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Psychological Differences in Shame vs. Guilt: Implications for Mental Health Counselors

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Recent work on the psychological distinctions between shame and guilt has important implications for mental health counselors. In particular, the work of Lewis (1971) and Tangney (1990, 1995; Tangney & Dearing, 2002) identifies psychological differences between shame and guilt and how they are phenomenologically expressed that provides helpful insight to those working with clients experiencing these emotions. This paper draws upon this work to establish criteria for distinguishing shame and guilt and to offer guidelines for their treatment.

Distinctions between shame and guilt are often overlooked by those in clinical work (Tangney & Dearing, 2002). Particularly in Western culture, they are often assumed to be interchangeable or synonymous terms (Gilbert, Pehl, & Allan, 1994). Erik Erikson (1950), one of the first to distinguish psychologically between shame and guilt, noted that "shame is an emotion insufficiently studied, because in our civilization it is so easily absorbed by guilt" (p. 252; cf. Lansky, 1995).

This failure to adequately distinguish shame from guilt ignores a growing body of research on important psychological differences between these two emotions (Tangney & Dearing, 2002). Especially noticeable is the absence of studies that explore the implications of these differences for counseling. Research exploring the psychological differences between shame and guilt notes that failure to distinguish between the two emotions contributes to the neglect of shame as a significant clinical problem (Capps, 1993; Konstam, Chernoff, & Deveney, 2001; Tangney & Dearing); furthermore, shame is often mistaken for guilt, leading to ineffective treatment for those suffering from shame (Lewis, 1971; Nathanson, 1992; Tangney, 1996; Tangney & Dearing; Tangney, Miller, Flicker, & Barlow, 1996). These problems are likely to

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increase, given the conclusion of several notable authors that shame, not guilt, is now the prominent emotion troubling Western culture (Scheff, 1995; Tangney et al., 1996; cf. Capps, 1993; Cheng & Page, 1995; Fowler, 1996; Kaufman, 2004).

Although shame and guilt show considerable overlap, often appearing together in clients (Tangney & Dearing, 2002), there is a heuristic as well as practical clinical value in reflecting on the differences. This paper reviews recent research on the psychological and phenomenological characteristics of shame as distinguished from guilt. It summarizes important distinctions between the two emotions and how they are experienced. It then outlines the implications of the differences for counseling.

Mental health counselors will especially be interested in the research on differences between shame and guilt because it helps highlight the developmental and growth aspects of these emotions, not simply the life difficulties that may accompany them. Attending to the developmental differences is especially important in formulating treatment goals and strategies.

DISTINGUISHING SHAME AND GUILT PSYCHOLOGICALLY

Erik Erikson (1950) made one of the first psychological distinctions between shame and guilt. His lifespan model outlined the growth of the self, both body and psyche, as it occurs in the context of expanding social interactions. He laid out critical tasks of emotional development occurring throughout the lifespan that promote healthy psychosocial growth. In Erikson's model, growth occurred through balancing the tension produced by certain polarities. However, this is not an even balance of polarities; although both polarities are necessary, health required an "overbalance" of the positive quality. The resolution of each crisis produced an ego strength that was integrated into one's emerging identity and helped one face the tasks of the next developmental stage. Erikson's list of critical tasks included articulation of the development of shame and guilt.

For Erikson (1950), shame preceded guilt developmentally. As with all the critical tasks, without a proper balance of the polarities one did not proceed well to the next task. This meant that without a proper measure of shame, neither guilt nor initiative developed appropriately. However, if there was too much shame, initiative and guilt were overshadowed by compulsive activity. Since shame was connected to the development of autonomy and the ego quality of will, an overbalance of shame and doubt (vs. autonomy with the optimal amount of shame and doubt) resulted in compulsive activity as the ego overcompensated in its attempts to master and manage the expressions of will. By contrast, guilt was associated with initiative and the emerging ego quality of purpose. An overbalance of guilt, instead of an optimal level of guilt with an overbalance of initiative, inhibited productivity and left the person lacking in purposeful drive toward future goals.

Since Erikson (1950), there has been considerable work, both theoretical and empirical, on the psychological distinctions between shame and guilt. Over the past three decades, Helen Block Lewis's distinction (1971) between shame and guilt has emerged as one of the dominant conceptualizations, in large part because it has received strong empirical support from a range of both quantitative and qualitative studies (Gilbert, Pehl, & Allan, 1994; Konstam et al., 2001; Tangney, 1990, 1991, 1995, 1996; Tangney & Dearing, 2002; Tangney, Miller, Flicker, & Barlow, 1996; Tangney, Wagner, Fletcher, & Gramzow, 1992; Tangney, Wagner, Hill-Barlow, Marschall, & Gramzow, 1996; Tracy, Robins, & Tangney, 2007). Lewis's theory and the empirical work it has inspired provide important groundwork for distinguishing shame and guilt psychologically. She articulated cognitive, affective, and motivational differences between shame and guilt that empirical studies have verified (see Tangney & Dearing, 2002, for a summary). Thus it is possible to define certain psychological markers that differentiate shame and guilt.

Cognitive Differences

One of Lewis's major contributions (1971) was to refute earlier social theories (e.g., Benedict, 1946) that described shame as a public emotion and guilt as a private one (Tangney, 1995). Lewis theorized that although the same situation could elicit shame in one person and guilt in another, the differentiating factor was the individual's interpretation of the role of the self in these situations, not whether the experience took place publicly or privately. This different way of seeing the self pointed to cognitive differences in the experiencing of shame and guilt. With guilt, the self was pronouncing judgment on its *activity*; with shame, the self pronounced a more summary judgment on the inadequacy of the *self* itself. As Lewis noted:

> The experience of shame is directly about the self, which is the focus of evaluation. In guilt, the self is not the central object of negative evaluation, but rather the thing done or undone is the focus. In guilt, the self is negatively evaluated in connection with something but is not itself the focus of the experience (p. 30).

One might say that the cognitive self-awareness attendant on shame is more encompassing than with guilt. According to Lewis, shame involved more self-consciousness, self-imaging, and greater body awareness than guilt. Similarly, persons experiencing shame seem less able to cognitively sort out their actions from the more fundamental sense of self.

In addition to greater cognitive self-awareness, there were cognitive differences in qualities attributed to the self. Those experiencing shame tended to

see themselves as worthless and powerless—unable to make changes in the environment or themselves. By contrast, those experiencing guilt saw themselves as able to take some sort of corrective action either toward the consequences of their behavior or toward future behavior (Tangney & Dearing, 2002; cf. Andrews, Qian, & Valentine, 2002; Efthim, Kenny, & Mahalik, 2001; Konstam et al., 2001).

Another aspect of the cognitive differences between shame and guilt concerned where the sense of evaluation seemed to originate. In shame, the source of blame or negative valuation of the self was localized as "out there," originating in the "other." This externalizing of blame was one of the chief markers of shame (Tangney & Dearing, 2002; Tangney et al., 1992, 1996). Even as an internal experience shame involved judgment of an internalized "disapproving other." With guilt, by contrast, the internal evaluation system was felt to originate more from within a person's own sense of self.

Affective Differences

There also are affective markers that distinguish shame and guilt. Using Lewis's (1971) theoretical distinctions Tangney (1990, 1995, 1996) has developed an instrument (the TOSCA—Test of Self-Conscious Affects) for measuring and distinguishing shame and guilt. Her work with this instrument has verified cognitive, affective, and motivational distinctions between the two emotions that can distinguish them. Following Lewis, Tangney concurred that the chief cognitive difference between shame and guilt was how the self was perceived, but she also pointed to affective differences between them.

Lack of empathy. One of Tangney's (1991; Tangney & Dearing, 2002) central findings was that empathy was a key marker for differentiating shame from guilt. This finding derived from Lewis's (1971) point that shame involves a more global evaluation of the self than did guilt. True interpersonal guilt (feeling bad when one was aware of doing someone harm) hinged on (a) an empathic awareness of and response to someone's distress and (b) an awareness of being the cause of that distress. From this perspective, empathy was an essential prerequisite for guilt (Tangney; cf. Konstam et al., 2001; Leith & Baumeister, 1998). According to Tangney, it was the absence of empathy that was striking about the presence of shame. Tangney theorized that this might be because shame is such a painful and overwhelming experience that it naturally draws the focus away from the distressed other back to the self. Even when a shame-prone individual noticed and initially empathized with another, his or her empathic response might become short-circuited. "When faced with a distressed other, shame-prone individuals may be particularly likely to respond with a personal distress reaction, in lieu of a true empathic response" (Tangney, p. 600). This preoccupation with the self is inconsistent with the other-oriented nature of empathy.

Anger and aggression. Another distinction is the link between shame, aggression, and anger that Tangney has demonstrated (Tangney, 1996; Tangney & Dearing, 2002; Tangney, Miller, Flicker, & Barlow, 1996; Tangney et al., 1992). This connection could take an active or passive form as the shamed individual attempted to manage his or her feelings. The more passive route was associated with anger turned inward (a ruminative, unexpressed anger), self-directed hostility, and a tendency to withdraw from anger-related situations. The more active route involved reactivating the impaired self through other-directed anger (e.g., by turning the tables and externalizing blame onto others involved in the shame-eliciting situation). For those who took a more active response, proneness to shame is associated with malevolent and fractious intentions and a likelihood of engaging in all manner of direct, indirect, and displaced aggression (Tangney & Dearing; Tangney et al., 1996).

By contrast, guilt-prone individuals were not disposed particularly to blame external factors or other people for negative events. Rather, when experiencing guilt they were likely to become aware of their role in negative interpersonal situations, and by extension felt an obligation to assess their impact on others. Thus, guilt produced a sense of tension and regret borne of empathy, which often led to reparative action such as confession, apology, or making amends (Tangney, 1996; Tangney & Dearing, 2002; cf. Konstam et al., 2001).

Motivational Differences

The movement toward reparative action provides a motivational marker for distinguishing shame and guilt. Shame involves a withdrawing from others—a shrinking or hiding, especially from shame-eliciting situations. Shame moves one away from others, perhaps through passive withdrawal or the externalization of blame. Guilt, on the other hand, moves one toward others in attempts to repair damage done, often through confession and restitution. Those experiencing guilt take responsibility for their actions and the consequences; the shame-prone person, unable to take responsibility, typically shifts the blame to another person (Tangney & Dearing, 2002; cf. Leith & Baumeister, 1998).

Thus, shame and guilt are experienced very differently, in terms of both thoughts and feelings as well as in behavioral motivations. As Tangney (1991) summarized it:

> Because of its focus on specific and presumably controllable behaviors, the guilt experience is uncomfortable but not debilitating. That is, the self remains "able." Not surprisingly, phenomenological reports indicate that guilt's consequent motivation and behavior tends to be oriented toward reparative action. Shame, on the other hand, is a much more global, painful, and devastating experience in which the self, not just behavior, is painfully scrutinized and negatively evaluated. This global negative affect is often accompanied by a sense of shrinking and being small, and by a sense of worthlessness and powerlessness.

> Phenomenological data also suggest that shame is likely to be accompanied by a desire to hide or to escape from the interpersonal situation in question (p. 599).

Tangney and Dearing (2002) further concluded that guilt as the more adaptive of the two emotions was the more developmentally mature emotion to move people toward.

IMPLICATIONS OF THESE DISTINCTIONS FOR MENTAL HEALTH COUNSELING

Although shame and guilt often occur together, the distinctions described provide not only a means for determining whether shame or guilt is the dominant presenting emotion but also offer suggestive lines for the treatment of shame vs. guilt. These two emotions are not only significantly different in a client's experience, they also reflect differences in developmental and coping abilities. Being able to distinguish shame from guilt will help mental health counselors to offer interventions more appropriate to the experience of each emotion.

Criteria for Distinguishing Shame and Guilt

Since shame and guilt are easily confused because they often co-occur (Lewis, 1971; Nathanson, 1992; Tangney & Dearing, 2002), the first way the distinctions noted are helpful for the counselor is in providing criteria for determining whether a person is struggling more with shame or guilt. Since treatment for the two emotions differs (see below), there are several things to listen for or attend to in a client's presentation to help sort out which is dominant.

The "self" vs. the "thing done." From Lewis (1971), one would conclude that if the presentation of a problem is focused on a global sense of the person's badness rather than feeling bad about a specific action, then shame more than guilt is the central emotion. Conversely, guilt dominates when the concern is over the thing done rather than the self. This distinction is important diagnostically because a client who can judge his or her actions is at a different place developmentally from one who makes global condemnations of the self. The former has a clear, stable sense of self; the latter has a more tentative, diffuse sense of self.

This difference in the stability and cohesiveness of the self shows up in therapy in various ways. For instance, a guilt-laden depression would be evident in talk about actions taken or not taken, while a shame-laden depression would be characterized by reports of worthlessness or badness of the person (the self) rather than the deeds. Similarly, anxiety in a guilt-prone person would derive from an awareness of others and the harm done to them (e.g., the person is

anxious about a mistake that has or will cause others to suffer). Anxiety connected to shame, however, would reflect a concern not with the other but with the self. Thus, the shame-prone person might be anxious because of a fear of being found out and judged (for a violation of standards and expectations either of one's own or others) or a fear of being asked to do things that would reveal one's deficiencies.

Boundary issues and compulsions. Erikson's (1950) placement of shame in a developmental conflict over autonomy suggests that the dominant emotion can be discerned through struggles over boundary issues and compulsions. For instance, clients who show no discretion in the choice of friends or indiscriminately let others take advantage of their good will are likely suffering from a deep sense of shame rather than guilt, which is connected to the less stable sense of self that is characteristic of a shame-dominated person. Because of the more diffuse boundaries to the self, the shame-prone person also might express a fear of intimacy as potentially engulfing. By contrast, the guilt-prone person with a clearer sense of self is not as fearful of the painful interaction with others that often accompanies having done wrong. The guilt-prone person has less fear of interaction because there is no concomitant fear that somehow the self will be overwhelmed or crushed in the exchange.

Boundary issues are discerned not only in concerns with their permeability but also through their rigidity and compulsivity. Learning boundaries (what is permitted or not; where self and other start and end), Erikson (1950) argued, develops the ego capacity of will. Compulsions would indicate deficiencies in ego capacity; the person feels less in control of thoughts or behaviors. Thus, a shame-dominated client will describe addictive behavior (e.g., gambling, alcohol, drugs) as simply his or her nature, something that cannot be controlled. Such a client, stuck in ruminations over how bad he or she is, would be paralyzed and unable to take reparative action. A guilt-dominated client is apt to describe these behaviors as bad choices, something for which he or she needs to make amends.

A different kind of compulsivity and rigidity can be seen in the perfectionist who compensates for a general lack of control by circumscribing a particular area for managing well. Such a person could be considered as struggling more with shame than with guilt. Similarly, the compulsive part of an obsessive-compulsive ritual is often a means of trying to regain control. Ironically, the absence of control over compulsive behavior often brings a greater sense of shame (cf. Carnes's [1983] description of the despair that follows acting out in an addiction cycle).

Although compulsive behavior occasionally can point to guilt (cf. Lady Macbeth's hand washing), Erikson (1950) would help the counselor appreciate compulsions as more a struggle over loss of control or will and thus more

shame-based. Conversely, the client who struggles with guilt more than shame is more aware of what he or she can or cannot "do" (i.e., issues of initiative and sense of purpose).

Lack of empathy. Tangney's (1991) work elaborated how the diffuse global evaluation of one's badness that distinguished shame from guilt often manifested as a preoccupation with the self, with a concomitant inability to express empathy for others. Thus, a lack of empathy points to a dominance of shame over guilt (Tangney & Dearing, 2002).

Lack of empathy is connected to developmental deficits in the formation of the self (see above). By contrast, when guilt predominates, there is an ability to empathize and an appropriate concern for damage to the relationship or reparation of the other's loss. Thus, anxiety that derives from a client's ability to see the impact of his or her behavior on others is indicative of guilt. Shame-based anxiety might be characterized by a desire that others see how debilitating the anxiety is for the client and how in need of care the client is.

Blaming and anger. Tangney and Dearing (2002) also pointed to the distinguishing markers of externalizing blame and excessive anger (either internalized or projected outward) as markers that can alert the counselor to the potential dominance of shame. When in describing a problem a person focuses on the fault of another rather than his or her own role in the problem, shame may be more prevalent than guilt. Blaming others is a way of defending against the global, negative evaluation of the self (cf. Nathanson, 1992). Thus, a spouse who has trouble seeing his or her part in the creation of the marital tension or a client who thinks his or her anger is due to the actions of others is likely suffering from a deep sense of shame. The guilt-prone person is more accurately able to accept his or her role in relational problems.

However, the mental health counselor also must remember that some clients will turn the anger and blame inward. The client characterized by a global self-loathing may appear to acknowledge fault but then uses this acknowledgement as an excuse to avoid action. Having declared how bad one is, responsibility is shifted to the other. Where guilt is more dominant, each partner not only can hear the other's side more readily but is in a better place to take restorative steps.

Withdrawal. Both Erikson (1950) and Tangney (Tangney et al., 1996) have noted that a marker for the dominance of shame over guilt is withdrawal from others, which may take the active form of blaming others. Blaming, with its attendant anger, creates distance from others, thus achieving the goal of withdrawal. However, the counselor also must be aware that withdrawal may take a more passive route of isolation from others: Given the global, negative self-evaluation, a client may withdraw out of the conviction that others would not wish to associate with someone so blameworthy. Self-blame as an excuse for lack of action can be another way clients withdraw. By contrast, when guilt is

the dominant emotion, the person is more likely to move toward others by making reparative gestures.

Treatment Differences

The characteristic distinctions between shame and guilt also point to important differences in treatment approach. Since shame and guilt often occur together, both will need a response but the proper response to each will differ. Developmental differences in the growth and stability of the self require treatments that take this trajectory into account. When dealing differentially with these two emotions, the focus, the goal, and the modality of the intervention will vary.

Focus of the intervention. When shame is the dominant emotion, the *experiences* rather than the *actions* of the self become the focus of interventions. Before someone overwhelmed with shame can properly evaluate the actions of the self, the person must come to grips with the more global negative evaluation of the self. Similarly, before the person overwhelmed by shame can have empathy for another's distress, the distress of the shame-filled person's sense of fundamental flaw must be addressed.

What this suggests in terms of treatment is an approach sensitive to the insight that developmentally shame precedes guilt. When issues of shame and the self lie behind a client's dysfunction, focusing on behavioral change to assuage guilt not only produces results that may be less than satisfactory but is apt to exacerbate feelings of shame. In fact, a counselor might discern when shame is the dominant emotion when a person engages (often repeatedly) in guilt remedies such as confession and forgiveness but finds no sense of relief.

For instance, those suffering from shame are sometimes counseled toward confession and forgiveness—appropriate responses to guilt, but premature or ineffective responses to shame. Forgiveness as an intervention for the guilt-prone is effective because there is a cohesive sense of self that can empathize (cf. McCullough, Worthington, & Rachal, 1997). For the shame-prone, thinking of forgiveness feels like a loss to the self, an invalidation of his or her wound. Even when the shame-prone person expresses a need to forgive, there is a self-focus to the motivation: For example, forgiving is a way to feel magnanimous or to be released from the added shame of not being a forgiving person.

Goals of the intervention. The developmental distinction between shame and guilt means the mental health counselor also must think developmentally about the goals of counseling. For instance, when shame is the dominant emotion, the goal becomes strengthening the self (e.g., helping the person learn to distinguish self from behaviors) as a necessary step to helping move the person toward ability to empathize with the other. Since shame short-circuits empathic response, because the person is too preoccupied with judging his or her flawed

nature to attend to the feelings of others, counseling needs to focus first on creating a safe, nonjudgmental context in which a self overwhelmed with shame can relax the defenses that belong to such self-judgment. Far from encouraging the self-absorption that accompanies shame, this aspect of counseling becomes a necessary step in nurturing the ego capacity that makes the next developmental step successful (cf. Erikson, 1950).

Counseling that is sensitive to the developmental relation between shame and guilt will see growth emerging in separate steps. Although the penultimate goal of counseling with those experiencing shame will be to strengthen the self overcome by its sense of being flawed, the ultimate goal with such a client would be to strengthen the self so that it might move toward guilt—that is, toward a response in which the self can see itself as acting badly, see the consequences of its actions, take responsibility for its actions, and move toward reparation in relationships rather than being stuck in self-loathing about feeling essentially and fundamentally flawed (Tangney & Dearing, 2002). Such self-preoccupation actually keeps one distant from others and unable to attend to how one's action affects the other.

Modality of the intervention. Not only must the focus and goal of the intervention be different for shame vs. guilt, its modality must be adapted as well. Since developmentally shame precedes guilt, it involves a different level of ego functioning. Conceptually shame might need more supportive or relationally oriented counseling; guilt would respond to more traditional insight or behavioral change counseling approaches. Behavioral interventions focused on things done, which might work well with guilt, need to give way to relationship building when shame dominates and the self needs strengthening. This is not to say that behavioral treatment will have no impact on shame issues, but it does argue that a shame-based person requires a qualitatively different kind of relational encounter than a guilt-based person. A shame-based person seems to need to experience affirmation and acceptance in the interchange with another, while a more cognitive verification or acknowledgement of the other's forgiveness seems to facilitate release of guilt. There is a subtle yet vital difference in these interactions. In actual practice, of course, for a number of reasons counselors find themselves moving back and forth between supportive and insight-oriented comments, but in this context it may be seen as an aspect of the fact that clients often bring guilt overlaid with shame to counseling (Tangney & Dearing, 2002).

When shame is more dominant than guilt, the client might be expected to be motivated to conceal issues due to fear of a negative evaluation from the counselor that would mirror the client's negative self-evaluation and heightened sensitivity to the thoughts of a projected disapproving other (Tangney & Dearing, 2002). Such negative expectations can impact the quality of the therapeutic relationship (i.e., "transference") and the client's ability to benefit (Gilbert, Pehl, & Allan, 1994). Attending to the quality of the relationship (e.g., negative transference) can open up opportunities for acknowledgement and exploration of shame. Mental health counselors can help those experiencing shame to move toward understanding what these experiences can teach about self and relationships by providing a safe, nonretaliating alternative to self-condemnation and the anticipated judgment from the counselor as disapproving other. This new kind of relationship can provide a foundation for and example of further development of empathy and guilt.

CONCLUSION

Recent literature, both theoretical and empirical, has verified that shame is an emotion distinct from guilt. However, a significant trend in clinical work has been to subsume shame under guilt, to treat it as secondary, or not to recognize it as an important, even key, emotion in its own right. Even though shame is a prominent emotion in our culture, current treatments often focus on modalities that are premature, ineffective, and sometimes harmful to those whose issues revolve around shame rather than guilt. We have argued for the need to recognize the psychological differences between shame and guilt so as to better distinguish and treat those suffering with these emotions. Although both often appear together in clients (to greater or lesser degrees), being able to distinguish between them has both heuristic and practical clinical value.

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Using Puppets with Children in Narrative Therapy to Externalize the Problem

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A clinical application is presented for using puppets with children in narrative therapy to externalize the problem. A case example illustrates the clinical application. Implications for the practice of narrative therapy are considered.

In the past two decades an increasing number of counseling and psychotherapy models have emphasized narrative conceptualizations of problems and change. Narrative therapy was developed by Michael White (1995, 2000, 2007) and his colleagues (e.g., White & Epston, 1990, 1992) at the Dulwich Therapy Centre in Australia. It views clients' problems as dominant stories or restraining narratives that are influenced by one's culture (White & Epston, 1990). In narrative therapy, clients are helped to replace problem-maintaining dominant stories with preferred narratives about their lives (M. White, 2000).

A fundamental principle in narrative therapy is externalizing the problem (M. White, 1989; White & Epston, 1990). According to White and Epston, externalizing the problem refers to "an approach . . . that encourages a person to objectify and, at times, to personify the problems that they experience as oppressive" (p. 38). The principle of externalization is aimed at helping clients view themselves as separate from their problems. In effect, they are encouraged to see that they are not the problem; the problem is the problem (White, 2004; White & Epston). The principle of externalization has been applied to a variety of clinical problems and clients. For example, V.E. White (2002) developed an externalization intervention for mental health counseling to help clients discriminate between their personal strengths and the pathologizing language of the

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