A test of shame in outpatients with emotional disorder

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Background: Shame is an acknowledged part of several psychopathological conditions, but is underrepresented in clinical research. Cook’s Internalized Shame Scale (ISS) is the most promising measure, but has mostly been used for testing small clinical samples biased toward depressive pathology and female participants. Aims: To contribute to establishing indicators of pathological shame in outpatients with depression and anxiety disorder, and to contribute to establishing norms for the ISS in Scandinavia. Method: The ISS was administered to $n = 200$ gender balanced non-patient and outpatient samples. A total of 100 patients each were diagnosed as suffering from a depression or anxiety disorder. The diagnoses were supported by Beck’s Depression (BDI) and Anxiety Inventory (BAI). The analyses used were the principal component analysis (PCA) and confirmatory factor analysis (CFA) for item structure and sample equivalence, ANOVAs, t-tests and Mann–Whitney non-parametric statistics for index scores, and the receiver operating curve (ROC) for break-off. Results: Patients’ ISS score were similar to the results from previous research, the effect size of patient–non-patient difference was 0.68, correlations indicated a higher level of shame in depression than in anxiety, and the BDI–BAI correlation was 0.56 for both clinical samples. The PCA showed three factors that were identified as: “Inadequacy”, “Emptiness”, and “Vulnerability”. Conclusions: The ISS is a viable instrument, which indicates a widespread shame pathology in both depressive and anxious outpatients. The instrument may not be uni-dimensional, but exploration of factor variation may be a promising goal for further research. Clinical implications: Assessment of shame should be included in diagnosis and treatment of emotional disorder.

The aim of the present study was to establish indicators for pathological shame in Norwegian outpatients with depression and anxiety disorder, which might contribute to a normation of Cook’s Internalized Shame Scale (ISS) (1, 2), and consequently to the identification of shame as part of the patients’ pathology. “Internalized shame” refers to enduring results of shame scenes that have become part of the self-concept (1), and is tapped by 24 global self-evaluative items.

Shame is typically expressed as eye aversion and turning of the head with the face pointing downwards. There is no single, authoritative definition, but shame is described as a complex emotion, which comprises experiences of awkwardness, exposure, self-paralysis, ridicule and scorn, the feeling of being the focus of disapproving observations from others (3), as well as feelings self-condemnation and worthlessness and a core feeling of not being loved or worthy of love (4–6). The emotion has been conceived as developmentally and causally associated with a negative evaluation of the person herself/himself in relation to some standard (5, 7).

Although noted as part of disorders from excessive shyness to substance abuse and paranoia (3), with the exception of a few pioneers (6, 8), shame was practically ignored in clinical literature and research until the late 1980s (9, 10). One reason for this may be that clinicians focused on guilt rather than shame, and used diagnostic signs for guilt, which actually are descriptions of shame (11). The main differences are that shame is associated with the self and is impaired by a global devaluation, whereas guilt is associated with specific behavior and shows a relatively unimpaired self. Shame furthermore...
results in a desire to hide or strike back whereas guilt results in the desire to confess, apologize and repair (8, 9, 12). Research has indicated effects of shame primarily in depression, obsessive–compulsiveness, and phobic anxiety, and effects of guilt in somatization, overt anxiety and paranoia (3).

Another reason for ignoring shame is that it is difficult to measure. Cook’s ISS (13) and Tangney’s Test of Self-Conscious Affect (TOSCA) (14) have emerged as the most promising measures. Whereas TOSCA taps shame experiences in specific situations, the ISS, with its focus on enduring experiences of shame, is most promising for clinical purposes. This is supported by higher ISS than TOSCA correlations with clinical measures. Correlations with Beck’s Depression Inventory (BDI) (15) have been noted in the 0.70–0.80 range for the ISS (2, 16, 17), and the 0.30 range for TOSCA (18, 19). Evidence is scarce for anxiety, but similar correlations have been shown, respectively, with the ISS and a trait measure (17), and with the TOSCA and various state indicators (19–21).

The significance of research on the ISS has, however, been restricted by a dominance of depression and dependency problems in the clinical samples (2), and by the use of comparison student samples with a two-thirds female bias. Another limitation is that practically all research has been conducted with North American samples, but US norms are not directly applicable as shame acts as a major constraint in social behavior (22, 23). Promising approaches to the application of the ISS have been made in Scandinavia by a Norwegian (17) and a Swedish (24) study, but the former comprised a small sample of 54 non-diagnosed outpatients, and the latter did not employ patients at all.

The present study comprised a gender balanced clinical and comparison sample. The clinical sample was also balanced for depression and anxiety emotional disorders, which represents the vast majority of Norwegian outpatients. A bias towards conceiving the self as failed and worthless in depression (25), and towards external threats in anxiety (26), suggests a view that is closer to the characteristic negative self-evaluation in depression than in anxiety, and leads to expectations of larger correlation between the ISS and measures of depression than between the ISS and measures of anxiety.

Method

Design

ISS scores were obtained through a questionnaire from matched samples of patients and non-patients. The dependent variable was shame, and the independent variations were diagnostic groups (depression or anxiety), gender and age. The study included tests of depression (BDI) and anxiety (BAI) as indicators of the relationship between shame and emotional problems.

The ISS was translated for the present study by the internationally approved procedure where items first were translated into Norwegian by two independent translators, discrepancies were then resolved by consensus and the resulting scale was translated back into English by two new, independent translators. Discrepancies in the back translation indicated adjustments in the forward translation, which then was employed as the ISS test.

The study was approved by the Regional Ethics Committee for Medical Research.

Participants

Clinical sample

One hundred women and 100 men with mean age (+standard deviation), respectively, 24.5±5.1 and 26.1±4.6 years seeking treatment for anxiety or depression (100 each). Sample mean age was 25.8±4.8 years. The participants were recruited from the university’s outpatient clinic (n=93), from a general outpatient clinic (n=65) and from four private practitioners (n=42).

Inclusion criteria were 18–35 years of age, and a psychiatric problem of anxiety or depression, either as referred for treatment from general practitioners, as assessed globally by their therapist, or as judged by the patients themselves. Variation in age was limited in order to obtain a fairly homogeneous young adult sample. Exclusion criteria were psychometric functioning, addiction problems and cultural background other than Norwegian.

Non-clinical sample

One hundred women and 100 men with mean age, respectively, 24.3±3.7 and 25.4±3.9 years, with sample mean age 24.9±3.84 years. One hundred participants were students, and 100 participants were recruited from their workplaces (several day-care institutions, a mental hospital, and a prison) in the local community.

As both samples comprised at least 50% university students, they showed an overrepresentation of education in comparison with the population percentages of 36.2% for women and 22.6% for men in age groups from 25 to 39 years with an education at college and or university level according to official Norwegian statistics for 2004.

Instruments

The ISS comprises 24 negatively worded items, which are shown as Cook’s (2) original items in Table 1. Six positively worded items (items 4, 9, 14, 18, 21 and 28) from Rosenberg’s 12-item Self-Esteem Scale (S-E) (27) are interspersed to counteract a negative response set. All ISS items are rated on 5-point scales from “never” to “almost always”. The ISS was completed by all samples, but BDI and BAI were completed by the clinical sample only.
Beck’s Depression (BDI) (15) and Beck’s Anxiety Inventory (BAI) (28) are both widely used inventories of 21 symptoms, which are rated for severity on 4-point scales.

The instruments were presented in self-completion questionnaires. Responses were scored as an assignment of 0–4 points for ratings for individual items in the ISS, and a 0–3 points for ratings of individual BDI and BAI items. Scores were added to form indexes for each measure.

**Procedure**
Participants were asked to note their age, gender and main problem as either anxiety or depression on the front page of the questionnaires. The sequence of instruments was fixed with the ISS as the first and the BDI as the last measure.

Data collection was pragmatic and had to vary according to the patients’ affiliation. A total of 92.4% (n=158) of the clinic patients completed the questionnaires after they told the reception secretary or one of the authors in the clinic’s reception area that they were willing to take part. The remaining patients, including the 42 participants from private practitioners, returned the questionnaires, which were handed out by their therapists after they agreed to cooperate. Refusals were infrequent, but were not registered. Because of problem types and treatment strategies for the institutions and the practitioners involved, 95% of the patients can be assumed to be in short-term treatment.

The students in the non-clinical sample completed the ISS at the start of a lecture; the others completed the inventory during breaks at their workplace.

**Analyses**
Analyses were focused on shame, and all references to ISS in the results are consequently made to the 24 shame items. The factor structure of the ISS was analyzed with a principal component analysis (PCA) with oblimin rotation, followed by a confirmatory factor analysis (CFA) to test for comparability of sample scores. Break-off on the ISS distribution was indicated by a receiver operating

| Table 1. Cook’s (2) original items and factor loadings for the 24 shame items in the Internalized Shame Scale (ISS). |
|---|---|---|
| Items | Factors |
| | I | II | III |
| 1. I feel like I am never quite good enough | 0.59 | 0.35 | 0.09 |
| 2. I feel somehow left out | 0.52 | 0.46 | 0.01 |
| 3. I think that people look down on me | 0.75 | 0.17 | 0.02 |
| 4. All in all, I am inclined to feel that I am a success | 0.31 | 0.05 | 0.48 |
| 5. I scold myself and put myself down | 0.70 | 0.21 | 0.01 |
| 6. I feel insecure about others’ opinion of me | 0.82 | 0.12 | 0.02 |
| 7. Compared to other people, I feel that I somehow never measure up | 0.58 | 0.24 | 0.18 |
| 8. I see myself as being very small and insignificant | 0.12 | 0.29 | 0.76 |
| 9. I feel I have much to be proud of | 0.44 | 0.30 | 0.31 |
| 10. I feel intensely inadequate and full of self-doubt | 0.38 | 0.30 | 0.30 |
| 11. I feel as if I am somehow defective as a person, like there is something basically wrong with me | 0.62 | 0.12 | 0.21 |
| 12. When I compare myself with others I am just not as important | 0.60 | 0.06 | 0.22 |
| 13. I have an overpowering dread that my faults will be revealed in front of others | 0.44 | 0.17 | 0.22 |
| 14. I feel that I have a number of good qualities | 0.72 | 0.26 | 0.02 |
| 15. I see myself as striving for perfection only to continually fall short | 0.12 | 0.29 | 0.76 |
| 16. I think that others are able to see my defects | 0.07 | 0.23 | 0.55 |
| 17. I could beat myself over the head with a club when I make a mistake | 0.07 | 0.23 | 0.55 |
| 18. On the whole, I am satisfied with myself | 0.23 | 0.05 | 0.62 |
| 19. I would like to shrink away when I make a mistake | 0.00 | 0.31 | 0.57 |
| 20. I replay painful events over and over in my mind until I am overwhelmed | 0.19 | 0.23 | 0.50 |
| 21. I feel I am a person of worth at least on an equal plane with others | 0.25 | 0.25 | 0.64 |
| 22. At times I feel I will break into a thousand pieces | 0.03 | 0.74 | 0.25 |
| 23. I feel as if I have lost control over my body functions and my feelings | 0.05 | 0.76 | 0.21 |
| 24. Sometimes I feel no bigger than a pea | 0.13 | 0.79 | 0.02 |
| 25. At times I feel so exposed that I wish the earth would open up and swallow me | 0.16 | 0.82 | 0.03 |
index (GFI) of 0.787, and root mean square error of approximations (RMSEA) of 0.087, which suggested an acceptable equivalence of factor structure. The most valid information on factor structure of the ISS responses could therefore be based on an analysis of the total sample (n=400).

The scree plot, including a solid reference line for Kaizer’s eigenvalue>1 criterion, is shown in Fig. 1. The pattern matrix of factor loadings is shown in Table 1. Figure 1 shows a very dominant Factor I. Eigenvalue and variance percentages for this factor were, respectively, 13.2 and 54.9, while corresponding data for Factor II were 1.4 and 5.9, and for Factor III 1.2 and 5.2. Table 1 shows that Factor I included items 1–3, 6–8, 10–13 and 15–16; Factor II items 26–27 and 29–30; and Factor III items 5, 17, 19–20 and 22–25. Correlations between factors were 0.44 for factors I and II, 0.58 for factors I and III, and 0.48 for factors II and III.

Results
Cronbach’s ISS alpha was 0.92 for both samples, and the mean item-total correlation was 0.61 (range 0.36–0.76) and 0.56 (range 0.35–0.72), respectively, for the clinical and non-clinical samples. Alphas for the BDI and BAI were, respectively, 0.89 and 0.92.

Factor analysis
The PCA showed five factors with eigenvalue>1 for both samples. The follow-up CFA on the clinical sample showed $\chi^2(252)=1034.72$, $p<0.01$, a goodness-of-fit

Curve (ROC) analysis and scale characteristics, while independent variation in ISS scores was tested by means of Pearson correlation analyses, tests of variance (ANOVA) and Mann–Whitney non-parametric statistics. Effect sizes were indicated by Cohen's $d$ (29).

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Table 2. Mean, standard deviation ($s$) and correlation between shame and the self-esteem measures for clinical and non-clinical samples, diagnostic groups, and gender.

<table>
<thead>
<tr>
<th>Sample</th>
<th>ISS</th>
<th>Self-esteem</th>
<th>Correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>$s$</td>
<td>Mean</td>
</tr>
<tr>
<td>Clinical (n=200)</td>
<td>50.19</td>
<td>18.39</td>
<td>11.50</td>
</tr>
<tr>
<td>Non-clinical (n=200)</td>
<td>21.89</td>
<td>11.87</td>
<td>17.82</td>
</tr>
<tr>
<td>Depressive patients (n=100)</td>
<td>52.92</td>
<td>16.34</td>
<td>10.96</td>
</tr>
<tr>
<td>Anxious patients (n=100)</td>
<td>47.45</td>
<td>19.78</td>
<td>12.07</td>
</tr>
<tr>
<td>Women (n=200)</td>
<td>37.53</td>
<td>21.59</td>
<td>14.54</td>
</tr>
<tr>
<td>Men (n=200)</td>
<td>34.53</td>
<td>20.20</td>
<td>14.79</td>
</tr>
</tbody>
</table>

ISS, Internalized Shame Scale.
The Factor I item sample was very similar to Factor 1 in the only other large sample factor analysis (12, \( n = 801 \)), and might be defined by the item content correspondingly as “Inadequacy”. Factor II also corresponded likewise similar to Factor 2, and were defined as “Emptiness”, whereas Factor III shared items with two factors in (13) and can be defined according to item content as “Vulnerability”.

Separate analyses for the clinical and non-clinical samples showed five factors. Both analyses showed a dominant inadequacy factor with a large overlap of items, the eigenvalue and variance percentages were, respectively, 10.28 and 42.86 for the clinical, and 9.03 and 37.61 for the non-clinical samples, with large overlapping of items, identical vulnerability factors and combinations of items from the inadequacy and emptiness factors in the other three factors.

**Variation in scores**

Table 2 shows mean ISS and S-E scores for clinical samples, diagnostic groups and gender.

Mann–Whitney \( z \) scores, which were used because of heterogeneous variances, were 13.76 and 12.45, respectively, for the ISS and S-E scales, both \( P < 0.01 \) for markedly lower ISS and higher S-E scores for the non-clinical than for the clinical sample. Cohen’s \( d \) was 1.83 and 1.54, respectively, for the ISS and the S-E scale, whereas the corresponding effect sizes were 0.68 and 0.61. A Fisher’s \( z \) score transformation test (30) showed a higher ISS–S-E correlation for the clinical than for the non-clinical sample, \( z = 2.52, \ P = 0.01 \).

The scores for diagnostic groups and gender were analyzed with univariate ANOVAs with the former as a fixed variable, and the latter, together with age, as a covariate. The ANOVA for ISS showed a main effect of gender, \( F(1, 196) = 6.32, \ P = 0.01 \), related to a higher score for women than for men. This was mainly because of results for anxious patients, where means of 52.2 for women and 42.5 for men corresponded to \( F(1, 98) = 5.95, \ P = 0.01 \).

The higher ISS score for depressive patients shown in Table 2 corresponded to \( F(1, 196) = 3.78, \ P = 0.05 \). The ANOVA did not show significant differences in S-E scores.

**Cut-off**

A cut-off can be indicated by the 0.68 effect size, with the mean of the clinical sample at the 75th percentile of the non-clinical sample. Another indicator is the sensitivity–specificity differential, which can be assessed by the

<table>
<thead>
<tr>
<th>Sample</th>
<th>Mean</th>
<th>s</th>
<th>Mean</th>
<th>s</th>
<th>ISS–BDI</th>
<th>ISS–BAI</th>
<th>Self–BDI</th>
<th>Self–BAI</th>
<th>BAI–BDI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>22.27</td>
<td>9.95</td>
<td>20.86</td>
<td>10.78</td>
<td>0.78</td>
<td>0.58</td>
<td>−0.53</td>
<td>−0.25</td>
<td>0.56</td>
</tr>
<tr>
<td>Anxiety</td>
<td>17.68</td>
<td>10.77</td>
<td>26.56</td>
<td>13.83</td>
<td>0.74</td>
<td>0.55</td>
<td>−0.72</td>
<td>−0.40</td>
<td>0.56</td>
</tr>
<tr>
<td>Total clinical</td>
<td>19.98</td>
<td>10.60</td>
<td>23.71</td>
<td>12.70</td>
<td>0.73</td>
<td>0.53</td>
<td>−0.64</td>
<td>−0.31</td>
<td>0.48</td>
</tr>
</tbody>
</table>

ISS, Internalized Shame Scale.

Table 3 shows the mean BDI and BAI scores according to diagnostic groups, and the correlation between these measures and the ISS and S-E indexes.

BDI and BAI scores were examined by univariate ANOVAS with diagnostic group as a fixed variable, and gender and age as covariates. The results showed main effects of the diagnostic group of \( F(1,195) = 9.06, \ P < 0.01 \), for BDI and \( F(1,195) = 9.43, \ P < 0.01 \), for BAI. As is shown in Table 3, the differences refer to higher BDI and lower BAI means for the depressives, and vice versa for the anxious group. Women scored higher than men on both measures, the ANOVA showed \( F(1,195) = 4.64, \ P = 0.03 \), for the BDI, and \( F(1,195) = 11.99, \ P < 0.01 \), for the BAI.

Table 3 shows similar correlations between ISS, BDI and BAI in the clinical groups, but higher correlations with BDI corresponding to \( z = 2.67, \ P < 0.01 \), for the depressive, and \( z = 2.31, \ P = 0.02 \), for the anxious patients. The higher S-E–BDI correlation indicated for anxious than for depressive patients showed \( z = 2.21, \ P = 0.027 \), the difference for BAI correlations was non-significant. Both clinical groups showed higher correlations between S-E and BDI than between S-E and BAI, \( z = 2.33, \ P = 0.02 \), and \( z = 3.32, \ P < 0.01 \), for the anxious group. The substantial BDI–BAI correlations in Table 3 indicate a high degree of co-morbidity in both diagnostic groups. A co-morbidity indicator consisting of 70 patients who scored higher than the 50th percentile for both measures showed an ISS mean of 65.3±13.4, i.e. a markedly higher ISS score than for each of the diagnostic groups in Table 2. “Pure” problem groups were created by selecting participants who scored over the 50th percentile on the BAI and below the 50th percentile of the BDI for anxiety (\( n = 19 \)), and vice versa for depression (\( n = 16 \)). Correlations between these groups were non-significant, and were, respectively, 0.07 and 0.37, ISS means were, respectively, 36.4±13.4 and 55.1±12.7.
ROC statistics. The ROC analysis showed an area under the curve of 0.898, with a standard error of 0.016 and a 0.866–0.929 lower–upper bound 95% CI. The area under the curve was slightly less than the 0.90 limit of “excellent differentiation”. The analyses indicated that the best differential was obtained at an ISS score of 38. A total of 76% of clinical participants scored higher, and 92% of non-clinical participants scored lower than this point. Thus, 336 participants, or 83.5% (n = 400), could be considered “correctly” classified at this point. Correctness percentages were 89 and 84, respectively, for the depressive and the anxiety diagnostic group.

Discussion

Indicators of reliability and internal consistency of the ISS were comparable with prior research (2, 12, 17), as were the main results of the study. One quality indicator is that the alpha of the 24-item ISS was very similar to the alphas of the uni-dimensional and thoroughly tested 21-item BDI and BAI scales. The present mean ISS score of 50.2 was, moreover, similar to the 51.9 and 52.2 mean score for outpatients noted, respectively, in studies (2) and (17), and the ISS–BDI correlation of 0.73 for the outpatient sample as a whole was similar to findings in other studies (2, 16, 17). The results seem to concur with the summary finding (2, p. 159) that almost every clinical sample that has been tested with the ISS has yielded a sample mean of 50 or higher, but prior research has not included patients with anxiety diagnoses.

Concurring with the expectations for the study, the lower BAI than BDI correlations with the ISS, as well as an ISS mean of 36.4 for a high anxiety sample with non-significant BAI–BDI correlations, suggested that shame is a more salient problem in depression than in anxiety disorders. The result for anxiety may, however, relate to the distribution of anxiety types rather than a generally lower level of shame. One indication is that shame has been specifically associated with social anxiety (31), and with the fear of evaluation by others and hypersensitivity to criticism, found to be associated features of social phobia in DSM-IV-TR (32), which by comparison refers to shame only as part of a demoralization which is related to panic disorder.

A limited gender effect was related to anxious patients, where women showed higher ISS scores than men.

Findings related to the six items that represented half of Rosenberg’s S-E scale are not generally reported in the literature, it can be noted that the S-E scores in the present study were similar to those in the prior Norwegian study (17), and that an S-E index was more negatively correlated with ISS in depressive than in anxious patients.

The results support other studies (17, 24) in suggesting that the ISS is a viable measure of shame and indicator of shame-related pathology in Scandinavia. One main limitation on these interpretations is the overrepresentation of highly educated and young participants in the outpatient sample. A full normative study in the present context should include a more extended distribution of age and education, as well as sample stratifications of debut and duration of problems, and time, repetitiveness and type of treatment, which all refer to variables that may be related to the ISS. Data in these respects must be supplied by further studies because a full normative study would require an at least five times increase in sample size as compared to the present study.

Another main limitation is the rather gross diagnostic procedure of the study. In fact, the procedure is probably better described as a problem identification, rather than as a formal diagnostic procedure. This procedure may have resulted in classification of some patients as suffering from depression rather than anxiety, and vice versa. The problem is counteracted by the rather large sample sizes, and the differences in BAI and BDI scores indicated valid classifications on the group-data level. The deviation from scores resulting from “perfectly diagnosed” samples may therefore not be as large as to doubt the ISS levels and differences shown by the results.

A further complication in this respect is that depression and anxiety show joint variation and form co-morbidity in clinical cases. The extent of this is indicated by the BDI–BAI correlations in the present study, which was within the 0.45 to 0.75 range of correlations commonly observed in studies of outpatients (33). The results indicated that co-morbidity may be associated with heightened shame problems, but the procedure could not show the frequency of co-morbidity cases in the clinical sample.

An additional note on the ISS results is that the substantial differences in mean ISS scores in the patient and non-patient sample were in the lower range of comparisons. One reason was that patients’ BDI and BAI scores indicated only mild to moderate problems, another was that the non-patient group was not a non-problem group. One indication of problem frequency in the non-patient high-education, low age group may be that epidemiological studies of Norwegian students have repeatedly shown a 12–15% prevalence of emotional problems, and an ISS score for a non-problem group may consequently be somewhat lower than in the present study.

The shortcomings mean that the validity of the ROC analysis cut-off for “shame pathology” at 38 points is rather questionable. A better indicator can be the 50-point ISS score, which was at the 50th percentile for the client and the ninth percentile for the non-client group in the present study, and which represents a level of mean scores for several studies of client samples.

Factor analysis of the ISS showed a dominant “Inadequacy” factor, which was similar to the first factor in the only other large sample analysis (13), and which comprised items that corresponded to the key characteristic of
shame as global feelings of self-condemnation and worthlessness. The medium inter-correlations between this factor and factors designated as “Emptyness” and “Vulnerability” in the present analysis suggested that the ISS might not be uni-dimensional. This is, however, in agreement with the conclusion (13, p. 211) that shame is not a single factor, but consists of different kinds of internalized feelings. Separate analyses of the clinical and non-clinical samples also showed a dominant inadequacy factor and a generally large overlap in item loadings.

A discussion of the differences in the results of these analyses is outside the scope of the present report, but analyses of variations in the structure as well as the index of shame in clearly delineated clinical groups may be promising goals for further research in the area. Promising research and treatment might finally also be related to the theoretical linking of shame to self-evaluation (5, 7), which suggests that the causal attribution of shame is focused on some concept of deficient personal processes, characteristics, or behavior.

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