have the experience of finding new things among their belongings that they do not remember buying.
  6. Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them before.
  7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person.
  8. Some people are told that they sometimes do not recognise friends or family members.
  9. Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation).
  10. Some people have the experience of being accused of lying when they do not think that they have lied.
- [Validity Item]. If you are reading this, please select 20% (third across).
11. Some people have the experience of looking in a mirror and not recognising themselves.
  12. Some people have the experience of feeling that other people, objects and the world around them are not real.

13. Some people have the experience of feeling that their body does not seem to belong to them.
14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event.
15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them.
16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar.
17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them.
18. Some people find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them.
19. Some people find that they sometimes are able to ignore pain.
20. Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time.
21. Some people sometimes find that when they are alone they talk out loud to themselves.
22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were two different people.
23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.).
24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing this (for example, not knowing whether they have just mailed a letter or have just thought about mailing it).
25. Some people find evidence that they have done things that they do not remember doing.
26. Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing.
27. Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing.
28. Some people sometimes feel as if they are looking at the world through a fog so that people and objects appear far away or unclear.

**Appendix I**  
**SSGS**  
(Marschall et al., 1994)

The following are some statements which may or may not describe how you are feeling *right now*. Please rate each statement using the 5-point scale below.

Remember to rate each statement based on how you are feeling *right at this moment*.

Not Feeling This Way At All	Feeling This Way Slightly	Feeling This Way Somewhat	Feeling This Way Strongly	Feeling This Way Very Strongly	
0	1	2	3	4	
I want to sink into the floor and disappear.	0	1	2	3	4
I feel small.	0	1	2	3	4
I feel like a bad person.	0	1	2	3	4
I feel humiliated, disgraced.	0	1	2	3	4
I feel worthless, powerless.	0	1	2	3	4

**Appendix J**  
**PDEQ-M**  
(Marshall et al., 2002)

[Baseline Instructions]

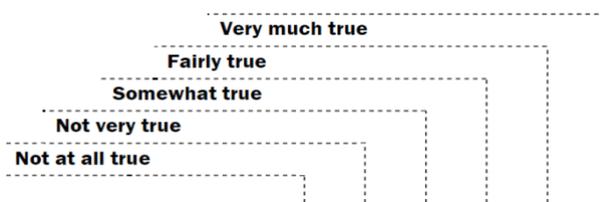
Please complete the items below by clicking on the choice that best describes your experiences and reactions *over the last few minutes*. If an item does not apply to your experience, please click on “Not at all true”.

[Post-Induction Instructions]

Please complete the items below by clicking on the choice that best describes your experiences and reactions *while you were writing about your experience and immediately afterward*. If an item does not apply to your experience, please click on “Not at all true”.

[Post-Reduction Instructions]

Please complete the items below by clicking on the choice that best describes your experiences and reactions *while you were talking to the researcher and immediately afterward*. If an item does not apply to your experience, please click on “Not at all true”.



- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. I had moments of losing track of what was going on – I “blanked out” or felt separate from what was going on.   | 1 | 2 | 3 | 4 | 5 |
| 2. My sense of time changed – things seemed to be happening in slow motion.  | 1 | 2 | 3 | 4 | 5 |
| 3. I felt as though I were a spectator watching what was happening to me, as if I were floating above the scene or observing it as an outsider.                | 1 | 2 | 3 | 4 | 5 |
| 4. There were moments when my sense of my own body seemed distorted or changed. I felt disconnected from my own body, or that it was unusually large or small. | 1 | 2 | 3 | 4 | 5 |
| 5. I felt as though things that were actually happening to others were happening to me – like I was being trapped when I really wasn’t.                        | 1 | 2 | 3 | 4 | 5 |
| 6. I felt confused; that is, there were moments when I had difficulty making sense of what was happening.  | 1 | 2 | 3 | 4 | 5 |
| 7. I felt disoriented; that is, there were moments when I felt uncertain about where I was or what time it was.  | 1 | 2 | 3 | 4 | 5 |
| 8. I have gaps in my memory and cannot remember parts of the experiment.   | 1 | 2 | 3 | 4 | 5 |

**Appendix K**  
**Single-Item Emotion Ratings**

[Post-Induction Instructions]

Please rate the feelings that you noticed having while you were writing about your experience.

[Post-Reduction Instructions]

Please rate the feelings that you noticed having while you were talking to the researcher and immediately afterward.

	<b>Not At All (0)</b>	<b>A Little (1)</b>	<b>Somewhat (2)</b>	<b>A Lot (3)</b>	<b>Extremely (4)</b>
Angry					
Ashamed					
Sad					
Anxious					
Guilty					
Calm					

**Appendix L**  
**Ratings of Helpfulness**

*Note.* Information denoted within square brackets was not displayed to participants.

**Approach-Withdrawal Responses**

Imagine that you have just shared a shameful personal experience with a therapist. Please rate how helpful you would find it if your therapist said the following:

Very Unhelpful										Very Unhelpful
1	2	3	4	5	6	7	8	9	10	

It must be very hard to feel this way about yourself. I know this may be difficult, but can you try staying with these feelings and tell me what this is like for you?  
[Feeling-focused response]

This sounds very distressing for you to discuss. Perhaps it might be best if we spoke about it when you are feeling better?  
[Withdrawal response]

It must be so difficult to think this way about yourself. I'm wondering if you can tell me more about the thoughts you have about yourself when you feel like this?  
[Cognitive-focused response]

This must be such a tough experience for you. Does it trigger any memories of similar past experiences?  
[History-focused response]

This must be difficult. Perhaps you can tell me some of the things you do to try and keep these feelings and thoughts at bay?  
[Management-focused response]

**Shame Alternative Responses**

Imagine that you have just shared a shameful personal experience with a therapist.  
Please rate how helpful you would find it if your therapist said the following:

Very Unhelpful										Very Unhelpful
1	2	3	4	5	6	7	8	9	10	

It sounds like that experience makes you feel ashamed. [Ashamed response]

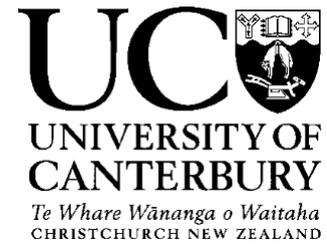
It sounds like that experience makes you feel mortified. [Mortified response]

That sounds tough. [Tough response]

It sounds like that experience makes you feel really bad. [Bad response]

It sounds like that experience makes you feel really bad about yourself. [Bad Self response]

## Appendix M Information Sheet



Department of Psychology  
Telephone: +64 3 364 2987 ext 94971

Email: [maryna.verynska@pg.canterbury.ac.nz](mailto:maryna.verynska@pg.canterbury.ac.nz)  
HEC Ref: 2018/117

### Life Experiences, Shame, and Dissociation Information Sheet

My name is Maryna Verynska and I am a Masters student in the Department of Psychology at the University of Canterbury. You are invited to take part in our research project 'Life Experiences, Shame, and Dissociation'.

The aim of this study is to investigate ways in which feelings of shame and dissociation (e.g., experiences that range from daydreaming to losing track of time and/or feeling disconnected from oneself) may be alleviated during discussions of emotional experiences in a face-to-face setting. If you choose to take part in this study, you will be asked to think back to, and write about, a personal experience when you had failed to achieve something you really wanted to or felt excluded from something you wanted to be a part of, and to subsequently tell the researcher about this experience. You will also be asked to fill out a series of questionnaires on the computer, which will ask you about different emotional and perceptual experiences.

You will receive a \$10 Westfield shopping voucher or course credit for your participation on completion of study participation. This study will take between 40-60 minutes to complete. Participation is voluntary and you have the right to withdraw at any stage or to take a break. You may ask for your raw data to be returned to you or destroyed at any point before it is merged with all other data. There will be no negative penalty to you if you withdraw from the study. If you complete the study and then elect to have your data withdrawn before it is merged with the other data, you will still receive the participation voucher or course credit. If you withdraw, we will remove information relating to you. However, please note that once this session has finished, information cannot be withdrawn from the project as it will be de-identified when it is entered into the computer.

You will be asked to recall an emotional experience, which you may find uncomfortable or distressing. Please let the researcher know if you would like to stop the study at any time to take a break or to withdraw entirely. The researcher will pay close attention in case you are becoming distressed, so that she can see if you are okay. However, if you find yourself feeling distressed, please let the researcher know. She will ask whether you would like to continue and reiterate that you are under no obligation to do so and that you can withdraw without penalty. If you decide to stop your participation and withdraw from the study, you will have an opportunity to talk about any thoughts you have regarding the study with the researcher (Maryna Verynska) and/or her supervisor (Martin Dorahy).

These are some agencies you may choose to contact for support:

#### Free Support Services:

Lifeline: 0800 543 354  
Youthline: 0800 376 633  
Samaritans: 0800 726 666

#### Counselling Services:

Petersgate Counselling Service: (03) 343 3391

#### Emergency Services:

Crisis Resolution: (03) 364 0482 or 0800 920 092

**OTHER RESOURCES THAT MIGHT HELP:****Stress Reduction web pages:***General Stress Reducing Strategies*

- <http://www.apa.org/topics/stress/index.aspx>
- [https://www.mindtools.com/pages/main/newMN\\_TCS.htm](https://www.mindtools.com/pages/main/newMN_TCS.htm) (Coping Strategies Tab)

*Emotion Management Strategies*

- <https://www.mindfulnessmuse.com/dialectical-behavior-therapy/top-10-ways-to-regulate-emotions-part-one>
- <https://www.mindfulnessmuse.com/dialectical-behavior-therapy/top-10-ways-to-regulate-emotions-part-two>

Results of the study may be published, but you can be assured of the complete confidentiality of the data gathered in this investigation: your identity will not be made public. To ensure confidentiality, no names will be used on the questionnaires or in the final report. Only Martin Dorahy, Kumar Yogeewaran, and Maryna Verynska will have access to the data, which will be securely stored electronically by password protection. After the conclusion of the study, Martin Dorahy will keep a copy of the data for five years, after which it will be destroyed.

The project is being carried out as a requirement for a Masters thesis by Maryna Verynska under the supervision of Professor Martin Dorahy, who can be contacted at [martin.dorahy@canterbury.ac.nz](mailto:martin.dorahy@canterbury.ac.nz). He will be happy to discuss any concerns you may have about participation in the project. A thesis is a public document and will be available through the UC Library. This project has been reviewed and approved by the University of Canterbury Human Ethics Committee, and participants should address any complaints to The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch ([human-ethics@canterbury.ac.nz](mailto:human-ethics@canterbury.ac.nz)).

Thank you for your willingness to participate in our study. If you agree to participate, you are asked to complete the Consent Form.

If you have any further questions regarding this project, please feel free to contact us:

Maryna Verynska	Martin Dorahy	Kumar Yogeewaran
Masters Student	Professor	Senior Lecturer
Dept of Psychology	Dept of Psychology	Dept of Psychology
University of Canterbury	University of Canterbury	University of Canterbury
Phone: +64 3 364 2987	Phone: +64 369 4337	Phone: +64 3 369 4379
<a href="mailto:maryna.verynska@pg.canterbury.ac.nz">maryna.verynska@pg.canterbury.ac.nz</a>	<a href="mailto:martin.dorahy@canterbury.ac.nz">martin.dorahy@canterbury.ac.nz</a>	<a href="mailto:kumar.yogeewaran@canterbury.ac.nz">kumar.yogeewaran@canterbury.ac.nz</a>

## Appendix N Consent Form

Department of Psychology  
Telephone: +64 3369 4336  
Email: [maryna.verynska@pg.canterbury.ac.nz](mailto:maryna.verynska@pg.canterbury.ac.nz)  
HEC Ref: 2018/117



### Life Experiences, Shame, and Dissociation Consent Form

#### Names of researchers:

Professor Martin Dorahy (Clinical Psychologist & Professor, University of Canterbury);  
Associate Professor Kumar Yogeeswaran (Associate Professor, University of Canterbury);  
Maryna Verynska (Masters Student, University of Canterbury).

- I have been given a full explanation of this project and have had the opportunity to ask questions.
- I understand what is required of me if I agree to take part in the research.
- I understand that participation is voluntary and I may withdraw at any time without penalty. Withdrawal of participation will also include the withdrawal of any information I have provided should this remain practically achievable.
- I understand that should I complete the project my individual data will be merged with data from other participants.
- I understand that information relating to general demographics (such as age and gender) will be collected.
- I understand that any information or opinions I provide will be kept confidential to the researchers, Maryna Verynska, Martin Dorahy, and Kumar Yogeeswaran, and that any published or reported results will not identify the participants. I understand that a thesis is a public document and will be available through the UC Library.
- I understand that all data collected for the study will be kept in locked and secure facilities and/or in password protected electronic form and will be destroyed after five years.
- I understand the risks associated with taking part and how they will be managed.
- I understand that I am able to receive a summary of the findings of the study by contacting the researcher at the conclusion of the project.
- I understand that I can contact the researcher, Maryna Verynska, ([maryna.verynska@pg.canterbury.ac.nz](mailto:maryna.verynska@pg.canterbury.ac.nz)) or the supervisor, Martin Dorahy, ([martin.dorahy@canterbury.ac.nz](mailto:martin.dorahy@canterbury.ac.nz)) for further information.
- If I have any complaints, I can contact the Secretary of the Human Ethics Committee, Level 5, Matariki South, University of Canterbury, Christchurch, New Zealand ([human-ethics@canterbury.ac.nz](mailto:human-ethics@canterbury.ac.nz))

**By clicking "Next" below and completing the survey, I understand what is required of me and I agree to participate in this research.**



**Appendix O**  
**Debriefing Sheet**

**Life Experiences, Shame, and Dissociation**  
**Debriefing Form**

Dear Participant,

Thank you for taking part in this study.

This study aimed to investigate whether describing a personal experience of shame can induce current feelings of shame and dissociation (e.g., experiences that range from daydreaming to losing track of time and/or feeling disconnected from oneself), and whether the researcher's different verbal responses have the capacity to reduce those feelings of shame and/or dissociation.

In order to answer these questions, we asked you to write down a personal experience when you had failed to achieve something you really wanted to or felt excluded from something you wanted to be a part of, and to subsequently describe this experience to the researcher. The researcher responded with one of three possible options (i.e., their responses included (1) the word 'shame', (2) a synonym of the word 'shame', or (3) a response that acknowledged your feelings without identifying your emotions). Additionally, both before and after you wrote and talked about your experience, we asked you to fill out questionnaires that measured your general proneness to shame and dissociation and current feelings of shame and dissociation during the study, which will help us understand the things you were feeling after writing and talking about your experience with the researcher. More specifically, these questionnaires will help us find out whether your current (or 'in-the-moment') feelings of shame and dissociation increased after you described your experience, and, if so, whether they subsequently decreased following the researcher's responses. You also rated how helpful you would find different responses if they were said to you by a therapist in response to a personal disclosure. Ultimately, we hope that insights from this study will help researchers and therapists to develop a better understanding of ways in which therapists can respond to their clients' disclosures of shame-laden experiences to alleviate their feelings of shame and dissociation during therapy sessions.

Now that the full nature of the study has been outlined, you may withdraw from the study if you decide that you no longer wish to contribute your information. There will be no negative penalty to you if you withdraw from the study. If you have completed the study and decide to have your data withdrawn before it is merged with the other data, you will still receive the participation voucher or course credit. However, please note that after this session has finished, information cannot be withdrawn from the project as it is de-identified when it is merged with the other data.

If you would like to speak with someone about the effect of this study on you, you are welcome to contact the researchers. If you feel distressed in any way following your participation today, please take care and consider contacting one of the following services:

**Free Support Services:**

Lifeline: 0800 543 354

Youthline: 0800 376 633

Samaritans: 0800 726 666

**Counselling Services:**

UC Health Centre: (03) 369 4444

Petersgate Counselling Service: (03) 343 3391

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- [https://www.mindtools.com/pages/main/newMN\\_TCS.htm](https://www.mindtools.com/pages/main/newMN_TCS.htm) (Coping Strategies Tab)

*Emotion Management Strategies*

- <https://www.mindfulnessmuse.com/dialectical-behavior-therapy/top-10-ways-to-regulate-emotions-part-one>
- <https://www.mindfulnessmuse.com/dialectical-behavior-therapy/top-10-ways-to-regulate-emotions-part-two>

Thank you for taking the time to participate in this study, your input is very much appreciated by the research team. If you are interested in obtaining a copy of the research when it is completed, please feel free to contact the primary researcher.

**Contact details of the researchers:**

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