Η διερεύνηση της σχέσης μεταξύ της ντροπής και του σωματικού πόνου

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ΠΕΡΙΛΗΨΗ

Η ντροπή είναι κοινωνικό συναισθήμα και επηρεάζει άμεσα την εικόνα του εαυτού, καθώς και την αντίληψη σχετικά με τη γνώμη των άλλων για τον εαυτό. Το ίδιο συμβαίνει και με τον σωματικό πόνο και την ασθένεια. Η παρούσα μελέτη σχεδιάστηκε για να διερευνήσει τη σχέση μεταξύ της ντροπής και ενός παρελθοντικού σωματικού πόνου. Τα 384 υγιή άτομα που συμμετείχαν στην έρευνα χωρίστηκαν σε δύο ομάδες. Η πρώτη ομάδα αποτελούνταν από 57 άτομα που ανέφεραν ότι είχαν ντραπέζης για έναν παρελθοντικό σωματικό πόνο, ενώ η άλλη ομάδα αποτελούνταν από 327 άτομα που ανέφεραν ότι δεν είχαν ντραπέζης. Τα αποτελέσματα εκτιμήθηκαν ότι από αυτοκρατορικό μια εκτιμήσεις SCL-90. Τα αποτελέσματα εκτιμήθηκαν ότι, όταν ντραπέζης για έναν παρελθοντικό βίωμα σωματικού πόνου, είχαν υψηλότερα επίπεδα εσωτερικής και εξωτερικής ντροπής, ψυχουσιατρικής και αυτοπεπτικής και ήταν σύμφωνες με ηπειρικών μελετών. Μέσα από την παρούσα μελέτη έγινε εμφάνιση της ευγένειας και αναγκαία αξιολόγηση και συνεκτίμηση της ντροπής των ασθενών από τους ειδικούς κατά τον σχεδιασμό του θεραπευτικού πλάνου.

Λέξεις-Κλειδιά: Εξωτερική ντροπή, εσωτερική ντροπή, σωματικός πόνος, ψυχουσιατρική, στηματισμός
An exploratory study on the relationship between shame and bodily pain

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ABSTRACT

Shame emerges through social life and influences directly self-image as well as the perception of what others think of self. Bodily pain and disease also influence self-image and others’ behavior towards self. The present study was designed to investigate the experience of shame in connection with a physical pain that occurred in the past. 384 healthy individuals participated to the present study. Two groups were formed according to the experience of shame. The first group constituted of 57 individuals who reported being ashamed of a past bodily pain, while the other group constituted of 327 individuals who reported not being ashamed of such a pain experience. The measures used were: a) A questionnaire concerning socio-demographic information, b) the Other As Shamer Scale (OAS), c) the Experience of Shame Scale (ESS) and d) the revised version of Symptom Check-List (SCL-90). Higher levels of internal and external shame and psychopathology were observed among participants who reported being ashamed for experiencing pain. The results of the present study replicated previous findings. The need for health professionals to assess shame in patients experiencing pain and apply relevant information to the therapeutic regimen was apparent.

Key words: external shame, internal shame, pain, psychopathology, stigma

INTRODUCTION

Although all people have a native ability to experience shame as a dispositional trait many different parameters influence each individual’s sensitivity to shame experience and response (Heller, 2003; Shweder, 2003). Few of them are: the cohesion of one’s family, the parental behavioral examples and the positive or negative reinforcement that the child receives from its close social environment (Gilbert, et al., 1996; Gilligan, 2003; Pulakos, 1996; Tangney & Dearing 2002).

Shame contains elements from both self and the social world (Shweder, 2003), it develops through primitive psychobiological defending mechanisms (Gilbert & McGuire 1998) and manifests through self-mirroring (Lewis, 2003). Neo-Freudians perceive shame as a result of a conflict between Ego and Ego-Ideal (Tangney & Dearing 2002).

The social factor that evokes shame is what Heller (2003) calls the “eye of the Other”, which is often internalized, resulting in accompanying the individuals even when they are alone. People usually try to avoid anything that could possibly lead to their rejection by others, a tactic which may cause a feeling of being trapped (Gilbert, 2003).

According to Tangney and Dearing (2002), people who tend to observe themselves closely are more likely to experience shame. Shame is relevant to the
feeling of being in the world as a self one does not wish to be (Gilbert, 1998) and refers to the individual as bio-psychological being (Heller, 2003).

An essential differentiation is between external and internal shame (Gilbert, 1998). External shame concerns the individual's belief about the others' judgements of the self (Gilbert, 2000), while internal shame concerns the individual's belief and the negative evaluations of the self (Benn, et al., 2005). Internal and external shame are usually correlated (Goss, et al., 1994).

Does shame serve a purpose similar to that of pain? Shame, like pain, is an aversive stimulus which leads the individual to repair the situation which led to experiencing this stimulus, as well as to avoid similar situations in the future. Like pain, shame expresses the following message: whatever you did, undo it if possible and do not repeat it (Bowles & Gintis 2002).

**Shame, pain and stigma**

At present, the transition from a society of shame to a society of guilt (Konstan, 2003), turns shame in an even more painful and stigmatized emotional experience (Hollander, 2003). Kurzban and Leary (2001) reported that shame, stigmatization and social exclusion are parts of the same process, according to which a social group decides who to relate with and who to reject. They further reported that stigmatization relates closely to signs of illness, physical deformity and poverty.

Individuals who suffer from physical pain usually experience the negative effects of stigma due to variant reasons, like the search for an explanation about their pain (Lennon, et al., 1989; Osborn & Smith 1998), the social comparison between themselves and others and the sense of not being believed by others. These result in the individuals treating their own pain as a stigma and being vulnerable to shame (Osborn & Smith 1998).

The idea of responsibility is central to pain, shame and stigma. The degree to which stigmatized individuals blame themselves or are being blamed by others actually reflects the degree of their shame experience (Lewis, 1998). Finally, the areas liable to rejection are relevant to social values, which each group wishes to preserve (Gilbert, 2003) and differentiate across different cultural groups (Shweder, 2003).

**Shame and psychopathology**

Several previous studies put a great emphasis on the complicated role of shame in the onset and course of psychopathological symptoms, such as depression, anxiety disorders and eating disorders (Goss, et al., 1994; Tantam, 1998; Andrews, et al., 2002; Tangney & Dearing, 2002; Lundback, et al., 2006; Birchwood, et al., 2007) as well as in drugs and alcohol abuse (Dearing, et al., 2005).

In an attempt to explain such emphasis, it could be asserted that shame relates to the internalization of an inferior self, which tends to be maintained (Gilbert, et al., 1996). The sense of “damaged self” is central also to the case of physical pain, since pain is perceived as a threat or damage to one's biological integrity (Chapman & Gavrin 1999).

**MATERIAL AND METHOD**

The general aim of the present study was to investigate the relationship between shame experience and the recollection of a past physical pain, regardless of the pain's origin or duration. The aim was to investigate whether the participants who relate the pain experience with shame, actually are individuals who are generally more shame prone than others.

On these grounds, external shame, internal shame and psychopathology were examined for individuals who reported either being ashamed of a past bodily pain experience or not being ashamed, by answering a relevant closed question which was included in the demographic variables. It was hypothesized that those reported being ashamed would score higher in the measures of shame and psychopathology.

**Subjects**

The present study was carried out by the Medical Psychology Laboratory of the University of Ioannina, Medical School, in Greece, from January to September 2007. The sample consisted of healthy individuals that were either: 1) Undergraduates and postgraduate students of Greek Universities or 2) Administrative employees at the above Universities or 3) Relatives and friends of the above individuals.

The total number of individuals who fulfilled study requirements and accepted to participate was 384. Those 384 individuals were divided in two groups. The first group consisted of 57 individuals (11 males and 46 females) with average age of 32.02 (S.D. 10.57), who recalled being ashamed of a bodily pain that they experienced in the past. The second group consisted of 327 individuals (85 males and 242 females) with average age of 31.46 (S.D. 11.40), who reported not being ashamed of such experience.

**Procedure**

People who accepted to participate, arranged an appointment with the researcher for the questionnaires to be administered to and completed. During the interview, the researcher described the nature and the aim of the study, making clear to the participants that it was up to them to decide whether they wished to take part to the study or not.

**Material**

1. Goss, Gilbert and Allan (1994) developed Other As Shamer Scale (OAS) in order to measure external shame. OAS contains 18 items assessing individual's beliefs about what others think of him/herself (e.g. “Others see me as...”). A five-point Likert scale (0-4) is used to rate how frequently the content of each statement is true for the individual. OAS items are divided into three subscales: a) inferior, b) empty and c) mistakes. A total score as well as a score for each subscale are obtained by summing up individual scores on relevant items. Cronbach's alpha for the Greek version of OAS was 0.87 (Paschou, et al., unpublished observations). OAS has been used in numerous studies on shame (Gilbert, et al., 1996;
Gilbert & Miles 2000; Gilbert, et al., 2005; Benn, et al., 2005).

2.**Experience of Shame Scale (ESS)** (Andrews, et al., 2002) consists of 25 items, measuring three areas of shame as a dispositional trait: characterological, behavioural and bodily shame. Each item is rated on a 4-point scale (1–4), indicating the frequency of experiencing (experiential), thinking (cognitive) and avoiding (behavioural) any of the three areas of shame in the past year. In their study, Andrews, et al., (2002) found ESS to have a high internal consistency (Cronbach's α=0.92). Internal consistency was also high for the Greek population (Cronbach's α=0.93) (Kaltsouda, et al., unpublished observations). ESS has been used in numerous studies and proved to be capable of predicting depressive symptoms (Andrews, et al., 2002).

3.**The Symptom Checklist-90-R (SCL-90-R)** was developed by Derogatis (1977) to evaluate a broad range of psychological problems and symptoms of psychopathology. It consists of 90 items that measure 9 primary symptom dimensions (that is, somatization obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism). It is rated on a 5-point scale (0-4), indicating the frequency of experiencing the symptoms described at a specific point in time. SCL-90 is designed to provide an overview of a patient's symptoms and their intensity. It has been standardised for the Greek population and found to possess satisfactory psychometric features (Ntonias, et al., 2002).

4. A **self-report questionnaire** asking for certain socio-demographic information was enriched with two closed questions regarding pain experience and shame: a) “have you ever experienced physical pain?” - this question determined whether the individual would be eligible to participate in the present study, and b) “have you been ashamed for experiencing such pain?”.

### Statistical analyses

For the description of sample’s social, demographic and psychological characteristics, distribution frequencies, median and variance were performed. $\chi^2$ (chi-square) test ( Paraskevopoulos, 1993; Siafaka, 2000; SPSS, 1999) was performed for the comparison:

- $\chi^2$ of Pearson for tables 3x2 in the cases where less than 25% of expected values was $<5$, no one of the expected values was $<1$ and the total of observations was $>24$.
- $\chi^2$ of Pearson was used for tables 2x2 in the cases where all the expected values were $>10$.
- $\chi^2$ of Yates was used for tables 2x2 in the cases where even one of the expected values was between 5 and 10.
- Fisher's Exact Test was used in the cases, where even one of the expected values was $<1$ and the $\chi^2$ test could not be applied.

The statistical analyses concerning the descriptive characteristics of the variables examined were performed by both Excel and SPSS10, while those concerning comparisons and correlations of quantitative and categorical variables were performed by the statistical parcel of SPSS10 only. For all statistical analyses $p<0.05$ was considered as statistically significant.

### RESULTS

Table 1 presents the means, standard deviations, medians and Mann-Whitney Tests for both groups and for all variables tested.

<table>
<thead>
<tr>
<th>Table 1. Means (standard deviations) and with Z tests differences</th>
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<td>SCL_90 - PST</td>
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***P<0.001; **p<0.01; *P<0.05; MS (Mat.b.binarily significant)(0.06<P<0.10)
**External and Internal shame**
The results of the present study demonstrated significantly higher levels of both external and internal shame for individuals reported being ashamed of a previous physical pain, when compared to those not being ashamed. Significant differences were observed when applying both Fisher Exact Test (external shame p= .002; internal shame p= .000) and Pearson’s $x^2$ (external shame p= .016; internal shame p= .000). Significant differences were also observed when the two groups were compared with the Mann-Whitney test (table 1).

**Psychopathology (SCL-90)**
Significantly higher psychopathology indices were found for those who reported being ashamed of their pain experience. Symptoms of compuliveness were greater for this group of participants (p=.002), as it was confirmed by the Fisher Exact Test. Similarly, symptoms of interpersonal sensitivity (p=.008), depression (p=.007) and paranoid ideation (p=.030) were also higher, according to the Fisher Exact Test, as well as symptoms of aggression (p=.018) according to Pearson’s $x^2$. The differences between the two groups were confirmed also by the Mann-Whitney test (table 1).

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<th>Table 2. Correlations</th>
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<td>Phobic anxiety</td>
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### DISCUSSION

The results of the present study demonstrated the association between increased levels of shame (both internal and external) in individuals who reported having being ashamed for a past pain experience. These findings further suggest that shame is related to perceived defects (that is, physical pain) and adverse characteristics of the self (e.g. coping with pain) as it had been already supported in the past (Gilbert, 1998; Heller, 2003).

Psychopathology manifestations were more frequently reported as well as more severe among individuals experiencing shame regarding a previous physical pain. Such finding was rather expected since numerous previous studies (e.g. Goss, et al., 1994; Gilbert, et al., 1996; Tantam, 1998; Gilbert & Miles 2000; Andrews, et al., 2002; Shapiro, 2003) had stressed out the association of shame with psychopathology. It seems that, people who tend to connect a previous physical pain experience to shame are dominated by a certain kind of internal conflict, which may have led to a negative representation of self. On these grounds, any physical symptom, like pain, may be considered as revealing the “weaknesses” of the self. For those people, pain becomes so undoubtedly present, making them believe that «being in pain» is the most vivid example of «being certain» of their defective and deficient nature. Pain also strengthens their belief of being far away from their ideal self, which has been common among individuals with increased levels of shame (Tangney & Dearing 2002; Rosenberger, 2005).

Interpersonal sensitivity was found increased in the group of participants that reported being ashamed of their previous pain experience. This finding was considered as a tendency of those individuals to closely observe the reactions of others. Such tendency can be understood as an attempt to “survive”, since shame is determined by the “gaze of Other” (Gilbert, 1998; Heller, 2003) and constitutes a common warning sign that the individual either does not evoke enough positive feelings or evokes negative feelings in others (2003).

In the present study, it was shown that demographic factors were correlated with both internal and external shame only for those who reported not being ashamed.
of a previous pain (table 2). It could be assumed, then, that shame constitutes a dispositional factor (Tangney & Dearing 2002), irrelevant to age, gender, profession, etc, for those reported being ashamed.

The direct question about feelings of shame in the present study, is in accordance to the remark made by Macdonald (1998) that people are willing to talk about shame, when they are directly asked, while the indirect questions about shame which are included in self-report questionnaires are thought to be more effective in capturing the unconscious feelings of shame (Andrews, 1998). Consequently, since such a direct question included in the present study was not in the frame of an interview, it seemed not to have activated unconscious defenses that would block the recollection of feeling ashamed but also allowed the assessment of the repressed sides of shame.

There are certain limitations of the present study. There is a possibility that people answered positively about shame, as a result of recalling a disease which led to pain in the past and not an independent pain experience. It is considered, though, that the way in which the question was stated (that is, it clearly referred to the recollection of a somatic pain experience and not a disease), in addition to the fact that pain does not necessarily result from a disease, may have assured that participants reported being ashamed or not due to the pain experience itself and not to a disease.

Secondly, the question regarding shame about a bodily pain concerned the past, a fact that put some questions relevant to memory reconstructions. Why did we choose to refer to a past pain and not to a present one? Because, people who are in pain at present will possibly either answer defensively (Papadatou, 1999) or they will find it difficult to talk about their feelings and thoughts due to the intensity of their pain, since physical pain destroys the use of language actively, resulting in a pattern of communication that involves shouts and screams (Scarry, 2004). Regarding the involvement of memory reconstructions, which possibly occurred in the present findings, it should be addressed that experiencing shame about a previous physical pain is itself impressed on memory as a part of an individual’s identity and influences his/her present as well as future independently of the reconstructions which may have occurred (Ioannidis, 2007).

To sum up, the conclusions drawn in the present study concerning the characteristics of people who reported being ashamed of a previous physical pain involve the following: These people tended to report higher levels of external and internal shame, as well as higher levels of psychopathology. Apparently, shame is a feeling that may accompany pain. In fact, one out of five participants have reported being ashamed of a physical pain in the present study.

On these grounds, serious concerns have arisen relevant to pain management. Shame should also be assessed in people suffering from pain, since it can prevent people from asking for help or even complying with therapy (Tangney & Dearing 2002). It can further result in the concealment of pain-related information as well as in a lack of satisfaction regarding medical care (Lazare, 1987).

The individuals, who connected in their mind the pain experience with shame, are individuals who are generally more shame prone. This leads us to the assumption that pain experience relates to shame in the case of people who generally tend to score higher in shame scales and not necessarily in the cases of pain.

In order to clear out whether shame relates to bodily pain, it would be necessary to measure shame in groups of people with chronic or present bodily pain and compare them to people without bodily pain. This could help to the understanding of whether people who have shame of pain actually cope with pain less well. Interesting research of a longitudinal nature, using people with chronic pain could profit from the initial discoveries made here.

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