UC/FPCE—2013

Universidade de Coimbra
Faculdade de Psicologia e de Ciências da Educação

"Shame on you" or "shame on me"? - O *coping* com a vergonha em adolescentes com perturbação de conduta, com fobia social e sem psicopatologia.

Liliana Magda Gageiro Caldas
(e-mail: LilianamgCaldas@gmail.com)

Dissertação de Mestrado em Psicologia Clínica na subárea de especialização em Intervenções Cognitivo-Comportamentais nas Perturbações Psicológicas e da Saúde, sob a orientação do Professor Doutor Daniel Maria Bugalho Rijo

***"Shame on you" or "shame on me"*? - O *coping* com a vergonha em adolescentes com perturbação de conduta, com fobia Social e sem psicopatologia**

Resumo

A temática da vergonha tem recebido crescente interesse teórico ao longo dos últimos anos. De acordo com a perspectiva evolucionária, a vergonha relaciona-se com o comportamento competitivo e com a necessidade de aceitação, havendo diversos estudos que associam a vergonha com diferentes quadros psicopatológicos. No entanto, tal parece ser um indicador de que poderão não ser apenas as actuais experiências de vergonha que estão na base da psicopatologia, uma vez que estas são comuns a vários quadros psicopatológicos. Existe também já alguma evidência de que estratégias maladaptativas de *coping* poderão estar relacionadas com diferentes condições psicopatológicas. Assim, o presente trabalho pretendeu testar se diferentes quadros psicopatológicos podem ser conceptualizados como resultado da adopção preferencial por diferentes estilos de *coping* com a vergonha. Para tal, recorreu-se a 3 grupos de sujeitos: perturbação de conduta (n=34), fobia social (n=18) e população não clínica (n=39). Os níveis de vergonha externa assim como os estilos de coping com a vergonha foram testados nos três grupos. Os resultados mostraram que as populações clínicas experimentam níveis significativamente mais elevados de vergonha externa quando comparadas com a população não clínica. Os sujeitos com fobia social e com perturbação de conduta não se distinguiram pelos níveis de vergonha externa, mas sim pelo endosso de distintos estilos de *coping* com a vergonha. Os sujeitos com perturbação de conduta parecem adoptar o *ataque ao outro* como estratégia de *coping* com a vergonha, enquanto os sujeitos com fobia social parecem adoptar preferencialmente o estilo de *coping* de *ataque ao eu*. Este estudo sustenta trabalhos anteriores que sugerem que não são as actuais

experiências de vergonha que predizem a psicopatologia, mas sim a forma como os sujeitos lidam com esta emoção. Tal parece ter algumas implicações clínicas, nomeadamente a importância de avaliar e intervir com os níveis de vergonha dos sujeitos, assim como a necessidade de programar intervenção específica para diferentes estilos de *coping* em diferentes quadros clínicos.

Palavras chave: vergonha, *coping* com a vergonha, perturbação de conduta, fobia social, análise da função discriminante.

"Shame on you" or "shame on me"? - Coping with shame in adolescents with conduct disorder, social phobia and without psychopathology

Abstract

Shame has received an increasingly theoretical interest over the last few years. According to evolutionary perspective, it is related to competitive behavior and to the need of acceptance and several studies associate shame to different psychopathologies. However, this seems to suggest that actual experiences of shame may not be the only basis of psychopathology, since these are prevalent in various disorders. There is also some evidence that maladaptive strategies of coping may be related to different psychopathologic conditions. Therefore, the present study aims to test if different psychopathologies may be conceptualized as resulting from a preference for different shame-coping strategies. Three groups of subjects were used: conduct disorder (n=34), social phobia (n=18) and nonclinical population (n=39). Levels of external shame and shame-coping styles were tested in the three groups. Findings showed that clinical populations has significantly higher levels of external shame, comparing to nonclinical populations. In addition, subjects with social phobia and conduct disorders are distinguished by endorsement of specific coping styles with shame, instead of levels of external shame. Subjects with conduct disorder seem to adopt the *attack other* as the preferred shame coping strategy, while social phobics seem to preferably adapt the *attack to self* coping style with shame. This study supports previous works suggesting that instead of being the current experiences of

shame that create individual problems, it is the way we cope with them that matters. This seems to have clinical implications, particularly in the importance of evaluation and intervention in subjects' levels of shame, as well as the necessity to desing specific intervention to different coping styles in the various psychopathologic conditions.

Key Words: Shame, shame-coping styles, conduct disorder, social phobia, discriminant function analysis.

Aos meus pais.

Agradecimentos

Ao Professor Doutor Daniel Rijo, pelo interesse genuino que deposita nos seus alunos. Pelo conhecimento e valores transmitidos. Pelo envolvimento com com este trabalho que me permitiu nunca desmotivar.

A toda a equipa do Professor. Doutora Paula Vagos e Mestre Diana Ribeiro, por todo o apoio e disponibilidade. À Mestre Carolina da Motta e ao Mestre Nélio Brazão pelo apoio, pelas experiências que me proprocionaram, por serem profissionais extramente humanos e nos terem transmitido isso.

Às minhas colegas Marlene, Cíntia, Liliana e Marilúcia pelo espírito de entreajuda.

À Professora Doutora Maria do Céu, ao Centro Educativo dos Olivais, à Dra. Helena Godinho, à D. Isabel Almeida, ao Frederico Viegas Neves e à Sara Assis por tornarem possível a recolha da amostra.

Ao corpo docente da Faculdade de Psicologia e de Ciências da Educação da Universidade de Coimbra pelas competências transmitidas ao longo do meu percurso académico.

Aos "principais" que tornaram estes 5 anos em Coimbra uma vivência que "levo comigo prá vida". Mário, Ricardo, Chico, Fred, Soraia, Sara, Mariana, Rita, Inês Margarida, Julieta, Nádia, Filipa, Paulo, Lupi, Zé Pedro, João Pinto, Basófias, Leonor, Lageanos. A todos aqueles que se cruzaram comigo ao longo deste percurso.

À Marlene Cardoso por toda a ajuda e amizade. Perguntaste-me o que o que é *soothing… soothing* és tu, entendes?

Ao Bruno Trindade pela cumplicidade, pelo apoio, pela paciência. Por seres um porto de abrigo. Por tudo o que não caberia aqui.

À minha mãe e ao meu pai por acreditarem sempre em mim, por se orgulharem em me deixarem orgulhosa, por tudo o que abdicaram. À minha irmã por ser a minha maior dor de cabeça e a minha maior alegria. Aos meus queridos avós por se preocuparem sempre com o meu bem-estar.

A Coimbra.

Índice

Introdução Geral

O presente trabalho é constituído por três partes. Inicialmente é feita uma introdução geral que visa a abordagem e desenvolvimento de alguns conteúdos relevantes para o tema estudado numa tentativa de complementar a informação teórica que é apresentada na secção seguinte, cujos requisitos exigidos não permitem uma maior extensão. São ainda focados alguns dos pontos-chave e os objectivos do presente trabalho. A segunda parte é constituída por um manuscrito, sendo que este se encontra de acordo com as normas de formatação da revista *Clinical Psychology* & *Psychotherapy*, para a qual se pretende submeter o mesmo. Por fim, é apresentada uma discussão geral sobre o trabalho realizado. Começa-se por discutir alguns resultados sendo também feita uma reflexão acerca das implicações terapêuticas dos mesmos.

Teoria das Mentalidades Sociais

O Ser-Humano é uma espécie eminentemente social que desenvolveu os seus comportamentos e mentalidades de modo a melhor se adaptar em sociedade, sendo que a probabilidade de reprodução e sobrevivência está altamente dependente da forma como nos relacionamos com os outros e de como os outros se relacionam connosco (Gilbert & Irons, 2009). Os mecanismos mentais evoluíram para responder aos desafios subjacentes à vivência em comunidade, nos quais se incluem a escolha de um parceiro, o sucesso reprodutivo, obtenção e prestação de cuidados e defesa de recursos. Gilbert (2000a) considera que estes desafios deram então origem a mentalidades sociais, as quais guiam a interpretação de sinais e papéis sociais congruentes com a motivação e objectivos biológicos que se pretendem alcançar. Estas têm a função de regulação psicobiológica do comportamento e sustentam formas universais de comportamento social (Buss, 1995; Nesse, 1998) em vários domínios, como: prestação de cuidados, obtenção de cuidados, escolha de parceiro, cooperação e formação de alianças e competição por *status* social (Gilbert, 2000a). Para corresponder desejavelmente aos papéis sociais nos vários domínios anteriormente mencionados, a nossa espécie desenvolveu formas de analisar e interpretar

sinais sociais respondendo a estes de forma a ter impacto na mente dos outros. Em função do sucesso ou fracasso no desempenho de um determinado papel social, surgem emoções positivas ou negativas, respectivamente (Bailey, 1987, Nesse, 1998). Para a compreensão do sentimento de vergonha, importa destacar o domínio do *ranking* social, uma vez que sinais de desaprovação e a percepção de uma posição desfavorável no *ranking* geram afecto negativo, particularmente vergonha (Gilbert, 2000a; Gilbert & McGuire, 1998; Nesse, 1998).

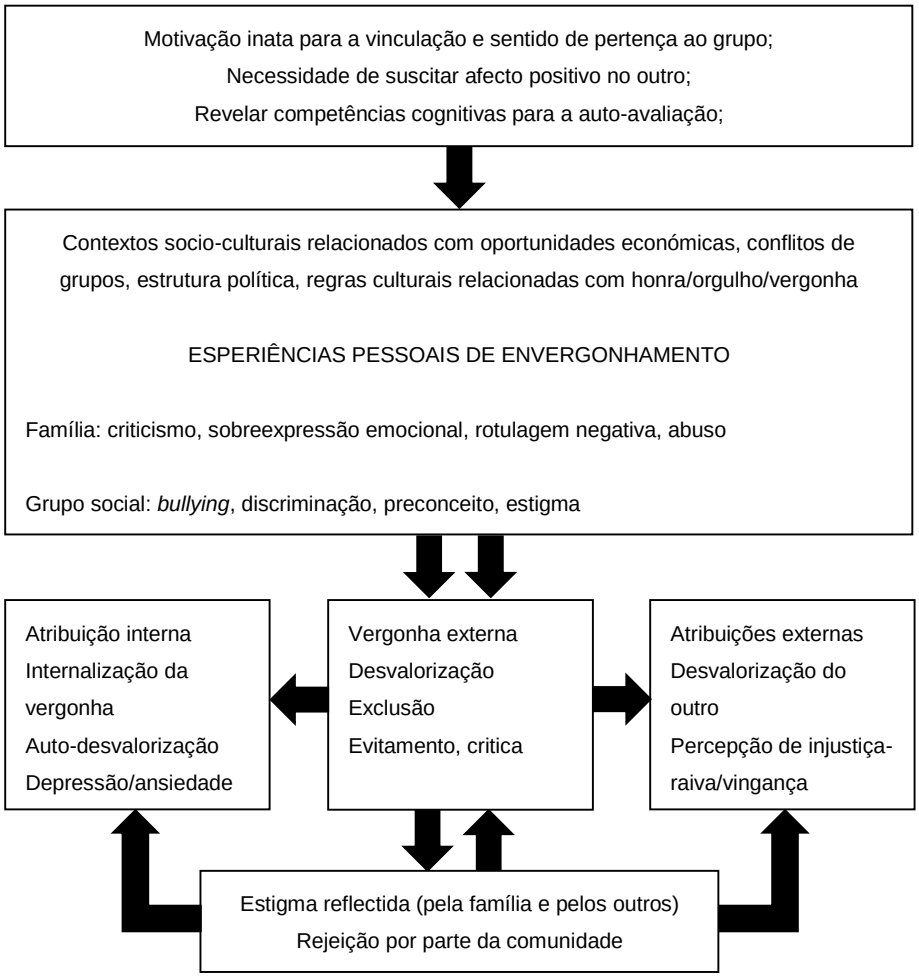
O modelo biopsicossocial da vergonha

O modelo biopsicossocial da vergonha centra-se no desenvolvimento de padrões de interacção entre diferentes sistemas cerebrais (e.g., informação genética, emoções, pensamentos e papéis sociais) e em como estes padrões são moldados através de relações sociais e de condições ecológicas. Este modelo integra a perspectiva da psicologia evolucionária, em particular a teoria das mentalidades sociais (Gilbert, 1989, 1995, 2000a, 2005a), assim como a teoria da vinculação (e.g., Bowlby, 1969, 1973) e uma abordagem biopsicossocial (e.g.,Gilbert, 1995, 2005b, Gilbert et al., 2009).

O modelo está representado na figura 1. No Ser-Humano existe uma predisposição inata relacionada com a necessidade de vinculação e recurso a figuras de vinculação como uma "base segura" com qualidades de *soothing* (Bowlby, 1969, 1973). Existe também uma necessidade inata relacionada com a capacidade de estimular afecto positivo na mente dos outros, o que nos permite estabelecer vínculos dentro e fora do nosso ambiente familiar. Relativamente à importância do contexto sociocultural, importa referir que as relações interpessoais se desenvolvem num determinado contexto, podendo este ambiente ser favorável ou, por outro lado, hostil. Este contexto influencia ainda o que é ou não considerado atractivo e aceitável. Tais experiências indicam se o indivíduo é então atraente, aceite, pertencente ou, pelo contrário, pouco atraente e vulnerável em situações sociais (Gilbert & Irons, 2009). No centro do modelo encontra-se a vergonha externa. Desta forma, quando percepcionamos afecto negativo por parte dos outros, isto é, quando sentimos

que não somos aceites, que os outros nos criticam, evitam ou excluem, o sentimento de vergonha externa é activado.

Figura 1. O modelo evolucionário biopsicossocial da vergonha (adaptado de Gilbert, 2002, p.34)



A componente chave do modelo relaciona-se com esta percepção de uma visão negativa do outro em relação *self*, a qual é experienciada como ameaça. Esta ameaça pode activar diferentes tipos de defesas. Uma possível resposta relaciona-se com a atribuição interna da experiência. O sujeito identifica-se com a avaliação negativa, autocritica-se e adopta um comportamento submisso. Por outro lado, pode ser activada uma outra defesa, esta relacionada com estratégias externalizantes. A natureza da experiência é a humilhação. O sujeito atribui intensões malévolas ao outro o que implica sentimentos de raiva e desejo de retaliação (Gilbert, 1998).

Assim, abordando a psicopatologia numa perspectiva evolucionária, quer o comportamento de submissão, quer as respostas agressivas podem ser

compreendidas como defesas à percepção de uma ameaça ao *self* e à sua posição no *ranking* social. De facto, a literatura aponta para uma forte relação entre a vergonha e a psicopatologia, havendo já vários estudos que evidenciam a relação da vergonha com diferentes quadros psicopatológicos como, por exemplo, ansiedade (e.g., Irons & Gilbert, 2005; Tangney, Wagner, & Gramzow, 1992), depressão (e.g., Allan, Gilbert & Goss, 1994; Andrews, 1995; Cheung, Gilbert, & Irons, 2004; Tangney, Wagner, & Gramzow, 1992; Thompson & Berenbaum, 2006), perturbações alimentares (e.g., Skarderud, 2007; Troop, Allan, Serpell, & Treasure, 2008) ou perturbações da personalidade (e.g., Kinston, 1987; Rüsch et al., 2007).

Existem também diversos estudos que relacionam a vergonha com a ansiedade social e com o comportamento agressivo (e.g., Allan & Gilbert, 2002; Clark & Wells, 1995; Gold, Sullivan, & Lewis, 2011; Leith & Baumeister 1998; Lutwak, Panish, Ferrari & Razzino, 2001; Gilbert, 2000b; Gilbert & Trower, 1990; Tangney & Dearing, 2002; Tangney, Wagner, Fletcher & Gramzow, 1992; Matos, Pinto-Gouveia & Gilbert, 2012; Owen & Fox, 2011). No entanto, a grande maioria destes estudos utilizou escalas de autorresposta; em contraponto, o presente estudo pretendeu, numa primeira fase, clarificar esta associação com recurso a grupos de sujeitos diagnosticados por meio de entrevista clínica estruturada. Os níveis de vergonha externa foram comparados entre os dois grupos clínicos assim como com um grupo de população não clínica.

A evidência da relação da vergonha com a psicopatologia parece tê-la tornado num mecanismo comum a diversos quadros psicopatológicos que não explica os diferentes fenótipos de psicopatologia. Assim, parece relevante tentar compreender quais os mecanismos que medeiam esta relação. Nathanson (1994) sugere que poderão não ser as actuais experiências de vergonha que criam os problemas pessoais, mas sim a forma como lidamos com esta. De forma semelhante, outros autores sugerem que estratégias de *coping* maladaptativas poderão estar relacionadas com diferentes quadros psicopatológicos (Morrison & Gilbert, 2001; Tangney & Dearing 2002).

Nathanson (1992) desenvolveu um modelo de estilos de *coping* desencadeados por uma situação de vergonha, o *Compass of Shame*. Este modelo descreve quatro estilos de *coping* visam reduzir, ignorar ou modificar o sentimento de vergonha (Elison, Lennon, & Pulos 2006; Nathanson, 1994;

Yelsma et al., 2002) e que são representados pelos quatro pontos cardeais da bússola (i.e., *compass*): a *fuga*, o *ataque ao eu*, o *evitamento* e o *ataque ao outro*. Na estratégia *fuga*, a mensagem da vergonha é aceite como válida, o sujeito tem tendência a retirar-se da situação com o objectivo de limitar a exposição da vergonha. Na estratégia de *ataque ao eu* a mensagem da vergonha é reconhecida como válida e é ampliada pela sua internalização; gera sentimentos negativos e cognições auto-depreciativas. Na estratégia de *evitamento* a mensagem da vergonha é negada; a tendência de acção do individuo relaciona-se com a tentativa de distrair os outros e a si próprio do mal-estar gerado pelo sentimento de vergonha, de forma a distanciar-se e minimizar esta experiência. Por fim, a estratégia de *ataque ao outro* está relacionada com a externalização da raiva e da culpa; o sujeito ataca verbal ou fisicamente outra pessoa com o objectivo de a fazer sentir-se inferior (Elison, Pulos, & Lennon, 2006).

Parece não existir ainda estudos que investiguem a relação de diferentes estilos de coping com a vergonha com diferentes quadros psicopatológicos. Assim, pela primeira vez, os estilos de *coping* com a vergonha são comparados em duas populações clinicas, a perturbação de conduta e a fobia social. Com base no modelo de Nathanson (1992), o presente trabalho foi então desenvolvido com objectivo de compreender se diferentes tipos de patologia podem ser conceptualizados como resultado da adopção preferencial de um estilo de *coping* com a vergonha. A escolha dos grupos clínicos - perturbação do comportamento e fobia social - relacionou-se com as características destas perturbações que sugerem que a perturbação de conduta está relacionada com estratégias externalizantes (nomeadamente o *ataque ao outro*) ao contrário da fobia social que se associa a estratégias internalizantes (nomeadamente o *ataque ao eu*).

A compreensão destes mecanismos poderá ter implicações clínicas, nomeadamente a nível da formulação de caso e planeamento de estratégias terapêuticas.

Os resultados são apresentados na secção seguinte.

Coping with Shame: a Comparison between Male Adolescents with Conduct Disorder, Social Phobia and Without Psychopathology

Liliana Caldas

Objectives: To test if different types of psychopathologies can be conceptualized as a result of preferential choices for different shame-coping strategies.
Method: A total of 91 male adolescents took part in this study: nonclinical (n=39), conduct disorder (34) and social phobia (n=18). The clinical participants were diagnosed using a structured clinical interview. Shame and shame-coping styles were assessed using self-report questionnaires. A Welch ANOVA analysis and a discriminant analysis were conduct.
Results: Subjects from the clinical groups reported significantly higher levels of shame that subjects from nonclinical group. Social phobics and the conduct disordered subjects did not differ in the endorsement of shame feelings. Interestingly, the conduct disordered subjects seems to adopt the attack to others, as the preferred coping style with shame, while social phobics adopt the attack to themselves as the preferred coping style with shame.
Conclusion: The findings in this study are in support of previous studies, claiming that the feeling of shame does not predict psychopathology, but the way in which we cope with such shame is key in the prediction of psychopathology. Therapeutically, the results underline the importance of working with shame and shame coping styles in different manners in different psychopathologies.

Key Practitioner Message:

- Shame and shame-coping strategies as relevant variables that explaining social phobia and conduct disorder.
- To guide therapeutic interventions according to the type of preferred shame coping strategy.
- To help to select intervention strategies focused in the reduction of shame.
- To establish the link between different maladaptive behaviors, coping strategies and underling shame feelings

Keywords: Shame, Shame-coping Style, Conduct Disorder, Social Phobia, Discriminant Function Analysis

[1] Nota: o manuscrito apresenta-se segundo as normas de formatação da revista *Clinical Psychology & Psychotherapy*, para a qual se pretende submetê-lo.

INTRODUCTION

Shame is an emotion related to self-focusing, a painful experience in which the self is negatively scrutinized and valued (Tangney, 1996). This can result in a perception modification, accompanied by feelings of inferiority and weakness (Lewis, 1971) and strong desires to hide and conceal the self (Gilbert, 1998; Tangney and Fischer, 1995). Evolutionarily, shame is related to the competitive behaviour and to the need of being accepted by others (Gilbert, 1989, 2002).

From birth and throughout life, connections between events and emotions will be created (Nathanson, 1994). Emotional memories of past events are important components of our life and identity as an individual, in a way that some of these emotional events may still cause stress across all life (Bluck & Habermas, 2000; McAdams, 2001; Pillemer, 1998; Singer & Salovey, 1993). According to Gilbert (2003) early shame experiences become fundamental to personal the development about self beliefs. These experiences are remembered in autobiographical memories and become self-descriptive with time.

Shame and devaluation experiences seem to have a significant effect on brain maturation and have been associated not only with the propensity to shame, but also with the vulnerability to psychopathology (Schore, 1998, 2001; Tangney, Burggraf & Wagner, 1995). It has been reported in previous studies a connection between shame and different symptoms and psychopathological disorders including: Alcoholism (e.g., Bradshaw, 1988; Brown, 1991); anxiety (e.g., Irons & Gilbert, 2005; Tangney, Wagner, & Gramzow, 1992); depression (e.g., Andrews, 1995; Cheung, Gilbert, & Irons, 2004; Allan, Gilbert & Goss, 1994; Tangney, Wagner & Gramzow, 1992; Thompson & Berenbaum, 2006), domestic violence (e.g., Dutton, van Ginkel & Starzomski, 1995; Lansky, 1987, 1992), eating disorders (e.g., Skarderud, 2007; Troop, Allan, Serpell, & Treasure, 2008); and personality disorders such as narcissistic personality disorder (e.g., Kinston, 1987) and borderline personality disorder (e.g., Rüsch et al., 2007).

Coping with Shame

Nathanson (1994) suggests that instead of being the current experiences of shame that create individual problems, it is the way in which we cope with them that matters. This idea is consistent with other authors (Morrison & Gilbert, 2001; Tangney & Dearing 2002), who considered that maladaptive shame-coping strategies may contribute to the development of different psychopathological disorders. According to Kaufman (1996), the preferred script to deal with shame will be developed in parallel with self-development and, as Nathanson (1994) sustains, it may be considered as part of the self. Elison, Lennon and Pulos (2006a) claim that when taking into account personality characteristics over time, some scripts are more frequently activated, thus being closely linked to individual characteristics.

Nathanson (1992) developed a model of shame-coping styles, the Compass of Shame, which was based on Tomkins's script theory (1991). Tomkins (1962-1991) proposed a group of nine primarily mechanisms that he calls "innate affects" which operate from birth, one of these being Shame-humiliation. Tomkins postulates that each one of these affects is triggered by discrete activators. The trigger of shame is any experience that requires rapid decrease in the affects of interest-excitement and enjoyment-joy, in situations where the organism wants to maintain the pre-existing affect states. Tomkins also proposes that the perceived decline in social rank may be considered a trigger given that the inefficacy is a potent releaser of shame. The assemblies of any affect that has been triggered with our memories of previous experiences of that affect, result in a larger category that he called "scripts". Those scripts, much like schemas, are defined as *"sets of ordering rules for the interpretation, evaluation, prediction, production, or control of scenes"* (Tomkins, 1991, p. 84). Nathansons's compass of shame has four cardinal points that represent the different

collections of scripts that aim to reduce, ignore, modify, or enhance shame (Elison et al., 2006a; Nathanson, 1994; Yelsma et al., 2002), which are *withdrawal*, *attack self*, *avoidance* and *attack other* (Table 1).

Table 1. Compass of Shame Strategies (Adapted from Elison et al., 2006b)

	Poles			
	Withdrawal	Attack Self	Avoidance	Attack Other
Shame's message	Is accepted as valid	Is accepted and magnified by internalization	Is not typically recognized or accepted	Could not be recognized and normally is not accepted
Phenomenological Experience	Is negative	Is negative	Is neutral or positive	Is negative
Action Tendency	To withdraw or hide from the situation	To criticize the self, conform, or show deference to others	To transform the situation into something neutral or positive	To verbally or physically attack someone
Aims	To limit shameful exposure	To be accepted by others	To prevent the conscious experience of shame	To make someone else feel inferior or worse and bolster one's self-image

A few studies have shown that maladaptive shame coping may be a contributing factor to specific psychopathological conditions such as psychopathy (Campbell & Elison, 2005; Morrison & Gilbert, 2001; Nyström & Mikkelsen, 2012) and borderline personality disorder (Nathanson, 1994).

Conduct disorder and Social Phobia

Research has shown that shame seems to be closely related to social anxiety and aggressive and hostile behaviours (e.g., Allan &

Gilbert 2002; Clark & Wells, 1995; Gold, Sullivan, & Lewis, 2011; Leith & Baumeister 1998; Lutwak, Panish, Ferrari, & Razzino, 2001; Gilbert 2000b; Gilbert & Trower, 1990; Tangney & Dearing, 2002; Tangney, Wagner, Fletcher & Gramzow, 1992; Matos, Pinto-Gouveia & Gibert, 2012; Owen & Fox, 2011).

Conduct disorder includes a repetitive and persistent pattern of behaviour that violates others' basic rights or major age-appropriate societal norms (American Psychiatric Association, 2013). Lewis (1971) stated that painful feelings of shame may turn into defensiveness, anger, rage or even aggression. Moreover, Scheff (1987) presented an explicative model of this relationship, "shame-rage spiral", where the pain felt from evaluating oneself as defective or inferior, may lead the shamed subject to lash out and blame others as a way to get the feeling of control over his life. When this occurs, it prompts similar behaviours in others, thus increasing shame in the subject which subsequently will turn right back into anger and destructive acts. Lewis (1992, 1993) states that anger and violent responses to shame, start against the person who induces this shame. This can create a hostile interpersonal style. The link between shame and aggressive or hostile behaviour may be understood from an evolutionary approach. As reported by Gilbert (1997), shame as an emotion evolved to protect one's social status by signalling a social threat to the status itself. The perception of threats to status evolved defence systems that are rapidly activated (Gilbert, 2002). According to the social rank theory, status can be maintained or improved not only by strategies that increase social attractiveness through prosocial behaviour, competence or talent ("Social Attention Holding Power"; see Gilbert, Price & Allan, 1995), but also by strategies that signal agency and power using anger and aggression ("Ritual agonistic behaviour"; see Gilbert et al., 1995). In the same sense, several studies suggest that attacks on rank, status and self-presentations are crucial for aggression (Berkowitz, 1993; Tedeschi & Felson, 1994). Clinical observation further suggests that individuals

with conduct disorder are hypersensitive to the possibility of status loss and unfavourable comparisons to others (Greenwald & Harder, 1998). This leads them to overreact and act out because of shame and anger (Lewis, 1971; Scheff, 1987), whenever the slightest hint of such judgments occurs. Also, individuals with antisocial personality disorder are especially sensitive to rank and prestige threats and, therefore, vulnerable to experiencing shame and humiliation (Morrisson & Gilbert, 2010).

Social Phobia is characterized by an intense and persistent fear of social or performance situations, in which embarrassment may occur due to the focus on the others' opinion about the self (APA, 2013). It is the self-focus as unattractive, the fear of being seen as inferior compared to others, and the fear of being judged negatively, that link social phobia with shame (Clark & Wells, 1995; Gilbert, 2001). According to Dienstbier et al. (1975), when shamed, the subject tends to focus its attention on the acceptance by others, increasing concerns about negative evaluations and experiencing anxiety in social situations. Shame is associated with a self-perception of an unfavourable social comparison (Gilbert, Allan, & Goss, 1996), subordinate and submissive behaviours (Gilbert 1989; Gilbert & McGuire, 1998). Therefore, the link between social shame and social phobia can be understood from a point of view of social rank theory (Gilbert & Trower, 2001; Trower & Gilbert, 1989). Price (2003) argues that the perception of a threat from conspecifics involves a choice between escalating and de-escalating strategies and that anxiety is a component of the de-escalating strategies. Social phobics tend to over-activate the social rank system (and under-activate the affiliation system) (Trower & Gilbert, 1989), which can cause a self-perception of inferiority. The individuals may thus view themselves as inadequate, undesirable and socially unattractive (Leary & Kowalski, 1995). In order to decrease possible punishments from dominant others, social phobic individuals tend to adopt an involuntary submissive behaviour

("Involuntary Subordinate Strategy"; see Sloman, Price, Gilbert & Garden, 1994). The avoidance of interpersonal contact, that is a hallmark of social anxiety (Clark & Wells, 1995), can be understood as a strategy that also reduces the probability of rejection.

AIMS

This study aims to test if different types of psychopathologies can be conceptualized as resulting from a preference for different shame-coping strategies.

First, this study intends to test if external shame has a different impact on nonclinical and clinical groups. Most previous studies relating shame with conduct disorder and social phobia resorted to self-report measures that may not allow to clearly identifying clinical subjects. In this study, these populations were identified by a structured clinical diagnostic interview. We hypothesize that external shame levels would be higher in conduct disorder and social phobia groups comparing to the nonclinical group.

In addition, we set out to explore if different shame-coping styles are associated with different interpersonal functioning styles. We hypothesize that individuals with social phobia and individuals with conduct disorder would not be distinguished by current shame feeling but by the preferred shame coping style they tend to use. Given the characteristics of these two pathologies, we hypothesize that conduct disorder would be most associated with *attack other* shame-coping style and that social phobia would be most associated with *attack self* shame-coping style.

METHOD

Participants and Procedures

Group 1: Nonclinical

The first group consisted of adolescents without psychopathology, recruited from the general community. It was initially composed by 62 subjects. In order to ensure that subjects did not have any form of psychopathology that could interfere with results, the participants were given a series of self-report questionnaires designed to measure depression (measured with the Depression Anxiety and Stress Scale-21's depression subscale, Lovibond & Lovibond, 1995; Portuguese version by Pais-Ribeiro, J.L., Honrado, A. & Leal, I. 2004) social *avoidance* (measured with the *avoidance* subscale of the Anxiety and Social Situations *Avoidance* Scale for Adolescents, Cunha, Pinto-Gouveia, Salvador, & Alegre, 2004) , and aggression (measured with the total score of the Aggression Questionnaire Buss, & Perry, 1992; Portuguese version by Simões, 1993). The subjects who scored above a defined cut off point were excluded. The final group was made of 39 subjects.

Group 2: Conduct Disorder

This group consisted of adolescents agreeing with the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; APA, 2000) criteria for conduct disorder all of them in a juvenile facility of the Portuguese justice for rehabilitation for the young offenders. Initially, it included 102 adolescents. Subjects answered to a structured diagnostic interview, the Mini International Neuropsychiatric Interview for Children and Adolescents Kid (Sheehan et al., 1998; Portuguese translation by Ribeiro da Silva, Motta, Brazão & Rijo). The diagnostic interview was initially used to confirm the diagnosis of conduct disorder. Furthermore, it was also possible to evaluate other pathologies and symptoms (including social phobia, major depression as well as

exclusion of medical, drug-related or organic causes). The subjects that scored on other psychopathologies were excluded from the sample. A group of 34 adolescents with conduct disorder was obtained, by which it did not fulfil the criteria for any other disorder.

Group 3: Social Phobia

This group was made of adolescents meeting DSM-IV (DSM-IV-TR; APA, 2000) criteria for social phobia. It was initially made of 26 adolescents. The adolescents were recruited from another research project, being conducted on regular schools. Additionally, adolescents being followed in outpatient care at the Coimbra University Hospital were also recruited for this study. Subjects answered to a structured diagnostic interview, the Anxiety Disorders Interview Schedule for Children and Adolescents (Silverman & Albano, 1996, Portuguese study by Cunha & Salvador, *non-published manuscript*) and also answered to a self-report questionnaire designed to measure aggression. The diagnostic interview was used at an earlier stage to confirm the diagnosis of social phobia, and also providing information on major depression, which was an exclusion criteria for this group. The total score of the Aggression Questionnaire (Buss, & Perry, 1992; Portuguese version by Simões, 1993) was used to exclude aggressive subjects from this sample.

Each participant was given a set of self-report questionnaires, designed to measure shame and shame-coping styles, as well as a social demographic questionnaire. The instruments were administered by the authors of this paper and by researchers at the Cognitive Behavioural Research Centre at the University of Coimbra collaborating in the data collection. The institutes where the data collection took place were contacted and the authorization for the participation of the individuals was obtained. In line with ethical requirements, before proceeding with the evaluation, an introductory statement was read to the subjects by the

researcher. This outlined aspects of confidentiality, the purpose of the study and the conditions under which the evaluation would proceed. It was also emphasized that the participants' co-operation was voluntary and the consents were obtained.

Measures

External Shame

Other As Shamer (OAS; Goss, Gilbert, & Allan, 1994) is a self-reported scale which measures the external shame (global judgments about "how I think that others look and think about me"). It consists of 18 items and is ideal to be administered to adolescents aged 12 to 18 years and items are rated on a scale of 5 points *Likert* (0= "Never"; 4- "Almost Always"). The original study of this instrument revealed excellent internal consistency (Cronbach's α = .92). Portuguese version of this scale was translated and adapted to Portuguese adolescent population (Barreto Carvalho, & Pereira, 2012, *non-published manuscript*). In the current study this scale showed an excellent internal consistency (Cronbach's α= .95).

Coping with shame

Compass of Shame Scale (COSS; Elison, Lennon, & Pulos, 2006) is a self-report scale and consists of 48 items that evaluate the use of four individual non-adaptive styles of coping with shame, described by Nathanson's (1994) shame model. The response styles are assessed to *attack self, attack other*, *avoidance* and *withdrawal* before certain situations. Herein are presented 12 scenarios inducing shame, followed by four answer choices, common in every situation, referring to each of the subscales. Items are rated on a 5-point *Likert* scale, (0: "Never" to 4: "Almost Always"), and those shows how often they meet each of the responses. In the original scale assessing Cronbach's alpha for the *attack self* was α = .91, α = .85 for the *attack other*, α = .74 for

avoidance, α = .89 to the *withdrawal.* Portuguese version of this scale was translated and adapted to Portuguese adolescent population (Fonseca, da Motta, Ribeiro da Silva, Brazão, & Rijo, *non-published manuscript*) with follow Cronbach's alpha values: α = .92 for *attack self*, α = .86 for *attack other*, α = .74 for *avoidance*, and α = .89 for *withdrawal*. In the current study they has good and excellent internal consistency. Cronbach's alpha for *attack self* was .94, α =.89 for the *attack other*, α =.81 for *avoidance*, and α = .91 for *withdrawal.*

Aggressive behavior

Aggression Questionnaire (AQ; Buss, & Perry, 1992) consists of 29 items that assessed physical aggression, verbal aggression, irritability and hostility. All items are rated on a 5 point Likert scale (1: "Never" and 5: "Always"). Scores can range from 29 to 145. The nonclinical and social phobia groups completed this scale to measure there aggressiveness. A convenience sample was used to determine a cut-off point, based on the calculation of the average plus one standard deviation. The respondents with scores above a cut-off point of 78.43 were excluded (n=348, average= 63.44; standard deviation= 14.99). The original scale assessing showed good internal consistency for the total scale with Cronbach's α = .89. This scale was also adapted for the Portuguese population (Simões, 1993) which consists of 29 items such as the original scale. Scale has good psychometric properties, with internal consistency to the total scale α = .87. In our study we obtained a good internal consistency, with a Cronbach's *α* of .79.

Social Anxiety

Anxiety and Social Situations Avoidance Scale for Adolescents (ASSASA; Cunha, Pinto-Gouveia, & Salvador, 2008) assesses situations in which intensity of anxiety and avoidance frequency causes significant interference in adolescents' lives. It is composed of 34 social situations and 2 subscales: discomfort/ anxiety and avoidance. All items

are rated on a 5 point Likert scale (1: "Nothing Anxious/ Never Avoid" to 5: "Extremely Anxious/ Avoid almost ever"). Scores can range from 34 to 170 in each subscale. The nonclinical group completed this scale to measure social anxiety. The avoidance scale was chosen, once the avoidance of social situations would be a discriminative feature of clinically relevant social anxiety.Through the study of development and psychometric validation of this scale (Cunha et al., 2008), a cut-off point was obtained based on the calculation of the average plus one standard deviation. The respondents with scores above a cut-off point of 79.37 were excluded (n=223; average=63.12; standard deviation= 16.25). To *Avoidance* subscale, Cronbach alpha value in original study was .87. In the present study the subscale shown good internal consistency, with a Cronbach's of .85.

Depressive symptoms

Depression, Anxiety and Stress Scale (DASS-21 Pais-Ribeiro, Honrado e Leal, 2004) is a reduced version from Depression, Anxiety and Stress Scales (DASS: Lovibond & Lovibond, 1995). The depressive symptoms in nonclinical group were measured with depression subscale of EADS's 21. This subscale has 7 items. Respondents rate on a four-point Likert scale (0:"Did not apply anything to me"; 3:" Applied to me most of the times"). Scores can range from 0 to 21. In the present study we used a convenience sample to determine a cut-off point based on the calculation of the average plus one standard deviation. The respondents with scores above a cut-off point of 10.25 were excluded (n=328, average= 5.41; standard deviation= 4.84). Cronbach value of in original study to depression subscale was α=.85. In the present study the Cronbach alpha in depression subscale was .66, which can be considered acceptable.

RESULTS

Data Analysis

Statistical analyses were performed using the software SPSS (Statistical Package for the Social Sciences), version 20 (IBM Corp, Armonk, NY, USA).

The differences between variables in study (external shame and shame-coping styles) in each group (nonclinical, conduct disorder and social phobia) were tested. The normal distribution and homogeneity of variances were tested with the Shapiro-Wilk and Leven's test. Given the non-normal distribution as well as non-homogeneity of variances, Welch ANOVA procedure was selected. For the identification of the variables which are better associated with the specific groups, a discriminant function analysis was used, differentiating the groups by the variables. The homogeneity of variance/covariance on each group were tested with Box'*M* statistics and that assumption was violated (*M*. =50.92; F (30, 10766.75) =1.54; *p*=.031). It is important to note that discriminant analysis is a robust procedure to the violations of normality and homogeneity of variance/covariance (Stevens, 1986), therefore the analysis was carried out.

Descriptive Data

There were significant differences in age between groups F (2, 48.09) = 7.538 p=.001 (table 2). The adolescents in the social phobia group were significantly younger than the adolescents in nonclinical and conduct disorder groups. The adolescents in nonclinical and conduct disorder groups had a similar age mean. There were also significant differences between groups in the socioeconomic level ($p < 0.001$)[1]. Table 3 gives the means (M) and standard deviation (SD) of

[1] To use the chi-square test the expected frequencies in each cell must be

the Other as Shamer scale and Compass of Shame Scale-5 in each group.

Table 2. Descriptive data across each group

	Groups		
	NC (n=39)	CD (n=34)	SP (n=18)
Age (Mean)	16.49	16.65	15.50
Socioeconomic level	n (%)	n (%)	n (%)
Low	15 (38.5)	30 (88.2)	4 (22.2)
Middle	24 (61.5)	4 (11.8)	9 (50)
High	0 (0)	0 (0)	5 (27.8)

NC, nonclinical; CD, conduct disorder; SP, social phobia; OAS, Other as Shamer (external shame).

Welch ANOVA

The Welch ANOVA revealed a significant effect of group on the external shame F (2, 39.97) = 8.214, p=.001, η^2_p = .144. *Post hoc* comparisons, using a Tukey HSD test, suggest that the nonclinical group was significantly different from both conduct disorder and social phobia groups. The variable group also had an effect on *withdrawal* shame-coping style F (2, 42.46) = 4.449, p=.018, η^2_p = .109. Tukey HSD *Post-Hoc* tests suggest that social phobia group was significantly different from the nonclinical group. Welch ANOVA further revealed a significant effect of the group on the *attack self* shame-coping style F (2, 45.65) = 3.606, p=.035, η^2_p = .076. Tukey HSD *Post-Hoc* tests suggest that the social phobia group was significantly different from both normal population and conduct disorder groups. The Welch ANOVA revealed no significant main effect of group on *avoidance* F

greater than 5, in order to preserve statistic strength. When that is not verified the Fisher's exact test should be used, which does not imply sample size restrictions in each cell. This procedure is normally used on 2 × 2 contingency tables and with small samples. However, it can be used on larger contingency tables (Field, 2009).

(2, 47.85) = 1.448, p=.245, and *attack other* F (2, 39.73) = 1.703, p=.195.

Table 3. Comparison of mean scores for external shame and shame coping styles on groups

	Subjects Groups								
	NC		CD		SP				
	M	SD	M	SD	M	SD	*Sig.*	*F*	*Post Hoc*
OAS	12.33	9.29	22.88	14.26	21.72	14.76	.001	8.214	NC<CD,SP
Withdrawal	9.00	8.05	11.76	8.85	17.28	10.53	.018	4.449	SP>NC
Avoidance	14.54	7.65	14.47	8.53	17.72	6.88	.245	1.448	
Self Attack	10.77	10.09	10.79	10.70	18.11	10.28	.035	3.606	SP>NC,CD
Other Attack	7.41	5.83	9.91	8.08	10.86	9.83	.195	1.703	

OAS, Other as Shamer (external shame); NC, nonclinical; CD, conduct disorder; SP, social phobia

The results summarised in table 3 show subjects from the nonclinical group endorsed lower levels of external shame in comparison to subjects from the conduct disorder or social phobia group. The results also show that subjects with social phobia had higher scores of *withdrawal* shame-coping style in comparison with subjects from the nonclinical group. It was also noted that subjects with social phobia had higher scores of *attack self* in comparison with subjects from the nonclinical and conduct disorder groups.

Discriminant Function Analysis (DFA)

A discriminant function analysis was carried out to identify functions that can significantly discriminate the three groups. Discriminant analysis extracted 2 discriminant functions that significantly distinguished the three groups. In the first discriminant function the relative measure of how different groups are, was λ=.274, which corresponds to 69.2% of between groups variance. In the second discriminant function it was obtained a λ=.122, which explains 30.8% of variance. Two discriminant functions were calculated with a combined Λ= .700; $\chi 2$ (10) = 30.723; p =0.001 indicating at least that

the first function is significant. After removal of the first function, was found $\Lambda = .891$; $\chi 2\ (4) = 9.894$; $p = 0.042$ which indicated that the discriminating power of the second function is statistically significant too.

The group means of predictor variables in discriminant function analyses are represented as centroids. These seem to indicate that the first discriminant function maximally separated the nonclinical group from the conduct disorder group with the higher values in the conduct disorder group. The second functions maximally separated the conduct disorder group and social phobia group with the higher values in the social phobia group.

The correlations between the group predictors and each of the discriminant functions are presented on table 4. All the variables were retained as statistically significant. The loading matrix showed that the largest predictors for the first discriminant function were external shame (r = 0.769) followed by *attack other* shame-coping style (r = 0.320). The largest predictors for the second function were *withdrawal* coping-shame style (r = 0.836), followed by *attack self* (r = 0.810) and *avoidance* (r = 0.470).

Table 4. Correlation between predictor variables and discriminant functions (Functions Structure Matrix)

Variable	Function 1	Function 2
OAS	.77	.23
Attack other	.32	.28
Withdraw	.37	.84
Attack self	.09	.81
Avoidance	.04	.47

Other as Shamer (external shame)

Classification results are presented on table 5. Results showed that 63.7% of the individuals who were classified into one of the three groups, based on discriminant functions, were correctly classified.

Table 5. Classification analysis

Actual group membership	n	Predicted group membership					
		NC		CD		SP	
		n	%	n	%	n	%
NC	39	31	79.5%	6	15.4%	2	5.1%
CD	34	10	29.4%	23	67.6%	1	2.9%
SP	18	9	50%	5	27.8%	4	22.2%

NC, nonclinical population; CD, conduct disorder; SP, social phobia
Note. Overall percentage of correctly classified cases = 63.7%

DISCUSSION

This study investigated the role of shame and shame-coping styles in externalizing and externalizing psychopathologies.

According to our hypothesis, results revealed that external shame have higher levels in conduct disorder and social phobia groups, in relation to the nonclinical group. These findings are in line with the previous researches showing that shame is closely related to conduct disorder and social phobia (e.g., Berkowitz, 1993; Tedeschi and Felson, 1994, Gilbert, 1989, 1992; Greenwald & Harder, 1998; Lewis 1971, 1992, 1993; Scheff, 1987). Shame can increase negative affect and reduce positive affect (Gilbert, 1992, 2007) and it has already been linked to a series of psychopathologies, so its role as a contributory factor to vulnerability to psychopathology seems to be clear (Schore, 1998, 2001; Tangney, Burggraf & Wagner, 1995). Results also showed that the two pathologies in study cannot be distinguished by severity of shame. This suggests that shame is common in both conduct disorder and social phobia, and that current experiences of shame cannot be the only responsible for creating individual problems (Morrison & Gilbert, 2001; Nathanson 1994 Tangney & Dearing, 2002).

Nonetheless, using a discriminant function analysis, it was shown

a function in which, in addition to external shame, the *attack to other* variable was considered. This function allowed to distinguish the three groups in the study and it had higher values on conduct disordered group, supporting our theoretical assumption that *attack other* shame-coping style is associated with this disorder. Using the *attack other*s as a coping style when feeling ashamed, minimizes the experience of shame, by externalizing or redirecting it (Elison at al., 2006a). Thus, individuals with conduct disorder seem to display aggressive and hostile behaviours as a way to get the feeling of control over their lives (Lewis 1971; Scheff, 1987), involving cognitions like "the problem is you, not me" (Tangney & Dearing, 2002). Since anger is an emotion of potency and authority (Tangney & Dearing, 2002), evolutionary, conduct disorder can be understood in light of the social rank theory (Gilbert, Price and Allan, 1995) as a strategic adoption of anger and aggression behaviors, which signal agency and power. This subjects values social domince goals and *attack other* strategies seem to provide them a comfortable position.

Concerning the social phobia group, results showed higher scores of *attack self* shame-coping style in this group comparing to other groups. These findings support the hypothesis that social phobia is associated with *attack self* shame-coping style. *Attack self* is characterized by the internalization of shame and it has an intrapunitive nature that magnifies the impact of shame (Elison et al., 2006). Thus, social phobics appear to make assumptions about how one is viewed by others (e.g., boring, stupid) (Clark & Wells, 1995), as someone who is unattractive and that can be rejected or excluded (Gilbert, 2001). To decrease the probability of punishments and increase the probability of acceptance, they adopt a subordinate and submissive behaviour (Gilbert, 1989, Gilbert & McGuire, 1998) congruent with de-escalating strategies (Price, 2003).

As expected, individuals from the social phobia group and individuals from the conduct disorder group should not be distinguished

by the levels of shame feelings but should also be evaluated by the shame-coping strategies that the subjects use to manage with these feelings. These findings are consistent with previous research that claims that it is not the current experiences of shame that create individual problems, but the way we cope with it (Elison et al., 2006; Nathanson 1994; Tangney & Dearing 2002). However, shame experiences should not be neglected, since they have been shown to have a significant impact on brain maturation and seem to be a central component to psychopathology (Schore, 1998, 2001; Tangney, Burggraf & Wagner, 1995). Instead, as suggested by Nathanson (1992), shame-coping strategies mediate the relationships between the experience of shame and psychopathology.

Clinical Implications

Although more research is required in order to clarify and validate the findings of this study, some clinical implications for psychotherapy can be identified.

Shame and shame-coping strategies seem to be relevant variables that explain both social phobia and conduct disorder. The high levels of shame and self-criticism of these populations appeal to the importance of working with shame and guiding therapeutic interventions according to the type of preferred shame coping strategy.

Compassion focused therapy (Gilbert 2006, 2007, 2009a; 2009b; Gilbert & Irons, 2005) may be an appropriate approach address shame and shame coping styles in therapeutic settings. Compassion is a skill that one can train. It refers to specific activities designed to develop compassionate attributes and skills, particularly those that influence affect regulation (Gilbert, 2009b). The aim of this therapy is to reduce the shame feelings. The individuals stop criticising, condemning and blaming themselves for their symptoms, thoughts and feelings, by learning to coping with them (Gilbert 2007).

If future research confirms these findings, they may have some implications at the case level formulation. May be important to understand not only how maladaptive coping strategies predispose individuals to psychopathology but also the implications of these mechanism in the maintenance of pathologies.

Limitations and Future Research

The present study has some limitations. First it was not possible to match groups in terms of age, social-economic level and size. Both clinical groups were recruited for separate studies and so the match was not possible. The small size of the groups, in particular the social phobia group, may limit the generalizability of the findings. One other limitation was the option to recruit only male population. Given the higher prevalence of conduct disorder on male adolescent population, it was not possible for us to recruit an equivalent sample of both genders, hence why only a male population was chosen as subjects. However, the exclusion of female subjects from the social phobia group limited the collection of data with this population. Therefore, future studies should recruit larger samples of both genders. It is also necessary to test the relationship of shame-coping style with other psychopathologies as well as with adult population.

ACKNOWLDEGEMENTS

The authors would like to thank researchers at the Cognitive Behavioural Research and Intervention Centre at the University of Coimbra and to PAIPA (an evaluation and psychotherapeutic intervention program for youth in contact with the justice system) researchers with subjects' recruitment and assessment.

REFERENCES[2]

[2] As referências do manuscrito são apresentadas no final deste documento, juntamente com as restantes referências desta dissertação.

Discussão Geral

Discussão de resultados

Os resultados comprovaram a hipótese de que os sujeitos com perturbação de conduta e os sujeitos com fobia social têm níveis mais elevados de vergonha quando comparados com os sujeitos da população não clínica. Tal vai de encontro a estudos anteriores que mostraram a relação da vergonha não só destes quadros psicopatológicos como também de diversas outras perturbações psicológicas (e.g., Allan & Gilbert 2002; Andrews, 1995; Irons & Gilbert, 2005; Gilbert 2000b; Gold, Sullivan, & Lewis, 2011; Leith & Baumeister 1998; Lutwak, Panish, Ferrari, & Razzino, 2001; Matos, Pinto-Gouveia & Gibert, 2012; Owen & Fox, 2011; Rüsch et al., 2007; Thompson & Berenbaum, 2006; Troop, Allan, Serpell, & Treasure, 2008). No entanto, e como esperado, os níveis de vergonha externa não permitiam distinguir as duas populações clínicas entre si o que parece sugerir não podem ser apenas as experiências de vergonha que explicam a psicopatologia.

Por outro lado, a perturbação de conduta e a fobia social mostraram-se relacionadas com diferentes estratégias de *coping* com a vergonha. Relativamente à perturbação de conduta, foi encontrada uma função na qual adicionalmente à vergonha externa é considerado o estilo de coping *ataque ao outro*, sendo que esta função tem valores mais elevados na perturbação do comportamento e permite distinguir este grupo dos restantes. Tal parece sugerir que esta perturbação está relacionada com a estratégia de coping *ataque ao outro*. Em relação à fobia, a estratégia de *ataque ao eu* permite distinguir este grupo dos restantes, evidenciando a relação da fobia social com esta estratégia de *coping*. Estes resultados parecem acrescentar evidencias a estudos anteriores (Elison et al., 2006a, 2006b, Nathanson 1994, Tangney & Dearing, 2002) que sugerem que poderão não ser as experiências de vergonha que conduzem as dificuldades individuais, mas sim a forma como os sujeitos lidam com estes sentimentos de vergonha, isto é, o estilo de coping a que recorrem.

Considerações Gerais

Segundo uma perspectiva evolucionária, os elevados níveis de vergonha exibidos pelos grupos clínicos, remetem para um funcionamento psicobiológico baseado na mentalidade de *ranking* social Tal implica que estes sujeitos estejam hiperatentos à sua posição e estatuto, façam constantes comparações e sejam hipersensíveis à crítica (Gilbert, 2000a; Gilbert & McGuire, 1998; Nesse, 1998). Parece, assim, existir uma hiperactivação do sistema de regulação emocional de ameaça/defesa, conduzindo à vulnerabilidade para a psicopatologia devido aos comportamentos defensivos adoptados. Segundo o modelo biopsicossocial da vergonha, os comportamentos defensivos podem ser de natureza internalizante ou externalizante (Gilbert, 1995; Gilbert 2002; Gilbert, 2006, Gilbert & Irons, 2009). No presente trabalho sugere-se que estratégias específicas maladaptativas de *coping* com a vergonha, desenvolvidas ao longo do tempo, podem estar na base da psicopatologia. No caso dos sujeitos com perturbação do comportamento a génese da patologia parece relacionar-se com a estratégia de coping *ataque ao outro*. Já no caso dos sujeitos com fobia social verificou-se uma relação com a estratégia de *ataque ao eu*, que sugere que o uso desta estratégia poderá estar na base deste quadro psicopatológico.

Implicações clínicas

Embora este trabalho deva ser considerado como um estudo piloto e, por tal, os resultados encontrados necessitem de maior suporte empírico, as suas implicações clínicas não devem ser descartadas.

Em primeiro lugar, a avaliação deverá compreender tanto os níveis de vergonha como o estilo de *coping* endossado, para que a intervenção seja direcionada de forma a abranger estes mecanismos. Tal parece ter também implicações a nível da formulação de caso. Para além da evidência de que o estilo de *coping* com a vergonha poderá estar na génese da psicopatologia, importa também considerar o papel destes mecanismos na manutenção da mesma.

Relativamente aos sujeitos com fobia social, estes tendem a dirigir a sua atenção para as pistas sociais de ameaça, assim como a distorcer a

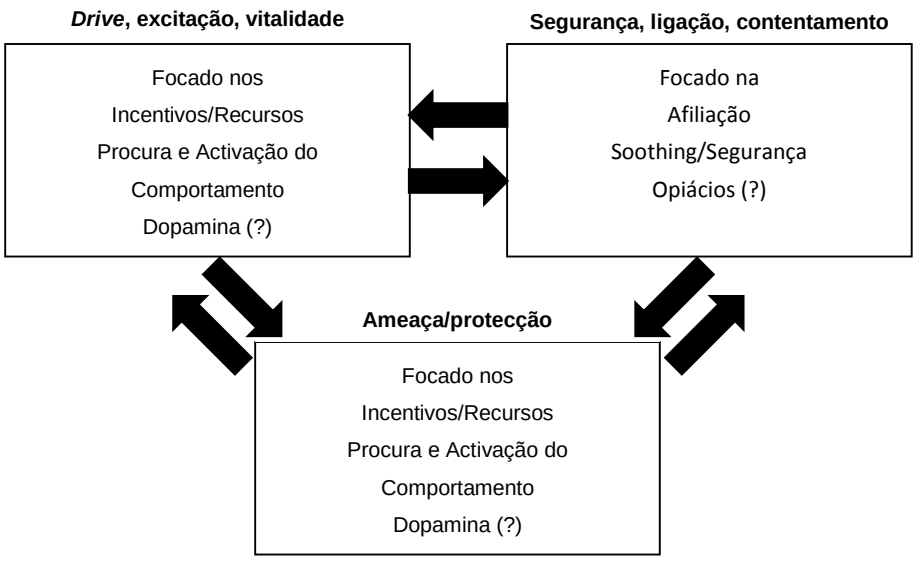
avaliação das suas experiências interpessoais (Beck, Emery, & Greenberg, 1985). Tendo em conta sobreactivação do sistema de ameaça, e considerando a estratégia de *ataque ao eu*, perante uma situação potencialmente indutora de vergonha, os sujeitos reconhecem a sua acção como vergonhosa ou como uma falha pessoal, sentem descontentamento, menosprezo e raiva auto-dirigida, elevando o impacto da mesma (Elison et al., 2006a). Estes sujeitos adoptam um comportamento submisso que serve a função de prevenir novas experiências de vergonha e que, possivelmente, reduz a probabilidade de resposta aversiva por parte dos outros, o que no momento poderá reduzir o desconforto relacionado com o medo de não serem aceites. No entanto, as cognições auto-depreciativas, ao manterem a visão negativa que têm de si mesmos, podem afetar o seu desempenho nas relações interpessoais, o que faz com que a esta estratégia possa contribuir para a manutenção da fobia social.

Os sujeitos com perturbação de conduta facilmente interpretam um acontecimento como uma provocação ou ameaça, sendo que a agressão é percecionada como uma forma eficaz de solucionar problemas sociais. A adopção da estratégia de atacar verbal ou fisicamente o outro parece ter a função de minimizar a experiência de vergonha e preservar a auto-imagem do indivíduo (Elison et al., 2006b). Esta estratégia envolve cognições do tipo "o problema és tu e não eu" (Tangney & Dearing, 2002) e, assim, a culpa é depositada na outra pessoa. Uma vez que a consciencialização da experiencia de vergonha é minimizada, o desconforto é também reduzido. O comportamento agressivo é uma estratégia que sinaliza uma posição superior no *ranking* social e, dado que estes sujeitos valorizam objectivos sociais de dominância, este comportamento deixa-os numa posição favorável. A adopção desta estratégia parece assim ter várias vantagens para o individuo, o que contribui para a explicação da dificuldade de mudança, sendo que uma substancial proporção dos sujeitos com perturbação do comportamento continua a revelar na idade adulta comportamentos que preenchem os critérios para perturbação anti-social da personalidade (APA, 2013). Importa também referir que a estratégia de *ataque ao outro* parece gerar défices no comportamento pró-social: as relações interpessoais são afectadas o que contribui para a visão negativa que estes sujeitos têm dos outros (e.g., abandonadores, injustos).

Tendo em conta a sensibilidade à ameaça quer dos sujeitos com perturbação do comportamento, quer dos com fobia social, assim como os seus elevados níveis de vergonha e as estratégias desadaptativas que utilizam para lidar com este sentimento, uma abordagem terapêutica baseada na compaixão, parece ser uma estratégia terapêutica pertinente, que poderá conduzir a mudanças significativas.

A terapia focada na compaixão é uma terapia integrativa e transversal que deriva da psicologia evolucionária, social, desenvolvimental, budista e das neurociências. Não se baseia num único modelo ou escola, mas sim no estudo e compreensão de como a nossa mente funciona (Gilbert, 2009b). A compaixão pode ser entendida como uma competência que cada um pode treinar, havendo evidências de que a sua prática pode ter influências neurofisiológicas e a nível do sistema imunitário (Lutz, Brefczynski-Lewis, Johnstone & Davidson, 2008). Este treino envolve actividades específicas, concebidas para desenvolver atributos e competências compassivas, especialmente aqueles que influenciam a regulação do afecto. Estudos recentes apontam para a existência de três sistemas de regulação de afecto: o sistema de ameaça e protecção; o sistema de procura (*drive*) e de vitalidade; e o sistema de *soothing*, contentamento e vinculação (Depue, 2005) (Figura 2).

Figura 2. Sistema de regulação do afecto (adaptado de Gilbert, 2005b)



Nos sujeitos com elevados níveis de vergonha e auto-criticismo, o que parece verificar-se na perturbação do comportamento e na fobia social, há uma orientação dominada pelo sistema de ameaça/defesa, ao mesmo tempo que existe um decréscimo de activação do sistema de *soothing*. Daí resulta uma elevada sensibilidade na percepção e reacção a uma ameaça e dificuldade em gerar sentimentos de segurança e de satisfação consigo próprios e com os outros. Evolucionariamente, o sistema de ameaça tem a função de detectar situações que representem um potencial perigo, de forma a que o animal possa reagir em sua defesa; despoleta sentimentos de raiva, aversão ou ansiedade e comportamentos de luta ou fuga e submissão (Marks, 1987; Gilbert, 2001). Assim, na formulação de caso, o terapeuta deve explorar experiências precoces (como possíveis situações de conflito ou abuso) que possam ter levado o indivíduo a desenvolver estratégias de defesa que o condicionaram a operar automaticamente neste padrão. Na intervenção terapêutica, é fundamental ajudar os indivíduos a compreender que a patologia e sintomas não são culpa sua, tendo sim se desenvolvido como uma estratégia de defesa. Assim, estes podem desenvolver uma atitude compassiva e ao mesmo tempo reconhecer que necessitam de desenvolver o sistema de segurança (Gilbert, 2009b).

Evolucionariamente, o sistema de *drive* relaciona-se com o sistema motivacional para a obtenção de recompensas. Nos Humanos tem a função de guiar para a procura de objectivos importantes (Depue, 2005). Para compreender a perturbação de conduta e a fobia social, parece necessário explorar também a interacção entre o sistema de ameaça e do sistema de *drive.* Relativamente à perturbação de conduta, estes sujeitos parecem ter um sistema de procura (*drive*) de *status* de forma defenderem-se de sentimentos de inferioridade, subordinação e rejeição. No caso dos sujeitos com fobia social, estes parecem ter também um sistema de procura de aceitação com o intuito de evitar o conflito, sendo que a rejeição representa uma ameaça.

Quando os animais não têm de lidar com ameaças e perigos e têm recursos suficientes, entram em estados de satisfação (Depue, 2005). O sistema de *soothing* associa-se à sensação de bem-estar, calma, aquiescência e positividade (Gilbert, 2009b) e, de acordo com Depue e Morrone-Strupinsky (2005), este sistema desenvolveu-se a par com o sistema de vinculação. Como já foi referido, os sujeitos com elevados níveis de vergonha e auto-criticismo

têm dificuldade em aceder ao sistema de *soothing*. Diversas razões poderão estar na base dessa dificuldade, mas é muito provável que este sistema tenha sido subestimulado ao longo do desenvolvimento do sujeito.

Assim, os objectivos terapêuticos com sujeitos com perturbação de conduta ou fobia social devem focar o reequilíbrio dos sistemas de regulação de afecto, nomeadamente o desenvolvimento do sistema de segurança. O objectivo do terapeuta é ajudar o sujeito a experienciar segurança na interacção consigo, a tolerar e sentir-se seguro com aquilo que é explorado na terapia, e substituir o auto-criticismo por um sentimento de bondade para consigo próprio (*self-kindness*).

Conclusão

Os caminhos percorridos na exploração da psicopatologia têm evidenciado cada vez mais a importância de compreender os processos inerentes às mesmas. Assim, este estudo não pretendeu de todo simplificar conceptualização da psicopatologia como resultado de um estilo de *coping* com a vergonha. Pretendeu sim explorar um mecanismo que parece ser relevante, e que poderá contribuir para a fundamentação teórica de modelos de intervenção integrativos, que possam conduzir à mudança do desconforto adjacente aos indivíduos diagnosticados com perturbação de conduta ou com fobia social.

Bibliografia Geral

Allan, S., & Gilbert, P. (2002). Anger and anger expression in relation to perceptions of social rank, entrapment and depressive symptoms. *Personality and Individual Differences, 32,* 551–565. doi:10.1016/S0191-8869(01)00057-5

Allan, S., Gilbert, P., & Goss, K. (1994). An exploration of shame measures-II: Psychopathology. *Personality and Individual Differences, 17*, 719–722. doi: 10.1016/0191-8869(94)90150-3

American Psychiatric Association. (2000). *Diagnostic and statistical manual of the mental disorders (DSM-IV-TR),* (4th ed.). Washington DC: American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of the mental disorders (DSM-V),* (5th ed.). Washington DC: American Psychiatric Association.

Andrews, B. (1995). Bodily shame as a mediator between abusive experiences and depression. *Journal of Abnormal Psychology 104,* 277–285. doi: 10.1037/0021-843X.104.2.277

Bailey, K.G. (1987). *Human paleopsychology. Applications to aggression and pathological processes*. Hillsdale, NJ: Lawrence Erlbaum Associates.

Beck, A. T., Emery, G. & Greenberg, R. L. (1985). *Anxiety disorders and phobias: A cognitive perspective*. New York: Basic Books.

Berkowitz, L. (1993). *Aggression: Its causes, consequences, and control*. Philadelphia, PA: Temple University Press

Bluck, S., & Habermas, T. (2000). The life story schema. *Motivation and Emotion, 24*, 121– 147. doi: 10.1023/A:1005615331901

Bowlby, J. (1969/1982). *Attachment and loss* (Vol. 1). London: Hogarth Press.

Bowlby, J. (1973). *Attachment and loss* (Vol. 2). London: Hogarth Press.

Bradshaw, J. (1988) *Healing the shame that binds you*. Deerfield Beach: Health Communications.

Brown, H. (1991). Shame and relapse issues with the chemically dependent client. *Alcoholism Treatment Quarterly, 8*, 77–82. doi: 10.1300/J020V08N03_07

Buss, A. H., & Perry, M. P. (1992). The aggression questionnaire. *Journal of Personality and Social Psychology, 63*, 452-459. doi:10.1037/0022-3514.63.3.452

Buss, D.M. (1995). Evolucionary psychology: A new paradigm for psychological science. *Psychological Inquiry, 6*, 1-87. doi*:* 10.1207/s15327965pli0601_1.

Campbell, J. S., & Elison, J. (2005). Shame coping styles and psychopathic personality traits. *Journal of Personality Assessment, 84*, 96-104. doi: 10.1207/s15327752jpa8401_16

Cheung, M., Gilbert, P., & Irons, C. (2004). An exploration of shame, social rank and rumination in relation to depression. *Personality and Individual Differences, 36*, 1143–1153. doi: 10.1016/S0191-8869(03)00206-X

Clark, D. M., & Wells, A. (1995). A cognitive model for social phobia. In R. G. Heimberg, M. R. Liebowitz, D. A. Hope, & F. R. Schneier (Eds.), *Social phobia: Diagnosis, assessment, and treatment* (pp. 69-93). New York: Guilford

Cunha, M., & Salvador, M. C. (em preparação). *A versão Portuguesa da Entrevista Estruturada para as Perturbações de Ansiedade na Infância e Adolescência (ADIS-C): Um estudo exploratório*.

Cunha, M., Gouveia, J. P., & Salvador, M. C. (2008). Social fears in adolescence – The social anxiety and avoidance scale for adolescents. *European Psychologist*, 13 (3), 197-213. doi: 10.1027/1016-9040.13.3.197

Depue, R. A., & Morrone-Strupinsky, J. V. (2005). A neurobehavioral model of affiliative bonding: implications for conceptualizing a human trait of affiliation. *Behavioral and Brain Sciences, 28*, 313–95 doi:10.1017/S0140525X05000063

Dohrenwend, B. P. (1975). Sociocultural and socio-psychological factors in the genesis of mental disorders. *Journal of Health and Social Behavior*, *16* (4), 365-392.

Dutton, G. D., van Ginkel, C., & Starzomski, A. (1995). The role of shame and guilt in the intergenerational transmission of abusiveness. *Violence and Victims, 10* (2), 121–131. Não encontro doi

Elison, J., Lennon, R., & Pulos, S. (2006a). Investigating the Compass of

Shame: the development of the Compass of Shame Scale. *Social Behavior and Personality, 34,* 221-238. doi: 10.2224/sbp.2006.34.3.221

Elison, J., Pulos, S., & Lennon, R. (2006b). Shame-focused coping: An empirical study of the Compass of Shame. Social Behavior *and* Personality, *34*, 161-168. doi: 10.2224/sbp.2006.34.2.161

Field, A. (2009). *Discovering statistics using SPSS: (and sex, drugs and rock 'n' roll)* (3ª ed.). Los Angeles: Sage Publications.

Fonseca, L., da Motta, C., Ribeiro da Silva, D., Brazão, & N., Rijo, D., (em preparação). *A bússola da vergonha: dimensionalidade e características psicométricas da escala de* coping *com a vergonha em adolescentes.*

Gilbert, P. & Irons, C. (2009). Shame, self-criticism, and self-copmpassion in adolescents. In N. B. Allen & L. B. Sheeber (Eds.) *Adolescent Emotional development and the emergence of Depressive Disorders*. Cambridge: Cambridge University Press.

Gilbert, P. (1989). *Human nature and suffering*. Hove: Lawrence Erlbaum Associates.

Gilbert, P. (1992). *Depression: The evolution of powerlessness.* Hove: Guilford/Lawrence Erlbaum Associates.

Gilbert, P. (1995). Biopsychosocial approaches and evolutionary theory as aids to integration in clinical psychology and psychotherapy. *Clinical Psychology and Psychotherapy, 2,* 135-156. doi: 10.1002/cpp.5640020302.

Gilbert, P. (1998). What is Shame? Some core issues and controversies. In Gilbert, P. & Andrews, B. (Eds.), *Shame: Interpersonal behavior, psychopathology and culture* (pp. 3–38). New York: Oxford University Press.

Gilbert, P. (2000a). Social mentalities: Internal 'social' conflicts and the role of inner warmth and compassion in cognitive therapy. In P. Gilbert & K. G. Bailey (Eds.), *Genes on the couch: Explorations in evolutionary psychotherapy*. Hove: Brunner-Routledge.

Gilbert, P. (2000b). The relationship of shame, social anxiety and depression: the role of the evaluation of social rank. *Clinical Psychology Psychotherapy, 7,* 174–189. doi:10.1002/1099-0879

Gilbert, P. (2001). Evolution and social anxiety: The role of attraction, social competition and social hierarchies. *The Psychiatric Clinics of North America, 24*, 723–751. doi: 10.1016/S0193-953X(05)70260-4

Gilbert, P. (2002). Body Shame: A biopsychopathology conceptualisation and overview, with treatment implications. In P. Gibert, & J. Miles (Eds.), *Body Shame: Conceptualisation, research and treatment* (pp.3-54). London: Brunner-Routledge.

Gilbert, P. (2003). Evolution, social roles, and differences in shame and guilt. *Social Research*: *An International Quarterly of the Social Sciences, 70* (4), 1205-1230.

Gilbert, P. (2005a). Social mentalities: A biopsychosocial and evolutionary reflection on social relationships. In M.W. Baldwin (Ed.), *Interpersonal cognition* (pp. 299-335). New York: Guilford.

Gilbert, P. (2005b). Compassion and cruelty: A biopsychosocial approach. In P. Gilbert (Ed.), *Compassion: conceptualisations, research and use in psychotherapy* (pp. 3-74). London: Routledge.

Gilbert, P. (2006). A biopsychosocial and evolutionary approach to formulation with a special focus on shame. In N. Tarrier (Ed.), *Case formulation in cognitive behaviour therapy: The treatment of challenging and complex cases* (pp. 81–112). Hove: Routledge.

Gilbert, P. (2007). Evolved minds and compassion in the therapeutic relationship. In N. P. Gilbert, & R. Leahy (Eds.), *The therapeutic relationship in the cognitive behavioral psychotherapies* (pp. 106–142). Hove: Routledge.

Gilbert, P. (2009a). *The compassionate mind.* London: Constable & Robinson.

Gilbert, P. (2009b). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment, 15* (3), 199–208. doi:10.1192/apt.bp.107.005264

Gilbert, P., & Irons, C. (2005). Focused therapies and compassionate mind training for shame and self-attacking. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 263–325). London: Routledge.

Gilbert, P., & McGuire, M. (1998). Shame, social roles and status: the psychobiological continuum from monkey to human. In P. Gilbert, & B. Andrews (Eds.), *Shame: interpersonal behaviour, psychopathology*

and culture (pp. 99-125). New York: Oxford University Press.

Gilbert, P., & Miles, J. N. V. (2000). Sensitivity to Social Put-Down: It's relationship to perceptions of social rank, shame, social anxiety, depression, anger and self-other blame. *Personality and Individual Differences, 29,* 757–774. doi:10.1016/S0191-8869(99)00230-5

Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: A pilot study of a group therapy approach. *Clinical Psychology and Psychotherapy, 13,* 353–379. . DOI: 10.1002/cpp.507

Gilbert, P., & Trower, P. (1990). The evolution and manifestation of social anxiety. In W. R. Crozier (Ed.), *Shyness and embarrassment: perspectives from social psychology* (pp. 144-177). Cambridge: Cambridge University Press.

Gilbert, P., & Trower, P. (2001). Evolution and process in social anxiety. In W. R. Crozier, & L. E. Alden (Eds.), *International handbook of social anxiety: Concepts, research and interventions relating to the self and shyness* (pp. 259-279). England: J. Wiley & Sons.

Gilbert, P., Allan, S., & Goss, K. (1996). Parental representations, shame, interpersonal problems and vulnerability to psychopathology. *Clinical Psychology and Psychotherapy, 3,* 23-34. doi:10.1002/(SICI)1099-0879(199603)3

Gilbert, P., Price, J. S., & Allan, S. (1995). Social comparison, social attractiveness and evolution: How might they be related?. *New Ideas in Psychology, 13,* 149–165. doi:10.1016/0732-118X(95)00002-X

Gold, J., Sullivan, M. W., & Lewis, M. (2011). The relation between abuse and violent delinquency: The conversion of shame to blame in juvenile offenders. *Child abuse neglect, 35,* 459–467. doi: 10.1016/j.chiabu.2011.02.007

Goss K, Gilbert P, & Allan S (1994). An exploration of shame measures I. The "Other as Shamer Scale". *Personality and Individual Differences, 17*, 713-717. doi*:* 10.1016/0191-8869(94)90150-3.

Greenwald, D. F., & Harder, D. W. (1998). Domains of shame: Evolutionary, cultural, and psychotherapeutic aspects. In P. Gilbert, & B. Andrews (Eds.). *Shame: Interpersonal behavior, psychopathology and culture* (pp. 225-245). New York: Oxford University Press.

Harder, D. W. (1995). Shame and guilt assessment, and relationships of shame and guilt-proneness to psychopathology. In J. P. Tangney, & K. W. Ficher (Eds.), Self-conscious emotions: The psychology of shame, guilt, embarrassment, and pride (pp. 368-392). New York: Guilford Press.

Irons, C., & Gilbert, P. (2005). Evolved mechanisms in adolescent anxiety and depressive symptoms: the role of the attachment and social rank systems. *Journal of Adolescence, 28*, 325-341. doi: 10.1016/j.adolescence.2004.07.004

Kinston, W. (1987). The shame of narcissism. In D. L. Nathanson. (Ed.). *The many faces of shame* (pp. 214–245). New York: Guilford Press.

Lansky, M. (1987). Shame and domestic violence. In D. L. Nathanson (Ed.). *The many faces of shame* (pp. 335–362). New York: Guilford Press.

Lansky, M. (1992). *Fathers who fail: Shame and psychopathology in the family system*. New York: Analytic Press.

Leary, M. R., & Kowalski, R. M. (1995). *Social anxiety*. New York, NY: The Guilford Press.

Leith, K. P., & Baumeister, R. F. (1998). Empathy, shame, guilt, and narratives of interpersonal conflicts: Guilt-prone people are better at perspective talking. *Journal of Personality*, *66*, 1-37. doi: 10.1111/1467-6494.00001

Lewis, H.B. (1971). *Shame and guilt in neurosis*. New York: International University Press.

Lewis, M. (1992). Shame: The exposed self. New York: Free Press.

Lewis, M. (1993). The development of anger and rage. In R. A. Glick, & S. P. Roose (Eds.), *Rage, power, and aggression* (pp. 148–168). New Haven, CT: Yale University Press.

Lovibond, P., & Lovibond, H. (1995). The structure of negative emotional states: Comparison of the depression anxiety stress scales (DASS) with beck depressive and anxiety inventories. *Behaviour Research and Therapy*, 3, 335–343. doi: 10.1016/0005-7967(94)00075-U

Lutwak, N., Panish, J. B., Ferrari, J. R., & Razzino, B. E. (2001). Shame and guilt and their relationship to positive expectations and anger expressiveness. *Adolescence*, *36* (144), 641–653.

Lutz A, Brefczynski-Lewis J, Johnstone T, Davidson RJ (2008) Regulation of

the Neural Circuitry of Emotion by Compassion Meditation: Effects of Meditative Expertise. *PLoS ONE 3*(3): e1897. doi:10.1371/journal.pone.0001897.

Marks, I. M. (1987). *Fears Phobias and rituals*: *Panic, anxiety and their disorders*. New York: Oxford University Press.

Matos, M., Pinto-Gouveia, J., & Gilbert, P. (2012). The effect of shame and shame memories on paranoid ideation and social anxiety. *Clinical Psychology and Psychotherapy*. doi: 10.1002/cpp.1766

McAdams, D. P. (2001). The psychology of life stories. *Review of General Psychology*, 5, 100–122. doi: 10.1037/1089-2680.5.2.100

Mills, R.S.L. (2004). Taking stock of the developmental literature on shame. *Developmental Review*, 25 (2005), 26-63. doi:10.1016/j.dr.2004.08.001

Morrison, D., & Gilbert, P. (2001). Social rank, shame and anger in primary and secondary psychopaths. *Journal of Forensic Psychiatry*, *12*, 330-356. doi: 10.1080/09585180110056867

Nathanson, D. L. (1992). *Shame and Pride*. New York: Norton.

Nathanson, D. L. (1994). Shame, compassion and the "borderline" personality. *Psychiatric Clinics of North America*, *17* (4), 785-810.

Nesse. R. (1998). Emotional disorders in evolutionary perspective. *British Journal of Medical Psychology*, *71*, 397-416.

Nyström, M. B. T., & Mikkelsen, F. (2013). Psychopathy-related personality traits and shame management strategies in adolescents. *Journal of Interpersonal Violence*, *28*, 519–37. doi:10.1177/0886260512455512

Owen, T., & Fox, S. (2011). Experiences of shame and empathy in violent and non-violent young offenders. *Journal of Forensic Psychiatry and Psychology, 22*, 551-563. doi: 10.1080/14789949.2011.602096

Pais-Ribeiro, J., Honrado, A., & Leal, I. (2004). Contribuição para o estudo da adaptação portuguesa das Escalas de Ansiedade, Depressão e Stress (EADS) de 21 itens de Lovibond e Lovibond. *Psychologica,* 5 (2), 229-239.

Pillemer, D. B. (1998). *Momentous events, vivid memories*. Cambridge: Harvard University Press.

Pinto-Gouveia, J., & Matos, M. (2011). Can shame memories become a key to identity? The centrality of shame memories predicts

psychopathology. *Applied Cognitive Psychology, 25*, 281–290. doi: 10.1002/acp.1689

Price, J. (2003). Evolutionary aspects of anxiety disorders. *Dialogues in Clinical Neuroscience, 5* (3), 223-236.

Rüsch, N., Lieb, K., Göttler, I., Hermann, C., Schramm, E., Richter, H., Bohus, M. (2007). Shame and implicit self-concept in women with borderline personality disorder. *American Journal of Psychiatry, 164*, 500–508. doi:10.1176/appi.ajp.164.3.500

Sanftner, J. L., Barlow, D. H., Marschall, D. M., & Tangney, J. P. (1995). The relation of shame and guilt to eating disorder symptomatology. *Journal of Social and Clinical, 14*, 315-324. doi: 10.1521/jscp.1995.14.4.315

Scheff, T. J. (1987). The *shame-rage spiral:* A case study of an interminable quarrel. In H. B. Lewis (Ed.). *The role of shame in symptom formation* (pp. 109-149). England: Lawrence Erlbaum Associates.

Schore, A. (1998). Early shame experiences and infant brain development. In P. Gilbert, & B. Andrews (Eds.), Shame: Interpersonal behavior, psychopathology and culture (pp. 57–77). New York: Oxford University Press.

Schore, A. (2001). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*, 201–269. doi: 10.1002/1097-0355(200101/04)22:1

Sheehan, D., Lecrubier, Y., Sheehan, K. H., Amorim, P., Janavs, J., Weiller, E., Hergueta, T., Baker, R., & Dunbar, G. C. (1998). The Mini-International Neuropsychiatric Interview (M.I.N.I): The development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of Clinical Psychiatry, 59*, 22-33.

Silverman, W. K., & Albano, A. M. (1996). Anxiety Disorders Interview Schedule for DSM-IV: Child version, Child Interview Schedule. USA: Graywind Publications Incorporated.

Simões, A. (1993*).* São *os* homens mais agressivos *que as* mulheres? *Revista Portuguesa* de *Pedagogia*, 27 (*3*), 387-404.

Singer, J. A., & Salovey, P. (1993). The remembered self: Emotion and memory in personality. New York: The Free Press.

Skårderud, F. (2007). Shame and pride in anorexia nervosa: A qualitative

descriptive study. *European Eating Disorders Review, 15*, 81–97. doi: 10.1002/erv.774

Sloman, L., Price, J., Gilbert, P., & Gardner, R. (1994). Adaptive function of depression: Psychotherapeutic implications. *American Journal of Psychotherapy, 48* (3), 401-416.

Tangney, J. P., & Fischer, K. W. (Eds.) (1995). *Self-conscious emotions: The psychology of shame, guilt, embarrassment and pride*. New York: Guilford Press.

Tangney, J. P., Wagner, P., & Gramzow, R. (1992). Proneness to shame, proneness to guilt, and psychopathology. *Journal of Abnormal Psychology, 101*, 469–478 doi: 10.1037/0021-843X.101.3.469

Tangney, J., & Dearing, R. (2002). *Shame and guilt*. New York: Guilford Press.

Tangney, J., Burggraf, S., & Wagner, P. (1995). Shame-proneness, guilt-proneness, and psychological symptoms. In J. Tangney, & K. Fischer (Eds.). *Self-conscious emotions: The psychology of shame, guilt, embarrassment, and pride* (pp. 343–367) New York: Guilford.

Tangney, J.P. (1996). Conceptual and methodological issues in the assessment of shame and guilt. *Behaviour Research and Therapy*, 34, 741-754. doi: 10.1016/0005-7967(96)00034-4

Tedeschi, J. T., & Felson, R. B. (1994). *Violence, aggression, and coercive actions*. Washington, DC: American Psychological Association.

Thompson, R., & Berenbaum, H. (2006). Shame reactions to everyday dilemmas are associated with depressive disorder. *Cognitive Therapy and Research, 30*, 415–425. Springer. doi: 10.1007/s10608-006-9056-3

Tomkins, S. S. (1962-1991). *Affect imagery consciousness* (Vols. 1-3). New York: Springer.

Troop, N. A., Allan, S., Serpell, L., & Treasure, J. L. (2008). Shame in women with a history of eating disorders. *European Eating Disorders Review, 16*, 480–488. doi: 10.1002/erv.858

Trower, P., & Gilbert, P. (1989). New theoretical conceptions of social anxiety and social phobia. *Clinical Psychology Review, 9*, 19-35. doi: 10.1016/0272-7358(89)90044-5

Yelsma, P., Brown, N. M., & Elison, J. (2002). Shame-focused coping styles

and their associations with self-esteem. *Psychological Reports, 90*, 1179-1189. doi: 10.2466/pr0.2002.90.3c.1179