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Shame- and guilt-proneness: Relationships with anxiety disorder symptoms in a clinical sample

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ABSTRACT

Researchers postulate that both shame and guilt are emotions important to anxiety disorders. Extant data, however, indicate that guilt-proneness shares non-significant relationships with psychopathology symptoms after controlling for shame-proneness. To further investigate the relevance of shame and guilt to the anxiety disorders domain, the current study examined associations between shame- and guilt-proneness and anxiety disorder symptoms using data from patients ($N = 124$) with primary anxiety disorder diagnoses. Results indicated that only symptoms of social anxiety disorder (SAD) and generalized anxiety disorder (GAD) shared significant relations with shame-proneness after controlling for other types of anxiety disorder symptoms, depression symptoms, and guilt-proneness. Further, changes in shame-proneness during treatment were found to share significant relations with changes in obsessive-compulsive disorder, SAD, and GAD symptoms. The current results indicate that shame is more relevant to symptoms of the anxiety disorders domain than is guilt. The implications of these results for the conceptualization and treatment of anxiety disorders are discussed.

Shame and guilt are often considered to be synonymous emotions, but they are clearly distinct (Tangney, Stuewig, & Mashek, 2007). Tangney et al. note that the distinction is best articulated by Lewis's (1971) assertion that shame leads one to focus on the self, whereas guilt leads one to focus on specific behaviors. The differential focus of these two emotions is believed to produce different associated concerns, with shame relating to concerns with others' evaluation of the self and guilt relating to concerns with one's effect on others (Tangney & Dearing, 2002). Based on their differential focus and associated concerns, it is not surprising that shame and guilt engender divergent phenomenological experiences: whereas shame is believed to lead to feelings of worthlessness and being exposed, guilt is believed to lead to feelings of regret and remorse (Tangney & Dearing, 2002). According to Tangney and Dearing, although both shame and guilt are thought of as negative emotions, shame is considered the more painful of the two. Specifically, the experience of guilt is thought of as maladaptive only when it becomes generalized to the self (i.e., becomes shameful). Without this generalization, guilt is believed to have a number of adaptive functions (e.g., motivating reparative action; Tangney et al., 2007).

Consistent with the notion that shame is the more painful emotion, Tangney, Wagner, and Gramzow (1992) found that shame-proneness is more strongly related to psychopathology symptoms than is guilt-proneness. Further, Tangney et al. found that relations between guilt-proneness and psychopathology symptoms are attributable to shared variance between shame- and guilt-proneness. Subsequent studies have validated Tangney et al.'s findings: shame-proneness has been found to share specific relations with psychopathology symptoms across studies, whereas the relations between guilt-proneness and psychopathology symptoms are consistently rendered non-significant after controlling for shame-proneness (e.g., see Pineles, Street, & Koenen, 2006).

Despite advances in understanding the distinct correlates of shame and guilt, Tangney et al. (1992) note that, "the clinical and empirical literature, however, is inconsistent with regard to the specific links between psychological symptoms and these moral affective processes" (p. 469). The anxiety disorders domain appears to suffer from this inconsistency. For example, both shame (Valentiner & Smith, 2008) and guilt (Shafran, Watkins, & Charman, 1996) are purported to be important in the etiology of obsessive-compulsive disorder (OCD) symptoms. Further, although shame has been implicated in the development and maintenance of social anxiety disorder (SAD) symptoms (Gilbert, 2000), guilt was also found to significantly relate to SAD symptoms in Gilbert's study.

Researchers have suggested that shame and guilt are relevant to symptoms of other anxiety disorders as well. For example, the worry found in generalized anxiety disorder (GAD) is believed

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to function, in part, as a way for one to reduce feelings of guilt (Freeston, Rheaume, Letarte, Dugas, & Ladouceur, 1994). However, researchers have suggested that feelings of shame might represent a reason why individuals worry as well (Gosselin et al., 2003). Further, shame surrounding the potential consequences of panic attacks (e.g., social humiliation) might be important in the catastrophic misinterpretations of body sensations seen in panic disorder (PD) (Austin & Richards, 2001). The role of shame in PD symptoms, though, has not received extensive empirical investigation and no known studies have examined the relation between guilt and PD symptoms.

In sum, the extant literature regarding the relevance of shame and guilt to symptoms within the anxiety disorders domain is not clearly specified. In particular, because guilt-proneness *per se* is purported to share no relation with psychopathology symptoms (Tangney et al., 1992), it is surprising that guilt is believed to be important in the development and maintenance of symptoms across many anxiety disorders. The primary purpose of the current study was thus to examine relationships of shame- and guilt-proneness with anxiety disorder symptoms using a clinical sample. Given Tangney et al.'s (1992) assertion that more research is needed to examine the *specific* links between shame and guilt and psychopathology symptoms, relationships of shame- and guilt-proneness with various anxiety disorder symptoms were examined controlling for other anxiety disorder symptoms and the other proneness dimension (i.e., shame- or guilt-proneness). To address concerns that relations between anxiety disorder symptoms and shame and guilt might simply be attributable to the symptom overlap between depression and anxiety disorders (e.g., Mineka, Watson, & Clark, 1998), and because shame and guilt appear relevant to depression as well (Gilbert, 2000), depression symptoms were also controlled for in these analyses.

Following from Tangney et al. (1992), shame-proneness was expected to emerge as the emotion more relevant to anxiety disorder symptoms relative to guilt-proneness. Thus, none of the correlations between the anxiety disorder symptoms and guilt-proneness were predicted to be significant after controlling for the other anxiety disorder symptoms, depression symptoms, and shame-proneness. Because shame is implicated in the development of symptoms across the anxiety disorders domain, tests regarding the *specific* associations between shame-proneness and anxiety disorder symptoms were considered exploratory in nature. In addition, the current study examined the relationships between changes in shame- and guilt-proneness with changes in the assessed anxiety disorder symptoms. Based on the idea that shame might decrease with psychopathology symptoms during the course of treatment (Pineles et al., 2006), we predicted that changes in shame-proneness, but not guilt-proneness, would share significant relationships with changes in the assessed anxiety disorder symptoms.

1. Method

1.1. Participants

Participants were 127 patients in an intensive outpatient anxiety disorder treatment program. The primary diagnosis for these patients was an anxiety disorder, and it was unaccompanied by diagnoses of psychotic disorder or an active (untreated) substance use disorder. The sample was 54% female ($n = 68$) and 95% Caucasian/White ($n = 120$). The mean age was 29.2 ($SD = 13.8$; range from 13 to 77) years.

Fifty-three (41.7% of total sample) participants received a primary diagnosis of OCD, 25 (19.6% of total sample) participants received a primary diagnosis of SAD, 28 (22.0% of the total sample) participants received a primary diagnosis of PD, and 18 (14.2% of the total sample) participants received a primary diagnosis of GAD. Three participants (2.4% of the total sample) received a primary diagnosis of Anxiety Disorder–Not Otherwise Specified and were removed from subsequent analyses. Many of the remaining 124 ($n = 58$; 46.8%) participants were diagnosed with multiple disorders. The presence of multiple diagnoses did not differ as a function of primary diagnosis [$\chi^2(4) = 7.46$, *ns*], and the most common additional diagnoses were major depressive disorder ($n = 16$), GAD ($n = 10$), OCD ($n = 9$), SAD ($n = 9$), and PD ($n = 7$).

1.2. Measures

A pre-treatment questionnaire packet completed by participants included a demographic questionnaire. The following measures were completed at both pre- and post-treatment. Shame- and guilt-proneness were assessed using the Test of Self-Conscious Affect (TOSCA; Tangney, Wagner, & Gramzow, 1989). The TOSCA is a 15-item measure believed to assess proneness to shame, guilt, externalization, detachment, and pride. The shame- and guilt-proneness scales – the TOSCA scales of interest in the present study – showed good internal consistency at pre- (shame-proneness: Cronbach's $\alpha = .82$; guilt-proneness: $\alpha = .76$) and post-treatment (shame-proneness: $\alpha = .84$; guilt-proneness: $\alpha = .81$).

OCD symptoms were assessed with the Obsessive-Compulsive Inventory–Revised (OCI-R; Foa et al., 2002). The OCI-R is an 18-item measure purported to assess OCD symptoms across six dimensions: washing, obsessing, ordering, checking, neutralizing, and hoarding. The OCI-R demonstrated good internal consistency at both pre- ($\alpha = .92$) and post-treatment ($\alpha = .93$).

SAD symptoms were assessed with the Social Interaction Anxiety Scale (SIAS; Mattick & Clark, 1998). The SIAS is a 20-item measure believed to assess cognitive, affective, and behavioral reactions to social interactions. The SIAS demonstrated good internal consistency at pre- ($\alpha = .96$) and post-treatment ($\alpha = .94$).

PD symptoms were assessed with the Panic and Agoraphobia Scale (PAS; Bandelow, 1999). The PAS is a 13-item measure purported to assess panic attacks (frequency, severity, and duration), agoraphobia, anticipatory anxiety, disabilities, and worry about health. The PAS demonstrated good internal consistency at pre- ($\alpha = .89$) and post-treatment ($\alpha = .88$).

GAD symptoms were assessed with the Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990). The PSWQ is a 16-item measure hypothesized to assess the tendency to engage in excessive and uncontrollable worry. The PSWQ demonstrated good internal consistency at pre- ($\alpha = .90$) and post-treatment ($\alpha = .93$).

Depression symptoms were assessed with the Beck Depression Inventory (BDI; Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961). The BDI is a 21-item measure believed to assess the intensity of depression symptoms. The BDI demonstrated good internal consistency at pre- ($\alpha = .88$) and post-treatment ($\alpha = .90$).

1.3. Procedure

Participants completed pencil-and-paper questionnaires at the time of their initial assessments (i.e., pre-treatment), during which eligibility for treatment was determined. They also completed questionnaires at the time of termination (i.e., during or just before the final treatment session; post-treatment). Diagnoses were based upon the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998). The MINI is a structured clinical interview used to assess 17 Axis I disorders. The MINI was administered by master and doctoral level clinicians who had prior experience in