UNIVERSITY OF OKLAHOMA

GRADUATE COLLEGE

PREDICTORS OF GUILT AND SHAME: RELATIONAL HEALTH, FAMILY EXPERIENCES, AND TRAUMA

A DISSERTATION

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements for the

Degree of

DOCTOR OF PHILOSOPHY

By

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Norman, Oklahoma
2018

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PREDICTORS OF GUILT AND SHAME: RELATIONAL HEALTH, FAMILY EXPERIENCES, AND TRAUMA

A DISSERTATION APPROVED FOR
DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

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To all of the authentic, engaging, and empowering loved ones who help combat shame every day. May we all find hope and peace in relationship.

Acknowledgements

"Success is not final; failure is not fatal: It is the courage to continue that counts."
– Winston S. Churchill

To all of my beautiful friends and family who empowered me to be brave and keep going, I could not have completed this without you. Thank you for the time and effort you put into me and our relationship. It is valued and treasured.

To all four of my wonderful parents who helped support this crazy dream of mine, thank you for believing in me. Thank you for everything. I love you all and you will always be my heroes. Momma and Daddy, thank you for showing me what can be accomplished through hard work, love, and healthy relationships. Brother, thank you for being a rock *and* a soft place to land. I love you.

Tanner, thank you for standing by me through it all and supporting me every step of the way. Your sacrifices and support have not gone unseen and mean the world to me. Because of you I am a better person and I am blessed to have you as my partner and husband. I love you most.

Dr. Frey, I would like to thank you for helping me enter the world of RCT and understand the value in authentic, empowering, and engaging relationships. It has changed the way I view the world and those in it. I believe I am a better therapist and overall human because of it. Thank you for the countless edits, time, and effort you put into me and this process.

To my committee members, Drs. Williams-Diehm, Heddy, Terry, and Mayeux, thank you for your individual contributions to this project. I appreciate the time and effort you put into my professional development.

Table of Contents

Acknowledgements iv

List of Tables vii

Abstract viii

Introduction 1

Guilt and Shame 3

Shame and Traumatic Experiences 8

Shame and Dissconnection 11

RCT, Relational Health, Family Experiences, & Trauma 17

Relational Disconnection 20

Relational Health 25

Family Experiences 27

Trauma and Relational Health 30

Purpose and Hypotheses 32

Method 33

Participants 33

Measures 35

Demographic Questionnaires 35

TOSCA-3 35

RHI 36

FEQ 38

DAPS-RTE 39

Procedures 39

Data Analysis 40
Results 41
Hierarchical Multiple Regression 1: Shame 42
Hierarchical Multiple Regression 2: Shame conrolling for Guilt 42
Hierarchical Multiple Regression 3: Guilt 43
Hierarchical Multiple Regression 4: Guilt controlling for Shame 43
Discussion 44
Predictors of Shame 45
Predictors of Guilt 47
Implications 49
Limitations and Future Research 51
Conclusions 53
References 54
Appendix A: Survey 60

List of Tables

Table 1. Means, SDs, Alphas, and Intercorrelations 79

Table 2. Hierarchical Multiple Regression 1: Shame 81

Table 3. Hierarchical Multiple Regression 2: Shame controlling for Guilt 83

Table 4. Hierarchical Multiple Regression 3: Guilt 85

Table 5. Hierarchical Multiple Regression 4: Guilt controlling for Shame 87

Abstract

Tangney and Dearing (2002) found evidence that shame and relational disconnection were significantly related and that shame linked to psychological distress. Relational-cultural theorists, Miller and Stiver (1997) believed chronic disconnection can lead to psychological distress and worse, psychological isolation, what they believe to be the most destructive and terrifying feeling a person can experience. Brown (2007) found shame was the cause and result of relational disconnection. Other experiences, such as trauma history and family experiences, have been linked to shameful emotions (Dorahy et al, 2013; Katz & Nelson, 2007). These links with shame are important to understand because healthy relationships (i.e. empowering, engaging, and authentic) have been demonstrated to increase psychological wellbeing, health, and positive psychosocial outcomes (Frey, Tobin, & Beesley, 2004; Guyll, Cutrona, Burtzette, & Russell, 2010). These findings were supported by this study whose purpose was to determine if there were predictive relationships between relational health, trauma history, family experiences, and guilt and shame proneness. Guilt and shame were found to significantly predict each other. Age and negative family experiences were found to be significant predictors of increased guilt proneness, while trauma history was found to be the most significant predictor of increased shame proneness. Community and peer relational health were found to significantly reduce shame, although only peer relational health was found to increase guilt proneness.

Introduction

Guilt and shame are two self-conscious (i.e. self-aware, insightful, reflective) and morally evaluative emotions that can be felt at the same time or separately (Tangney & Dearing, 2002). Guilt is viewed as a prosocial emotion that focuses on behavior and often leads to repair, whereas shame is a disadvantageous emotion that focuses on negative self-evaluation and often leads to withdrawal (Brown, 2007, 2012; Tangney & Dearing, 2002; Lewis, 1971; Lopez, et al., 1997). As one would imagine, guilt and shame are linked to romantic, peer, and familial relational health (Brown, 2007; Black, 1999; Lancaster, 2011) and psychological distress, specifically trauma (Tangney and Dearing, 2002; Dyer et al., 2017; Robinaugh and McNally, 2010). In a study examining effects of shame in clinical and non-clinical populations, Dryer et al. (2017) found that shame was linked to clinical levels of depression and trauma. Further, those with a complex trauma history reported more frequent coping skills associated with shame (i.e. withdrawal). Hatton et al. (2008) discovered that negative family experiences were correlated with shame and higher levels of disconnection between adult romantic partners.

Relational-cultural theorists believe past relational connections, or lack thereof, impact expectations about how individuals should act, think, and feel, along with ways in which others may react to them, and may alter ways in which individuals form future relational connections with family, peers, and romantic partners (Jordan, 2010; Miller & Stiver, 1997). For example, individuals who have been in relationships with partners who are invalidating and not open to

discussing problems, may develop the belief that their interpretation of events and emotional responses are inaccurate and that they are not worth their current partner's time and effort (Jordan, 2010; Miller & Stiver, 1997). They may also believe their partner will not be willing to communicate with them about these things, whether they attempt to communicate with their partner or not. However, Relational-Cultural Theory (RCT) suggests if individuals are engaged in growth fostering (i.e. empowering, engaging, and authentic) relationships, individuals learn to approach disconnection and as a result can experience five positive impacts of healthy relationships: a sense of zest; an enhanced capacity to act or be productive; a better understanding of the self, other, and relationship; a sense of worth; and increased desire for connection (Miller & Stiver, 1997).

Family experiences and psychological distress, specifically trauma, have been linked to the development of these relationship expectations and, therefore, influence future relational health (Jordan, 2010; Miller & Stiver, 1997; Feeney, 1999; Frey, Tobin, & Beesley, 2004; Frey, Beesley, & Miller, 2006). While there is evidence that guilt and shame, family experiences, trauma, and relational health are linked, there is a gap in the literature examining whether relational health, trauma, and family experiences actually predict guilt and shame proneness. Therefore, the purpose of this study is to examine the links among these variables with the expectation that when family experiences and trauma are controlled, relational health will be a predictor of guilt and shame proneness. This information is important for mental health professionals who specialize in working with couples and families in order to help them understand the ways in which relational interactions influence guilt and shame

emotional responses and contribute to psychological distress. Because the differences between guilt and shame responses are vast and significantly influence psychological distress, it is important that mental health professionals are aware of variables that impact guilt and shame. With this understanding, it will be possible to better facilitate client prosocial shifts from psychologically distressing shame-prone emotions to guilt-prone emotions. A shift toward the prosocial emotions of guilt may be an important step in promoting client relational healing.

Guilt and Shame

In the fictional motion picture, *Harry Potter and the Order of the Phoenix* (Rowling, Goldenberg, & Yates, 2011), Sirius Black offered a piece of emotional advice to Harry. He said, "You're not a bad person. You're a very good person who bad things have happened to. Besides, the world isn't split into good people and Death Eaters. We've all got both light and dark inside us. What matters is the part we choose to act on." Events which ended negatively had recently taken place. These events were outside of Harry's control and as a result of the events Harry began to believe he was a bad person. Harry was struggling with shame. Harry seems to struggle with shame through the entire Harry Potter series. At this point, he was unable to control his shame and he started believing he was a bad person. This is consistent with Brown's (2012) scholarly work on shame; Brown noted that unless one can learn to cope with their shame and struggles, they will begin to believe they are bad and start acting on those beliefs.

Guilt and shame are two emotions that bring about emotional discomfort, as well as certain behavioral responses. They are similar in that they both trigger feelings of disturbance; however, they differ in the behavioral and relational responses that follow. Tangney and Dearing (2002) described guilt and shame as important emotions that effect people both individually and relationally, in that experiences of guilt and shame guide behaviors and influence the ways in which people view themselves in relation to others. While there are many similarities between the constructs, there are also important differences. Tangney and Dearing surveyed college undergraduates to determine their understanding of guilt and shame and found students experienced these as distinct emotions, but could not define them concretely and as a result, students used the terms interchangeably. When Tangney and Dearing reviewed the literature, they found many researchers used the constructs of guilt and shame interchangeably as well.

Lewis (1971) was one of the first researchers to determine there was, in fact, an empirical difference between the emotions of guilt and shame. According to Lewis, and supported by numerous guilt and shame researchers since (e.g. Lopez et al., 1997; Brown, 2007; Tangney & Dearing, 2002), guilt causes a focus on specific behavior, whereas shame focuses on the global self. Guilt is theorized to focus on one's undesirable behaviors in negative situations and allows the individual to take reparative actions, whereas shame focuses on one's undesirable personal characteristics in negative situations and often leads to the individual withdrawing or avoiding others (Cohen, Wolf, Panter, & Insko, 2011).

Lopez et al. (1997) associated guilt with behavioral transgressions that are inconsistent with what an individual would expect from themselves. The emotional

disturbance of guilt focuses one's discomfort around behaviors and is less self-punishing than shame. In contrast, according to Brown (2007), shame is a powerful emotion that creates within individuals the belief that they, as individuals, are flawed and unworthy. Jordan (2010) suggested shame extends beyond a sense of unworthiness and shares many characteristics of *condemned isolation* (p. 102), that is, a belief that one is beyond empathetic understanding and as a result cannot be fully in relationship. Guilt involves comparing actions against ethics, morals, and values, whereas shame focuses on identity and character (Brown, 2007). The differentiation between guilt and shame is important because shame can have significantly negative effects on individual and relational well-being.

Roos, Hodges, and Salmivalli (2014) echoed Tangney and Dearing (2002) in noting that guilt is aroused by internal and specific events that cause the individual to experience a desire to "fix" the situation by approaching others, which leads to experiencing guilt as an "interpersonal emotion that strengthens social bonds and attachments" (Roos, et al., 2014, p. 941). As Baumeister, Stillwell, and Heatherton (1994) suggested, guilt is a motivational tool to improve or preserve a relationship because guilt is based on a threat to relational closeness. It is suggested that this desire for relationship will cause individuals experiencing guilt to take prosocial action such as helping others in hopes of repairing that communion. Rangganadhan and Todorov (2010) reported that adults who had guilt-prone experiences exhibited approach motives to repair relational closeness that enhanced social behavior. Using a guilt/shame proneness measure as well as peer report, Roos et al. (2010) found that children

who felt guilt as opposed to shame were more likely to display adaptive, prosocial behaviors. Also, Lopez et al. (1997) found that individuals who were more prone to experience guilt were more likely to have stronger collaboration skills with intimate partners. These findings suggest guilt to be a prosocial emotion across the developmental life span that can be used to foster interpersonal relations.

On the other hand, individuals who were prone to experience shame were found to avoid conflict and be less likely to collaborate with their peers (Lopez et al., 1997). They have also been found to have more difficulty with cooperative problem solving and a higher level of hostility, if the individual does not avoid conflict altogether (Lopez et al., 1997). Experiences of shame frequently result in more internal threats to self, along with anger and aggression, when compared to experiences of guilt (Roos et al., 2014; Tangney & Dearing, 2002; Tangney, Wagner, Hill-Barlow, Marschall, & Gramzow, 1996). That is, individuals experiencing shame tend to experience internal self-blame and attack their own character, while simultaneously lashing out externally and blaming other individuals. Brown (2007) noted the biggest concern with these self-punishing thoughts is that the individual begins to also believe the negative thoughts they experience even when they are out of the shame state. Individuals who feel shame have more feelings of worthlessness and powerlessness, as well as concern with the evaluation of others (Akbağ &Îmamoğlu, 2010). They have been found to have a high need for approval and acceptance, and appear to avoid and withdraw from others when the approval and acceptance is not present, which results in increased isolation (Lagattuta & Thompson, 2007; Eisenberg, 2000; Ferguson, Stegge, & Damhuis, 1991; Rangganadhan & Todorov, 2010). Tagney and Dearing (2002) discovered shame-prone

individuals were also inclined to seething, bitterness, and resentful anger, as well as the tendency to blame others for negative events.

Interestingly, shame emotions have been reported to also increase aggressive behavior patterns in children (Roos et al., 2010). Using peer report, Roos et al. discovered children who frequently used aggression toward disliked peers due to shameful emotions tended to "dehumanize and attribute blame to their targets and, in turn, feel decreasingly guilty about aggressing toward them" (p.944). Overall, unlike guilt, shame appears to hinder individual and relational well-being across the life span.

Tangney and Dearing (2002), along with Brown (2007), emphasized that today's society is a *shame-phobic* one, as discussing shame causes individuals to become uncomfortable, defensive, or avoidant, even when the shameful event is in the past, and as a result it causes pain. The pain is aroused because individuals are able to perspective-take; that is, they too begin to feel the others' painful emotion of shame and remember their own shameful experiences (Brown, 2007). Because of the aversive internal reactions to shame, individuals fear and avoid discussing it. Hartling (2000) explained that individuals risk feelings of disempowerment, disgrace, and potential triggers for more shame when recollecting shameful experiences. However, feelings of comfort may also accompany the feelings of pain, stemming from the recognition that they are not the only one to experience shame.

As evidenced above, shame is a maladaptive emotion that can lead to personal and relational damage, whereas guilt is more prosocial and adaptive. It

is important for researchers to examine not just the effects of guilt and shame, but predictive factors in hopes of gaining a better understanding as to how to alter the negative effects of shameful experiences.

Shame and Traumatic Experiences

Through her qualitative research with all types of trauma survivors, Brown (2012) discovered one of the ways survivors begin to live happy and healthy lives is that they acknowledge there is a problem, seek professional help, work through shame and secrecy, and approach the reintegration of vulnerability as a daily practice. This finding suggests shame is a component of trauma; however, even following the traumatic experience and shameful emotions, individuals are capable of leading happy, wholehearted, and connected lives.

In the *Diagnostic Statistics Manual Fifth Edition* (DSM-5; American Psychiatric Association, 2013), two potential symptoms of Posttraumatic Stress Disorder (PTSD) in response to traumatic experiences are "Persistent exaggerated negative beliefs or expectations about oneself, others, or the world" and "Persistent negative emotional states (e.g., fear, horror, anger, guilt, or shame)." This suggests that guilt, shame, and the cognitive ideas they foster about the self and the world can be responses to the experience of trauma. This is supported by Dorahy et al. (2013) who found individuals with clinically significant levels of PTSD were more likely to experience both shame and guilt and have a coping style in which they denigrated themselves. When comparing shame in clinical and non-clinical populations around the world, Dyer et al. (2017) found support for the theory that shame and guilt were associated with clinically significant levels of depression, dissociative identity disorder, and trauma distress, and

there were no significant differences in shame levels across groups. The dissociative identity disorder, general mental health, and complex trauma groups reported significantly higher amounts of coping styles that are associated with shame, such as withdrawing and negative self-evaluations, when compared to a healthy population.

Further, when researching links between guilt, shame, trauma, and depression, Robinaugh and McNally (2010) found that when asked to describe a shame or guilt inducing memory, participants were most likely to describe a time in which they betrayed a loved one or when they inflicted harm on another individual. Both shame and guilt emotions that were experienced as a result of the memory were significantly correlated with depression and trauma symptoms. Specifically, shame was found to be a significant predictor of both depression and trauma related symptoms. When participants experienced low levels of shame, guilt was found to be negatively correlated with trauma symptoms, but guilt was positively correlated when shame levels were high. This suggests guilt may serve as an adaptive emotion at times. When individuals are prone to experiencing more guilt than shame, there may be a protective buffering factor against experiencing trauma symptoms as a result. However, when shame and guilt are both experienced at high levels, the combination of emotions may increase the likelihood that someone will experience depression and trauma related symptoms. This suggests shame may be the primary pathogenic factor (Robinaugh & McNally, 2010).

Undergraduate students who experienced higher amounts of negative self-evaluation (i.e. “I did a bad thing; therefore, I am bad.”) were more likely than those who did not experience negative self-evaluations to experience shame (Platt & Freyd,

2012). Further, undergraduates who received negative feedback experienced shame inducing emotions; however, those who were low in negative self-evaluations and without a trauma history experienced lower amounts of shame (Platt & Freyd, 2012). Also, students who were high in negative self-evaluations and without a trauma history experienced the average amount of shame, but those with high negative self-evaluations and a trauma history experienced substantially more amounts of shame after negative feedback than students in other groups (Platt & Freyd, 2012).

Platt (2014) found college students who had experienced high betrayal trauma (i.e., physical, sexual, and emotional abuse by someone with whom they had a close relationship) were more likely to experience increased shame and dissociation when asked to view images involving interpersonal threat. Those who were exposed to low betrayal trauma (i.e., physical, sexual, and emotional abuse by someone with whom they did *not* have a close relationship) experienced increased fear but not shame or dissociation. Additionally, chronic dissociation and hallucination symptoms of trauma were significantly related to increased shame emotions. When working with women who experienced interpersonal violence and abuse, Beck et al. (2013) discovered that high levels of shame were correlated with higher levels of negative thoughts about the self. According to Beck et al. (2013), this suggested that women who experienced trauma (i.e., interpersonal violence) had a tendency to experience shameful emotions and therefore developed negative cognitive schemas about the self. Similarly, Schoenleber, Sippel, Jakupcak, and Tull (2015), found that men who experienced interpersonal trauma at some point in their lives experienced shameful emotions, which were linked to aggression. Further, trauma severity was found to be a significant

predictor of powerlessness and self-blame, two residual effects of shame, for adolescent females who had experienced childhood sexual abuse (Makija, 2014). These results indicate that there is indeed a link between the experience of traumatic events and the emotional experience of shame.

This study hopes to lead to a better understanding of trauma and shame by determining whether trauma history is a predictor of guilt or shame proneness. As mentioned above, those with a trauma history tend to experience shame. It is possible the relationship between shame and trauma is a cyclical one in that one who experiences trauma tends to experience shame and then is more susceptible to effects caused by traumatic experiences and so forth. This information is important because knowing whether trauma is a predictor of the maladaptive experience of shame may allow individuals in helping professions intervene in the already difficult experiences of those with a trauma history.

Shame and Disconnection

Brown (2007) theorized that fear is the root of shame and suggested the relationship between fear and shame is a cyclical one in that shame produces fear and fear in turn produces more shame. Individuals experiencing shame fear what they think of themselves and what others think of them but, most importantly, they fear disconnection. Many theorists have emphasized that humans are biologically, emotionally, socially, and cognitively reliant on connecting with others (e.g. Brown, 2007; Miller & Stiver, 1997; Jordan, 2010; Maslow, 1943; Tannen 1990). Consistent with this conceptualization, Lee (1994) discovered that poor communication was correlated with high internalized shame in married couples. Likewise, Schibik (2002)

explored the association between shame and different relational features such as cohesion, adaptability, and communication. In his study with 278 males who were adjudicated for domestic violence, Schibik discovered that shame was significantly related to partner abuse and that cohesion, adaptability, and communication were significant deficits in those who experienced strong internal shame. Schibik also found shame to be negatively correlated with communication; as shame increased, communication decreased, suggesting that shame hindered communication. It is possible this relationship is also a cyclical one. For example, if one is not receiving empowering and empathetic responses from their partners, shame is likely to be induced and further communication reduced due to the negative messages shame is relaying.

Congruent with Brown's (2007) theory, Black (1999) theorized that underneath layers of shame is fear of abandonment; as a result of past abandonments, individuals fear how people will react to imperfections and shameful secrets. Miller and Stiver (1997) and Jordan (2010) refer to these patterns and expectations as *relational images* (i.e. templates created by past relational patterns that allow a sense of what to expect from relationships). Similarly, Tangney and Dearing (2002) report the majority of personal problems and relational disconnections stem from shame. Consistent with this theoretical assumption, Lancaster (2011), Brown, and Black found empirical evidence that connection and shame were significantly related. As shame increased, connection decreased, and vice versa.

Notably, connection is often stifled by withdrawal, a typical coping mechanism related to the experience of shame, leading to other problems (Tangney & Dearing, 2002; Brown, 2007; Black, Curran, & Dryer, 2013). For instance, Black, et al. (2013)

reported psychological and physical withdrawal as a result of shame predicted depression and low relational satisfaction. Their findings suggested individuals used disengagement (i.e., disconnection) to relieve immediate feelings of shame; however, withdrawal led to more dissatisfaction and disconnection in the long-term (Black et al., 2013).

It is theorized that the fear of disconnection stems from not being able to reach the expectations placed on individuals by others, particularly loved ones (Black, 1999; Tangney & Dearing, 2002; Brown, 2007). When one fails to live up to an expectation, shame may set in and fear of disconnection or abandonment soon follows. However, expectations are sometimes difficult for individuals to achieve because they may have unclear or false beliefs about what is expected of them and what will happen if they fail to live up to those expectations (Tangney & Dearing, 2002). Black's (1999) theory suggests individuals expect loved ones to abandon them when they find out about secrets and imperfections, and a lack of communication perpetuates these beliefs. In Brown's (2007) qualitative (i.e. grounded theory) study of women, it was found that shame was the most powerful when the women failed to fulfill real and imagined expectations placed by themselves or by a close companion or loved one.

Correspondingly, Elison and Partridge (2012), discovered that shame in college athletes was related to perfectionism and a fear of failure. McGregor and Elliot (2005) found those with a high fear of failure were more likely to experience high levels of shame as opposed to those with a low fear of failure.

Further, those who experienced a high fear of failure and greater amounts of shame were less likely to disclose failure experiences to their close family members. Chen, Hewitt, and Flett (2015) discovered associations between interpersonal perfection and feelings of shame that suggested failing to live up to the standard of perfection results in overwhelming shame. Brown (2012) noted, "When shame becomes a management style, engagement dies. When failure is not an option we can forget about learning, creativity, and innovation" (p. 15). According to Brown's (2007; 2012) theory, when one believes they must be and act a certain way, they are ignoring their authentic self and begin to feel disconnected from their sense of self. She suggested that those who strive for perfection have no option but to settle with imperfection, which leads to shame and fear, and ultimately to disconnection.

In qualitative interviews, Brown (2007) determined feelings of disconnection were equal to feeling "diminished, rejected, unworthy, and reduced" (p. 28) and suggested disconnection is both the cause and the result of shame. Disconnection and shame were reported to be expected parts of the relationship cycle, allowing a relationship to grow and develop if approached as opposed to avoided (Brown, 2007). When avoided, however, feelings of shame and disconnection can turn to feelings of isolation, which can be detrimental to an individual and their relationships (Brown, 2007; Miller & Stiver, 1997; Jordan, 2010). Miller and Stiver (1997), noted:

> We believe the most terrifying and destructive feeling that a person can experience is psychological isolation. This is not the same as being alone. It is a feeling that one is locked out of the possibility of human connection and of being powerless to change the situation. In the extreme, psychological isolation can lead to a sense of hopelessness and desperation. People will do almost anything to escape this combination of condemned isolation and powerlessness (p. 72).

Brown (2007) suggested there are two forms of disconnection that create concern: disconnection from others and disconnection from the self. She noted disconnection from others is what often leads to feelings of isolation, but disconnection from the self is perhaps more painful, as that leads to the loss of authenticity. Disconnection from the self may cause an individual to attempt to manage how they are viewed by others, which creates and perpetuates inauthentic relationships, and therefore, disconnection from others (Brown, 2007; Cohen et al., 2011). Black (1999) suggested that when an individual represses their feelings, as many do with shameful emotions, they become distracted from being their true self. When sacrificing authenticity in order to move away from shame, individuals often lose the genuine connection they are attempting to achieve (Brown, 2007; Miller & Stiver, 1997). Miller and Stiver (1997) hypothesized that because authenticity is a necessity for connection with others, when individuals lose the connection to self they likely lose the ability to make meaningful changes *and* the meaningful connections they so desperately desire.

Jordan (2010) defined authenticity as, "The capacity to bring one's real experience, feelings, and thoughts into relationship, with sensitivity and awareness to the possible impact on others of one's actions" (p. 101). Tangney and Dearing (2002) and Brown (2007) reported when individuals feel shame, they often feel imperfect, flawed, and unworthy of connection. Brown hypothesized when people feel this way, it is nearly impossible to be authentic in relationship. Findings from Lancaster (2011) and Black et al. (2013) support

Brown's hypothesis. Shameful emotions lead to disconnection from the authentic self and hinder connection with others.

Further supporting the importance of authenticity, Brown (2007) asked a large group of eighth graders to describe differences between fitting in and belonging. She discovered that the youth believed belonging does not require a change in our actions in order to fit in; however, it does require authenticity. Chen, Hewitt, and Flett (2015) discovered preoccupied attachment styles influenced the need to belong, which in turn influenced shame. Further, when the need for belongingness was not met for those with insecure/preoccupied attachments, the need to hide flaws and imperfections increased. This is consistent with the previously discussed theories of Brown, Cohen et al. (2011), and Miller and Stiver (1997) suggesting that a lack of meaningful connection results in decreasing authenticity.

Brown (2012) noted that when individuals stop engaging due to shame, they stop contributing to the relationship. Hartling (2000) suggested if one is striving for mutuality (i.e. a way of relating that ensures all involved are participating as fully as possible; Miller & Stiver, 1997) in a relationship, the individuals in the relationship must move away from degrading dynamics that perpetuate shame. She proposed shame does not and cannot promote mutuality in healthy relationships. However, Crothers (2000) found women and men experience relational mutuality differently. Men were split in the type of relationship (i.e. friendship or romantic) in which they experienced more mutuality; however, women reported more experiences of mutuality in friendships than romantic relationships. Women and men with higher mutuality in romantic relationships, though, were found to be more satisfied with their romantic relationships

than those who experienced higher friendship mutuality. Further, when one experienced more mutuality in friendships than romantic relationships, they experienced higher levels of depression, shame, silencing of the self, and relational dissatisfaction. According to Carothers, these negative effects were stronger in males than in females, suggesting that the high mutuality experienced in women's friendships buffers the negative effects of low mutuality in romantic relationships. Women and men who felt shame as a result of low mutuality were also less likely to seek counseling for shameful emotions (Carothers, 2000). While Carothers discovered low romantic mutuality to be predictive of significant depressive symptoms in men, Genero, Miller, Surrey, and Baldwin (1992) found low romantic mutuality to be a significant predictor of depression in women but not in men.

As shame and relational disconnection have been found to be highly correlated, a better understanding of relational health's impact is important. The evidence provided above suggests shame and disconnection go together; however, it is important to know whether healthy connection can serve as a protective factor against the negative effects of shame. This study hopes to determine whether authentic and engaging connections are not only associated with reduced shame, but predict the adaptive emotion of guilt.

Relational Cultural Theory, Relational Health, Family Experiences, and Trauma

Relational Cultural Theory (RCT) is a well-developed relational framework aimed at understanding relational health. It incorporates aspects of psychodynamic and feminist theories to emphasize the importance of human

connection and relationships throughout the lifespan. Relational-cultural theorists believe humans not only grow through connection with others, they grow "toward connection" (Jordan, 2010). Jordan (2010) explained humans need connection with others to flourish and they suffer when isolated. She described humans as inevitably interdependent throughout the lifespan. RCT holds that the healthy relationship is one in which each participant is authentic, mutually engaging, and mutually empowering (Jordan, 2010). These engaging, empowering, and authentic relationships are achieved through mutual empathy. RCT focuses on increasing healthy relational characteristics and decreasing chronic disconnection to reduce life and relational stressors and suffering.

Jordan (2010) proposed that "the need for connection in which growth is a priority is the core motivation in peoples' lives" (p. 25). Relational-cultural theorists believe it is when individuals are in growth fostering relationships that they are able to bring themselves into authentic connection (Jordan, 2010). Relational health results in increased engagement, authenticity, and empowerment. These relational qualities result in the five positive outcomes of a growth fostering relationship: a sense of zest; a better understanding of the self, other, and relationship; a sense of worth; an enhanced capacity to act or be productive; and an increased desire for more connection (Miller & Stiver, 1997).

These assumptions have received some empirical support. For instance, it was found that healthy peer and community relationships predicted decreased psychological stress in college women and healthy community relationships predicted decreased psychological stress in college men, even more so than attachment styles to parents,

year in school, and family experiences (Frey, Tobin, & Beesley, 2004; Frey, Beesley, & Miller, 2006). Supporting Frey et al. (2006), Mereish and Poteat (2015) discovered growth fostering relationships predicted health and overall well-being in an LGBT population. Among a sample of African American community members, Guyll, Cutrona, Burzette, and Russell (2010) discovered high quality relationships also predicted better health and psychosocial outcomes, even amongst individuals with highly hostile personalities. They suggested this finding was due to committed, warm, and supportive relationships, resulting in less frequent physical, psychological, and social stressors.

Attachment theorists report the goal of life is to develop healthy attachments to other individuals while also feeling stable in one's own independence and individuality (Bowlby, 1982). Relational-cultural theorists suggest connection with others replaces the autonomous self as a driving life goal (Miller & Stiver, 1997; Jordan, 2010). They describe high quality relationships as moving, dynamic processes (Miller & Stiver, 1997) and propose that enhancement of relationships is a more vital developmental goal than independence, with relationship enhancement leading to greater individual fulfillment (Miller & Stiver, 1997; Jordan, 2010). According to RCT, the majority of individuals are in relationships and the important part is whether or not the relationships are mutually beneficial (Miller & Stiver, 1997).

The above information suggests healthy relationships may decrease psychological distress, such as that caused by shame. The relational cultural framework

will be used in this study to determine whether empowering, engaging, and authentic relationships can predict guilt and shame proneness.

Relational Disconnection

Miller & Stiver (1997) define disconnection as, "the psychological experience of rupture that occurs whenever a child or adult is prevented from participating in a mutually empathetic and mutually empowering interaction" (p. 65). According to RCT, disconnection can be a normal part of relationships and occurs when a person feels misunderstood, invalidated, excluded, humiliated, or another aversive affective reaction in response to the other individual in the relationship (Jordan, 2010). Disconnections happen in all relationships and, when addressed, they may not be problematic and potentially lead to increased authenticity, empowerment, and engagement in both partners (Brown, 2007; Miller & Stiver, 1997; Jordan, 2010). If the injured individual is able to express their experience of the disconnection and is met by the partner with compassion, empathy, interest, and concern, the relationship strengthens because the places of empathetic failure are replaced with trust (Jordan, 2010). However, if the injured individual is unable to express their experience of the disconnection or they are consistently met by the partner with more negativity and hurt, they learn to stay inauthentic and bring less and less of their real experience into the relationship until eventually they lose touch with their own feelings and inner experiences (Jordan, 2010). This perpetuates the movement out of the growth-fostering relationship through less engagement, empowerment, and authenticity (Jordan, 2010). Individuals who have less power tend to believe they are to blame for the disconnection and their sense of isolation is only increased (Jordan, 2010). This is a shame prone reaction to

disconnection. That is, individuals begin to turn the blame in toward the true self, as opposed to evaluating the situation as a whole. This negative self-evaluation causes individuals to distance themselves and feel isolated, which pushes individuals further away from being authentic and engaging. Sometimes individuals use specific s*trategies of disconnection* (Miller & Stiver, 1997) to prevent themselves from harm, but ultimately push themselves further from connection. It is during this moment of disconnection, motivated by conflict between the desire for, yet fear of, connection that further disconnection occurs (Miller & Stiver, 1997).

Major disconnections also occur when relational partners are repeatedly unresponsive (Miller & Stiver, 1997). Often, these unresponsive incidences can happen multiple times in daily interaction. It is when these unresponsive incidents occur over an extended time and/or in conjunction with more destructive situations, such as abuse (i.e. verbal, physical, sexual), that chronic disconnection occurs. When disconnection persists over time, Miller and Stiver (1997) theorize it becomes difficult for individuals to validate their own feelings of distress because each incident may appear small or isolated, but when taken as a whole, they constitute a major disconnection. Having feelings that appear invalid can contribute to shameful emotions. It is possible that when individuals question their own affective responses to disconnection and ability to accurately read situations, they experience shame and become less authentic in their responses. This can further perpetuate the distance between the individual and a mutually engaging and empowering relationship.

RCT suggests relational disconnection is the route to much stress and psychological distress. Miller and Stiver (1997) suggest "when others cannot respond with some mutuality and some recognition of one's feeling-thoughts, one tends to take on the notion that all of the feelings and all of the difficulties must be one's own" (p. 69). This hypothesis is consistent with the way shame causes individuals to isolate themselves in their thoughts and feelings. It causes them to believe the problem is within the self as opposed to a consequence of the external situation.

When there is chronic disconnection, there are long-term consequences. Individuals can attempt to reconnect with others but, when met with disengagement and disempowerment, it generally causes more disconnection. Because humans desire connection, individuals change who they are and how they present themselves in an attempt to portray themselves in an image that will please others (Miller & Stiver, 1997). This change is made because, as previously noted, shameful emotions cause the individual to believe the problem is within themselves. As a result, in attempting to change their image, individuals often lose their authentic selves (Miller & Stiver, 1997).

When disconnection from significant relational figures and models happens at a young age, shameful emotions and the disconnection from the self can become long-lasting. Children come to believe they must feel and act certain ways at all times in order to have a connection with other people (Miller & Stiver, 1997). When they encounter situations that invoke thoughts and emotions they perceived as being disrespectful, rude, or wrong in previous relational interactions, they undergo significant distress. Instead of the experience of new feelings, adventures, and relationships leading to zest, understanding, worth, productivity, and connection,

individuals begin to feel threatened (Miller & Stiver, 1997). This threatening, disempowering feeling perpetuates an individual's likelihood of acting in ways they believe others want them to interact, as opposed to interacting authentically (Miller & Stiver, 1997). It also leaves them unable to authentically communicate shame they experienced as a result of previous interactions.

Relational-cultural theorists believe humans develop relationships throughout the lifespan that shape a person's life through the disconnections and resultant relational expectations people hold. Jordan (2010) noted that although these expectations may, or may not, be conscious, they influence feelings and behavior. Previously, theories about relationship expectations and shame by Black (1999), Tangney & Dearing (2002), and Brown (2007, 2012) were discussed. Relational-cultural theory refers to these expectations as relational images. Miller and Stiver (1997) suggested relational images are "images that portray the patterns of their relational experience. These images also embody what each person expects will happen in future relationships as they unfold" (p. 40). Relational images are templates created by what has happened in the past and become a framework for developing a sense of self, what one is capable of, and how worthy one is (Miller & Stiver, 1997). Depending on previous interactions, shame may play a role in whether a relational image results in someone putting their authentic self on display. Further, relational images generalize from past relationships to present ones and are carried throughout the lifespan, although they can be changed.

The *Central Relational Paradox,* described by Miller and Stiver (1997), explains that although we desperately desire connection with others, the fear of what will happen if we allow ourselves to be vulnerable can prevent us from sharing authentic parts of

our lives. This fear of vulnerability is generally developed as a result of negative relational images created by disconnecting, disempowering, disengaging, and inauthentic interactions. As a result, individuals create *strategies of disconnection* (i.e. methods of preserving connection that ultimately lead to disconnection) to protect the vulnerable and authentic self and avoid isolation (Miller & Stiver, 1997). However, strategies of disconnection further contribute to isolation because despite the yearning for connection, protective strategies prevent one from taking the risk of being authentic, which in turn decreases empowerment and engagement (Jordan, 2010).

People also develop relational images that explain *why* relationships are the way they are and, often, these images are shame inducing. These relational images have been created by previous relationships or societal interactions and can cause the individual to misattribute blame for isolation to themselves. For instance, Mereish and Poteat (2015) discovered growth fostering relationships between sexual minorities predicted lowered psychological distress and increased health in general; however, they discovered this predictive association did not exist between sexual minorities with high internalized homophobia and heterosexual individuals despite the quality of the relationships. The authors suggested the findings may be caused by the "self-disparaging relational images" (p. 343) of the sexual minorities with high internalized homophobia, which inform the individual they should be cautious and expect harmful disconnects from their heterosexual friendships. It is likely these relational images have developed due to disempowering, disengaging, and inauthentic relationships with other heterosexual individuals and the societal marginalization of sexual minorities.

Negative self-evaluations often lead to inauthenticity and isolation, as individuals withdraw to prevent others from seeing their flaws and in an attempt to protect themselves from emotional harm (Jordan, 2010; Mereish & Poteat, 2015). As an individual withdraws from the relationship, so does their engagement. In the midst of the shame inducing state, the relational image also influences the individual regarding what to do about their experience of disconnection. If an individual's relational image supports the expectation that they can approach others in a warm, prosocial manner and receive the same engagement, empowerment, and authenticity in return, they may be less likely to experience shame inducing isolation. This is precisely what this study is attempting to examine, that is, whether healthy relationships with others, despite trauma and aversive family relationships, predict healthier self-conscious emotions, such as guilt as opposed to shame.

Relational Health

RCT proposes healthy interactions emerge from "power with" or "power emerging from," as opposed to "power over" (i.e. dominant) interactions of traditional models (Surrey, 1991). The RCT model suggests power, or the ability to act, is abundantly available through authentic and engaging interactions, suggesting both partners have power or the capacity to act when the relationship is mutually empowering, engaging, and authentic. In other words, power is not limited to one partner. Both partners may feel more powerful when engaged and empowered through growth-fostering relationships comprised of the five good things: zest; the capacity to act; increased understanding of the self, other, and relationship; a sense of worth; and an increased desire for more connection (Miller & Stiver, 1997).

Zest is described as an energizing feeling that accompanies feelings of connection (Miller & Stiver, 1997). It is important to note that feelings of zest or vitality and energy do not negate or diminish difficult emotions (i.e., sadness, fear, guilt) experienced by individuals; however, it does increase the connection with others and the feelings that arise out of the experience of feeling connected. Zest leads to the capacity to act.

When feelings of zest are increased through connection, individuals feel empowered to "act in the moment of the immediate exchange (Miller & Stiver, 1997, p. 31)," meaning individuals impact each other and work together to create change in the relationship through immediate experiences. Miller and Stiver (1997) suggested it is only through interacting that we are able to affect each other. It is theorized that once someone has felt empowerment through interactions, they are able to act in the world beyond that single connection (Miller & Stiver, 1997). Individuals who are unable to make empowering connections may struggle to have a broader impact in the world. It is possible their relational images convey that being authentic, engaging, and empowering in interactions with others is potentially dangerous.

Through authentic and empathetic interactions, individuals develop a better understanding of emotions and thoughts within the self and others. They become more knowledgeable about themselves, those with whom they were interacting, and the relationship itself (Miller & Stiver, 1997). However, this process is difficult for individuals who experience perpetual disconnection and shameful emotions. Shame leads to inauthenticity because of the negative thoughts and skewed beliefs the individuals develop about themselves.

When interactions with others shape relational images in a positive manner, participants' sense of worth increases. Through authentic, empowering, and engaging interactions with others, individuals receive messages that they are "worthy of another person's recognition and attention in the experiencing of these feelings and thoughts" (Miller & Stiver, 1997, p. 32). Brown (2007) suggested individuals who experience disengaging, disempowering, and inauthentic connection are likely to develop shame emotions, which in turn increase the belief they are not worth empathy and positive interaction.

As a result of feeling more zest, empowerment, knowledge, and worth in connection, individuals often experience a wish for more connection (Miller & Stiver, 1997). Individuals having this response value the other person in a way that leads to a deeper desire for connection.

The five good things are mutually received by both partners in connection. Regardless of one's own feelings, it feels good to respond to others' feelings with feelings of one's own (Miller & Stiver, 1997). This pleasure in connection is not dependent on the positivity of the emotions; however, it is dependent on experiencing those feelings *with* another individual.

Family Experiences

Hatton et al. (2008) found family experiences and personal characteristics were correlated and both were associated with adult relational health and disconnection. Further, negative emotionality regarding family experiences was correlated with negative self-evaluations (i.e. shame) and both uniquely contributed to disconnection in interpersonal relationships as adults. Therefore, it seems that authentic, engaging,

empowering familial relationships influence the development of personal characteristics and beliefs about the self that affect other interpersonal relationships in positive ways.

It is important to remember that it is harder to attempt to repair disconnections in relationships in which one person holds more power than the other, such as parent-child relationships. It is important for children to feel safe and believe their parents are able to hear and respond to their concerns and experiences (Miller & Stiver, 1997). There is some question about whether children can change negative relational images they developed at an early age through negative and/or traumatic relationships with their parents. Miller & Stiver (1997) theorized that negative relational images can become static and difficult to alter if there are not others who can engage the individual in mutually engaging, mutually empowering, and authentic interactions. Congruent with this assumption, Feeney's (1999) qualitative study with university students discovered positive family relationships increased positive relationship behaviors (i.e., demonstrating caring, reliability, sensitivity) and effective interpersonal communication, whereas negative family relationships did the opposite. Participants described their romantic partners who had positive family relationships as empowering and engaging. Further, those whose partners experienced negative family relationships reported more disengagement, inauthenticity, and disconnection resulting in their partners isolating themselves. Participants who experienced negative family experiences themselves described specific strategies of disconnection (i.e., attention seeking, refusing to express emotion, withdrawal) in which they engaged in an attempt to experience a connection with their partner; however, because of their inauthentic and disengaged behavior, they found themselves more isolated. Interestingly, those whose

partners reportedly confronted their inauthenticity and disconnection in empowering and engaging ways learned to become more authentic and reported having a better quality relationship. This suggests that negative family experiences may be overcome through later relationships that are high in relational quality (Frey et al., 2004; Frey et al., 2006).

Donnelan, Larsen-Rife, and Caonger (2005) determined nurturant-involved parenting (i.e., engaged and empowering parenting) during adolescence was positively correlated with early adult romantic relationship quality and negatively correlated with disconnection between romantic partners. However, when they controlled for prior influence of romantic relationship quality, negative interaction between partners, and parenting styles, positive emotionality was determined to be a stronger predictor of early adult romantic relationship quality. Thus, although engaging and empowering family experiences are related to romantic relationship health, there seem to be stronger predictors than family experiences alone.

Aversive family experiences are linked to poor psychological health, not just poor relational health. For instance, Katz and Nelson (2007) found past family unfairness and family stress were predictors of self-criticism in undergraduate students, with students more likely to criticize themselves based on their own high expectations and when comparing themselves to others. It is possible students with internalized, comparative self-criticism developed these expectations through relational images created by early familial interactions that were disengaging, disempowering, and inauthentic. Frey et al. (2004) discovered peer and community relational quality predicted less psychological distress even in those whose family experiences resulted in

distress. This suggests that, although negative family experiences can create psychological distress, authentic, empowering, and engaging relationships with peers and one's community may be beneficial in buffering or even overcoming psychological stress. Further, Frey et al. (2006) discovered that college students with insecure attachments to their parents were more likely to experience psychological distress; however, peer and community relationships that were empowering, authentic, and engaging, were positively influential at buffering this distress despite problematic parental attachment. This provides further support for the idea that engaging, authentic, and empowering relationships can protect against the negative effects of chronic disconnection and damaging relationships. It provides evidence that relational images may not be static and can change and develop over time and through multiple interactions, as posited by relational cultural theory.

Trauma and Relationships

There are conflicting research findings about trauma's influence on relational health. It is possible that trauma affects beliefs about the self and one's cognitive schemas, which in turn, can influence relational health. Busby, Walker, and Holman (2011), examined perceptions of the self and partner's personalities with couples in which one partner experienced childhood physical abuse, both partners experienced childhood physical abuse, or no partners experienced childhood physical abuse. They found couples where at least one partner experienced childhood abuse were more likely than those who had not experienced abuse to have negative views about themselves and their partners, even when relational health was held constant. Those who experienced abuse were more likely to describe themselves and their partners as neurotic and

conflictual, although the partner who was not abused did not describe themselves in this way. Further, neither emotional support or negative interaction from the participant's partner mediated the effects of trauma on psychological distress, although both relational variables influenced general psychological distress (i.e. Cox, Buhr, Owen, & Davidson, 2016). This suggests that, although relational quality and disconnection influence perceptions of the self and partners, they may not influence the effects of trauma specifically.

In contrast, however, other researchers have discovered trauma does affect relational health and disconnection. For example, Makhija (2014) examined a number of outcomes for adolescent females who experienced childhood sexual abuse and found perceived family support (i.e., family members who provide relationships allowing the individual to feel loved and valued) predicted experiences of betrayal, suggesting those with higher perceived family support experienced less feelings of betrayal by their loved ones. Further, those with high perceived family support reported less unhealthy attitudes (e.g., acceptance of physical, sexual, psychological, or emotional aggressions) toward romantic relationships. Individuals who experienced high betrayal trauma (i.e., abuse by someone trusted, close, or depended upon) have also been found to be more prone to shameful emotions compared to those who were abused by a stranger (Platt & Freyd, 2015). Godbout et al., (2017) reported French-Canadian children who had high exposure to family violence experienced higher levels of attachment insecurity, higher risk of perpetrating violence in relationships, and poorer relationship satisfaction as adolescents and emerging adults. Therefore, when individuals are betrayed by, or

significantly disconnected from, someone they trust, they may internalize the event and as a result experience negative thoughts (e.g. shame) and poorer relational health.

In a qualitative study with Canadian military members who had been deployed, received treatment for trauma, and were in recovery for at least two years, Ray and Vanstone (2009) discovered themes regarding the impact of family relationships on healing from trauma. One theme was emotional numbing and anger that affected the relationship in a negative manner, in which both the veteran and family members engaged in withdraw and retreat behaviors (e.g. avoiding social situation, avoiding emotional connection and attachment, physically separating themselves from the family). As previously noted, withdrawal behaviors are commonly associated with shame. Another theme was that emotional withdrawal negatively impacted healing from trauma. This suggests trauma negatively affects engaging and empowering relationships by closing one off from emotional communication and understanding. If communication is closed, one becomes isolated and unable to act within relationships.

Purpose and Hypotheses

The purpose of this study is to explore predictive relationships among relational health, family relationships, trauma, and guilt/shame proneness. Because trauma and family experiences have been linked to guilt, shame, and relational health, they will be used as control variables in order to determine whether relational health is a significant predictor of guilt and shame proneness beyond demographic information, family experiences, and trauma history. Hypotheses include:

1. Relational health, trauma history, and family experiences, as a set of variables, will significantly predict guilt and shame.

2. Relational health, trauma history, and family experiences will individually and significantly predict guilt and shame.
3. Relational health will be a significant predictor of guilt and shame beyond variance accounted for by trauma history and family experiences.
    a. Higher relational health will predict increased guilt as opposed to shame.
    b. Lower relational health will predict increased shame as opposed to guilt.

Method

Participants

Participants were recruited via posts on social media (Facebook and Reddit), snowball sampling, and an online data collection website (Amazon Mechanical Turk) where participants were paid $0.75 for their time. Participation eligibility included individuals who were over the age of 18-years-old.

Originally 341 people began the survey; however, only 237 individuals completed the survey and demographic information. One hundred of the 237 participants were recruited using Amazon Mechanical Turk. One hundred forty (60.1%) participants identified as female, 89 (38.2%) participants identified as male, four (1.7%) identified as nonbinary gender. The mean age of participants was 36 (*SD* = 11.55, range = 18 – 65). One hundred forty-seven (62.8%) of participants identified as European American or White, 42 (17.9%) participants identified as Asian American, 10 (4.3%) participants identified as Bi-Racial, 10 (4.3%) participants identified as Native American or Alaskan Native, 4 (1.7%) participants identified as African American, 5 (2.1%) participants identified as Hispanic or Latino, and 16 (6.8%) participants identified as another race or ethnicity (e.g. Middle Eastern). Regarding sexual identity,

202 (86.3%) individuals identified as heterosexual, 16 (6.8%) individuals identified as bisexual, 4 (1.7%) identified as lesbian or gay, and 12 (5.1%) individuals identified as another sexual identity. In terms of education, 97 (41.5%) participants reported having a bachelor's degree, 68 (29.1%) participants reported having a graduate degree, 41 (17.5%) reported having a general education development (GED) or high school diploma, 19 (8.1%) individuals reported having an associate's degree, 5 (2.1%) participants reporting having graduated from trade school, and 4 (1.7%) reported not having a high school diploma or GED. Annual income was reported to be less than $32,500 for 76 (32.5%) of participants, between $32,500 and $60,000 for 63 (26.9%) participants, between $60,000 and $100,000 for 58 (24.8%) participants, between $100,000 and $150,000 for 30 (12.8%) participants, and $200,000 or above for 7 (3%) participants. In terms of their childhood living arrangements, 216 (92.7%) participants reported living with their biological parents, 4 (1.7%) participants reported living in foster care, 4 (1.7%) participants reported living with non-biologically related adoptive parents, and 9 (3.9%) participants reported having other living arrangements. Participants reported that most of their lives, 171 (73.1%) participants reported their parents were married, 33 (14.1%) participants reported their parents were divorced, 16 (6.8%) reported their parents were never married, 5 (2.1%) participants reported their parents were separated, 5 (2.1%) reported their parents were widowed, and 4 (1.7%) participants reported their parents had other relational arrangements that were not specified. Thirty-one (13%) participants reported being an only child, 87 (36.7%) participants had only one sibling, 55 (23.2%) participants had two siblings, 30 (12.7%) had three siblings, 17 (7.2%) participants had four siblings, 6 (2.5%) participants had

five siblings, 10 (4.2%) participants had more than six siblings. One hundred nineteen (53.1%) participants spent the majority of their childhood living in the South, 46 (20.5%) participants spent the majority of their childhood living in the West, 35 (15.6%) in the Midwest, and 24 (10.7%) spent the majority of their childhood living in the Northeast (see the picture in the survey, Appendix A, for the map used to clarify).

Measures

Demographic questionnaire. Participants completed a survey consisting of personal information such as age, gender, sexual orientation, socio-economic status, geographic location, number of siblings, and so on. Information was also gathered about relationship with parents (i.e., biological/adoptive/guardianship), marital status, custody arrangements, and living arrangements.

Test of Self-Conscious Affect-3 **(TOSCA-3; Tangney & Dearing, 2002).** The TOSCA-3 uses situations people are likely to face in everyday life and common reactions to those situations to determine guilt and shame proneness of participants. The reactions provided "capture the affective, cognitive, and behavioral features associated with shame and guilt" (Tangney & Dearing, 2002, p. 39). Tangney and Dearing (2002) reported an advantage to using scenario based surveys to measure guilt and shame is that they elicit less defensive responses.

The TOSCA-3 is composed of 11 negative situations and five positive situations. These situations yield six different indices: Shame-Proneness, Guilt-Proneness, Externalization, Detachment/Unconcern, Alpha Pride, and Beta Pride. For the purposes of this study, only the responses for the Shame-Proneness and Guilt Proneness indices were used. Participants respond by using a Likert response format

from 1 (*not likely*) to 5 (*likely*). They were asked to respond to each reaction to each situation; that is, they responded to both Guilt-Proneness (16 items) and Shame-Proneness (16 items) reactions for each situation. The range of responses for each scale is 16 to 80.

The Shame-Proneness subscale measures reactions that include negative emotion, negative-self-evaluation, and withdrawal behaviors. An example item is, "You make plans to meet a friend for lunch. At 5'oclock, you realize you stood your friend up." The shame response to this scenario is "You would think: 'I'm inconsiderate.'" The guilt response to this scenario is "You'd think you should make it up to your friend as soon as possible." Tangney and Dearing (2002) determined Cronbach's alphas to be .88 and .83 for the Shame-Proneness and Guilt-Proneness scales, respectively, when used with students from a large public university. The TOSCA-3 has been demonstrated to have convergent validity with the Self-Conscious Affect and Attribution Inventory, another scenario-based measure; concurrent validity with the Beck Depression Inventory and Symptom Checklist – 90; and test-retest reliabilities of .85 and .74 for the Shame-Proneness and Guilt-Proneness scales respectively (Tangney and Dearing, 2002). Cronbach's alphas for this study were .86 for Shame and .83 for Guilt.

***Relational Health Indices* (RHI; Liang, Tracy, Taylor, & Williams, 2002).** The RHI is a 37-item self-report scale that was developed from relational-cultural theoretical assumptions and measures grow-fostering qualities of engagement ("perceived mutual involvement, commitment, and attunement to the relationship," Liang et al., 2002, p. 26); empowerment ("the experience of feeling personally

strengthened, encouraged, and inspired to take action," Liang et al., 2002, p. 26); and authenticity ("the process of acquiring knowledge of the self and the other and feeling free to be genuine in the context of the relationship," Liang et al., 2002, p. 26). The RHI assesses these qualities across peer (12 items), mentor (11 items), and community (14 items) subscale domains. Participants respond using a 5-point Likert response format from 1 (*Never*) to 5 (*Always*) with a possible range of 12 to 60 for the peer scale, 11 to 55 for the mentor scale, and 14 to 70 for the community scale. Higher scores suggest higher relational health (i.e., greater relational engagement, empowerment, and authenticity). An initial study with 450 female undergraduate students yielded Cronbach's alphas between .85 and .90 for the peer, mentor, and community subscales (Liang et al., 2002). The RHI has been demonstrated to have convergent validity with related instruments such as the Quality of Relationships Questionnaire and the Mutual Psychological Development Questionnaire, as well as concurrent validity with Rosenberg's Self-Esteem Scale, University of California Los Angeles Loneliness Scale, the Center for Epidemiological Studies Depression Scale, and the Perceived Stress Scale (Liang et al., 2002). Further, loneliness was most strongly negatively correlated to each of the RHI subscales, but less so with the subscales on the mentor scale. Self-esteem was found to be weakly related to peer and community relational health. Depression and perceived stress were moderately negatively related to community relational health.

In a study determining the validity of the RHI in a mixed-gender sample of college students seeking services from a university counseling center, Frey, Beesley, and Newman (2005) found Cronbach's alphas to be .90, .91, and .86 for the peer,

mentor, and community scales, respectively. They determined the dimensions for all three scales remained stable for women and men. A unidimensional structure was found for the peer and mentor scales; however, the community scale was determined to have a two-component structure, connection with community and alienation from community. This suggests "the RHI may be most appropriately used as a measure of overall quality of relationships within specific relational domains" (Frey, et al., 2005, p. 161). For the purposes of this study, only the peer and community subscales will be used. Cronbach's alpha for the peer scale was .91 and for the community scale was .87.

An example item on the peer scale is "Even when I have difficult things to share, I can be honest and real with my friend." Finally, an example of an item on the community scale is "I feel a sense of belonging to this community."

***The Family Experiences Questionnaire* (FEQ; Draper et al., 2002).** The FEQ is an 18-item questionnaire used to measure troubling or concerning family experiences that may have an impact on psychological distress. For the purposes of this study the FEQ will be used as a control variable, as family experiences have been demonstrated to influence guilt and shame proneness, as well as relational health. Participants respond to different family experiences, such as "parents frequently moved", "frequent hostile arguing among family members", "family member attempted suicide." Frey et al. (2004) used the original 3-point Likert scale (1 = *no*, 2 = *unsure*, 3 = *yes*) with a Cronbach's alpha of .70 (women) and .72 (men). In this study, due to ambiguity of the *unsure* response, it was decided to limit responses to *yes* or *no*. "Yes" items were scored as a 2 and then summed. The range is from 12 to 36 and higher scores suggest more negative family experiences. The Kuder-Richardson 20 (KR20) for this study was .81.

***Relative Trauma Exposure Section of the Detailed Assessment of Posttraumatic Stress* (DAPS-RTE; Briere, 2001).** The overall DAPS consists of 105 questions that provide the researcher with information about the participants' histories with trauma as well as their responses to the trauma(s), symptoms, and level of impairment. The DAPS is broken into five different components: reliability scales, trauma specification exposure, immediate trauma impacts, posttraumatic responses, and supplementary scales.

For the purposes of this study, only the 12 relative trauma exposure items will be used as a control variable to determine traumatic events the participant has been exposed to throughout life. The DAPS-RTE items include accidents, natural disasters, rape, physical assaults, and other items where the individual was injured or feared injury or death. Participants respond to these items by answering "Yes" or "No" to questions about potential traumatic experiences throughout their lifetime. "Yes" responses are given a score of 2 and added. The range is from 12 to 24 with higher scores suggesting more traumatic experiences. Example items include: "Someone threatening to injure you or do something sexual to you against your will, although they didn't actually do anything to you, when you were afraid you would be hurt or killed?"; and "Being in a war, when you were seriously hurt or were afraid you would be hurt or killed?". The KR20 for this study was .82.

Procedures

After obtaining approval from the university Institutional Review Board, a link to the survey (see appendix A) was posted on the researcher's social media pages and Amazon Mechanical Turk. To reach participants with a range of backgrounds and

geographical locations, participants who found the survey via social media were asked to share the survey with others who might be interested (i.e. snow ball sampling). Those who completed the survey on the Amazon Mechanical Turk website received $0.75 upon the completion of the survey. Due to limited funds (the researcher used her own money), only 100 people could complete the survey on Amazon Mechanical Turk. When participants followed the link to the survey, they were presented with the option to give consent or decline participation. There were not any direct benefits or incentives to participants who completed the survey via social media.

The survey was placed online using the Qualtrics software. The TOSCA-3 was presented first for all participants; the presentation order of the RHI, FEQ, and DAPS-RTE was randomized; and the demographics were presented last for all participants. The data was stored on the Center for Educational Development and Research (CEDaR) secure server. The anonymous survey took participants an average of 20 minutes to complete. Upon completion, participants were provided with information for counseling resources in the unlikely event that difficult emotions arose as a result of taking the survey. No identifying information was recorded.

Data Analysis

Four hierarchical multiple regressions models were developed to determine whether the predictor variables of relational health, traumatic history, and family experiences had relationships with (a) guilt and (b) shame proneness. Two models were developed with guilt as the outcome variable. The first model included Shame at the first step in order to control for shared variance with guilt. Age was entered at the second step since it was determined to be the only significant demographic variable

related to guilt. At the next step, the results from the DAPS-RTE and the FEQ were entered to control for experiences of trauma and family experiences; as previously mentioned, trauma and family experiences are known to influence relational health, as well as guilt and shame proneness. Finally, the RHI peer (RHI-P) and RHI community (RHI-C) subscales were entered as a block because they were hypothesized to be significant individual predictors of guilt and shame proneness after accounting for the variance explained by trauma history and family experiences. The second model for guilt included the same predictors except with the omission of shame. Two models were developed for shame. The first model included guilt at the first step to control for shared variance with shame. The DAPS-RTE and FEQ were entered at the second step and the RHI-P and RHI-C were entered at the third step. The second model for shame included the same predictors with the omission of guilt at the first step.

Results

Four hierarchical multiple regressions were used to determine the predictive relationships between relational health, family experiences, trauma history, and guilt/shame proneness. In preliminary analyses (i.e., bivariate correlations, t-tests, ANOVAS), relationships between demographic variables and criterion variables (i.e., shame proneness, guilt proneness) were explored, but all were determined to be nonsignificant, except for a significant bivariate correlation between age and guilt proneness. All assumptions of the multiple regression were met (i.e. no multicollinearity, no significant outliers, normality, sample size). Bivariate correlation analyses determined the guilt scale was significantly correlated with shame, RHI-P, and the FEQ. Shame was significantly correlated with the FEQ and DAPS-RTE. The means,

standard deviations, and intercorrelations for all variables included in the regression models are included in Table 1.

Hierarchical Multiple Regression 1: Shame

As shown in Table 2, the R^2 value explained by the full Shame multiple regression without controlling for guilt was .09, adjusted R^2 = .08, $F(2, 232) = 5.55$, $p \leq .01$, which is a small effect size (Cohen, 1988). At the first step, the block of DAPS-RTE and FEQ accounted for a significant 5% of the variance. The block of RHI-P and RHI-C explained an additional significant 4.3% of the variance at the second step. The RHI-C and the DAPS-RTE were significant individual predictors at the final step (RHI-C = $p \leq .05$; DAPS-RTE = $p \leq .01$), with the DAPS-RTE making the largest contribution. The FEQ and RHI-P did not make significant individual contributions. In summary, higher levels of shame were predicted by higher levels of trauma exposure and lower levels of community relational health.

Hierarchical Multiple Regression 2: Shame Controlling for Guilt

As shown in Table 3, the R^2 value explained by the full Shame multiple regression when controlling for guilt was .26, adjusted R^2 = .24, $F(2, 231) = 11.29$, $p \leq .00$, which is a medium effect size (Cohen, 1988). At the first step, guilt accounted for a significant16% of the variance. At the second step, the block of DAPS-RTE and FEQ explained an additional significant 2.6% of the variance. The third block of RHI-P and RHI-C explained an additional significant 7.2% of the variance at the third step. Guilt, DAPS-RTE, RHI-C, and RHI-P were significant individual predictors at the final step (DAPS-RTE = $p \leq .05$; Guilt, RHI-P, and RHI-C = $p \leq .01$). Guilt was the strongest individual predictor, followed by the DAPS-RTE and the RHI-C and RHI-P. The

DAPS-RTE, RHI-C, and RHI-P individually contributed relatively similar amounts to the model. In summary, higher levels of shame were predicted by higher levels of guilt and trauma exposure, and lower levels of community and peer relational health.

Hierarchical Multiple Regression 3: Guilt

As shown in Table 4, the R^2 value explained by the full Guilt multiple regression when not controlling for shame was .14, adjusted R^2 = .12, $F(2, 227) = 8.90$, $p \leq .00$, which is a medium effect size (Cohen, 1988). At the first step, age accounted for a significant 3.5% of the variance. The second block of DAPS-RTE and FEQ explained an additional significant 3.3% of the variance. The final block of RHI-P and RHI-C explained an additional significant 6.8% of the variance at the third step. Age, FEQ, and RHI-P were determined to be significant individual predictors at this step (age and FEQ = $p \leq .05$; RHI-P = $p \leq .001$). The strongest individual predictor was RHI-P followed by the FEQ and age respectively. In summary, higher levels of guilt were predicted by increased age, higher negative family experiences and better peer relational health.

Hierarchical Multiple Regression 4: Guilt controlling for Shame

As shown in Table 5, the R^2 value explained by the full Guilt multiple regression when controlling for Shame was .34, adjusted R^2 = .32, $F(2, 226) = 16.65$, $p \leq .001$, which is a large effect size (Cohen, 1988). At the first step, shame accounted for a significant 17.2% of the variance. At the second stage, age accounted for an additional significant 5.6% of the variance. The third block of DAPS-RTE and FEQ explained an additional non-significant 1.3% of the variance. The final block of RHI-P and RHI-C explained an additional significant 9.7% of the variance. Shame, age, FEQ, and RHI-P

were determined to be significant individual predictors at this step (FEQ = $p \leq .05$; shame, age, and RHI-P = $p \leq .001$). Shame was the strongest individual predictor, followed by RHI-P, age, and the FEQ respectively. In summary, higher levels of guilt were predicted by higher levels of shame, increased age, higher negative family experiences as evidenced by the FEQ, and better peer relational health as evidenced by the RHI-P.

Discussion

The current study explored whether trauma history, negative family experiences, peer relational health, and community relational health predict guilt and shame proneness. As stated in the first hypothesis, the full set of variables were significantly predictive for all four regression models. There was partial support for the second and third hypotheses.

Overall, as seen in the shame and guilt regression models, both guilt and shame were significant positive individual predictors of the other. Thus, the results from this study support claims that guilt and shame are linked (Tangney & Dearing, 2002; Brown, 2012). As guilt increased, shame increased in both models. This is not surprising as guilt and shame are both moral emotions that guide behavior (Tangney & Dearing, 2002). In fact, Tangney and Dearing (2002) reported guilt and shame are distinct emotions, but can be felt at the same time. It is possible that guilt and shame are linked because they both focus on unwanted behaviors and/or emotions. Supporting this study's findings, Tangney and Dearing, Robinaugh and McNally (2010) found that both guilt and shame predicted symptoms of depression and PTSD; however, when researchers controlled for the effects of shame, guilt was no longer a significant

predictor. Further, when high levels of shame were activated, high levels of guilt were also found. Thus, while guilt and shame may be overlapping experiences, shame seems to be unique in contributing to more enduring psychological symptoms; that is, it is the latter that leads to negative self-esteem and overall psychological distress. These negative effects of shame could be especially prominent if an individual does not have protective buffering factors in place, such as healthy relationships, to insulate one from focusing on shameful, immobilizing personal characteristics. Because of the significant overlap between guilt and shame found in this study, the models controlling for each will be the focus of interpretation.

Predictors of Shame

Results of the first regression model predicting shame show that trauma history, community relational health, and peer relational health were determined to be significant individual predictors of shame after controlling for guilt. These predictors contributed about equal amounts to shame proneness.

Community and peer relational health were found to significantly predict lower levels of shame proneness when community and peer relationships were rated as healthier. This suggests healthy relationships in the community and with peers can serve as a protective buffering factor for maladaptive emotions such as shame. This finding lends support for the importance of a supportive, authentic, and engaging community in reducing shame prone reactions, like withdrawal and isolation. That is, when one has a healthy community relationship, they are likely to have the group support they need to engage in reparative actions rather than engaging in self-degradation, avoidance, and isolation. This finding is supported by Lloyd et al. (2017) who found that domestic

violence survivors across the United Kingdom, Greece, Italy, Poland, and Slovenia who participated in therapy groups focused on empowerment reported overcoming shame and feeling pride in themselves, and experiencing increased self-esteem. Women in this study reported the empowering and engaging support they got from the women and facilitators in the groups was the most satisfactory aspect of the experimental empowerment group.

Regarding peer relational health, as Jordan (2010) and Miller and Stiver (1997) suggested, a healthy peer relationship is one in which both partners take part in engaging, authentic, and empowering interactions. As theorized by RCT, this study provided evidence that healthy peer relationships are effective in helping individuals move away from shame. It is important to note that peer relational health was as significant of a predictor of reduced shame as community relational health. This may suggest individuals who have both high-quality peer and community relationships may be more effective at reducing shame than those who do not. It may also be that one needs healthy peer *and* community relationships in order to most effectively reduce shame.

Trauma history was found to be a significant individual predictor of increased shame when trauma history was high. This is congruent with research findings that suggest individuals with trauma history have coping styles that are consistent with shame (e.g., self-degration, withdrawal, and isolation). Dorahy et al. (2013) found that individuals with a high trauma history experienced higher amounts of both guilt and shame than those without a trauma history. Although the participants experienced both guilt and shame, they reported coping strategies more consistent with that of shame than

guilt, such as self-blame or attacking the self. Also, Dryer et al. (2017) found that attacking the self as a coping style not only predicted higher shame states in clinical populations (i.e., dissociative identity disorder, complex trauma, general mental health problems), but the participants also reported higher levels of withdrawal coping styles and shame and guilt as compared to general populations.

Predictors of Guilt

In the guilt model peer relational health was the strongest predictor of guilt after controlling for shame, followed by age and negative family experiences, respectively. Regarding peer relational health, in a recent study on adolescent friendships and authenticity, Peets and Hodges (2017) discovered that adolescents who felt they could be more authentic in their friendships reported higher self-esteem, were less lonely, were more satisfied with their relationships, and reported greater overall well-being. It is possible these authentic, engaging, and empowering relationships lead to higher relational satisfaction because of the increased guilt responses. That is, as one engages in healthier relationships, they may become more attuned to undesirable behaviors and to the importance of taking reparative actions. Interestingly, community relational health was not a significant individual predictor of guilt. It is possible that guilt prone behaviors are not as relevant and influential in community relationships as they are in peer relationships. In peer relationships, undesirable behaviors and the need for reparative actions may be much more obvious and personal.

Negative family experiences also were found to significantly predict guilt, but not shame. The more negative family experiences one reported, the more likely they were to report guilt prone behaviors. Surprisingly, not much research has been

completed on negative family experiences and guilt and shame proneness. At face value, one may think that negative family experiences would increase shame proneness; however, there are several possibilities for the increase in guilt proneness as opposed to shame proneness. It is possible that individuals who have experienced more negative family experiences, have learned how to appropriately address negative situations without internalizing the problems and shaming themselves. Also, it is possible that those with negative family experiences have found healthy peer relationships that have changed their relational and personal images as they have grown and developed. Frey et al. (2004; 2006) found that relational health protected against the negative effects of damaging relationships, including family relationships. As discussed previously, relationships that are authentic, empowering, and engaging increase communication and decrease isolation (Miller & Stiver, 1997). With the increase of communication, one is more likely to focus on personal behaviors, engage in reparative actions, and be less likely to attack themselves because of the healthy images they have developed.

Last, age did not have a significant impact on shame but it did significantly predict guilt, finding that as a person ages, they become more guilt prone. Lin, Ankudowich, and Ebner (2017) asked individuals to identify personality characteristics consistent with different age groups. They found that older individuals not only rated traits typical for their age group as typical for themselves, they were more likely to rate positive personality traits as typical for themselves. Thus, Lin et al. suggested that as individuals age, they begin to focus on more positive personality traits of others and themselves. Further, Ebner, Riediger, and Lindenberger (2009) discovered younger and older individuals were more likely to categorize older people as being emotionally

focused on loss-prevention. This suggests as individuals age, they may become more focused on positivity and preserving important relationships, which may include guilt prone characteristics such as repair.

Miller and Stiver (1997) suggest healthy relationships result in the five good things (i.e. zest; capacity to act; better understanding of the self, other, and relationship; increased self-worth; and a deeper desire for connection). Thus, overall, the results of this study provide some support for relational cultural theoretical assumptions. Specifically, results support the assumption that healthy relationships may provide a protective factor against maladaptive emotions such as shame. Further, peer relational health may prompt reparative action regarding guilt feelings, perhaps due to increased awareness of self and the desire for continued connection.

Implications

These findings of this study are important because not only do they lend empirical support for relational cultural theory, they decrease the gap in the literature on factors related to guilt and shame proneness. Relational cultural theory suggests relational disconnection is the root of psychological distress and this study provided evidence that growth fostering relationships are able to reduce the psychologically distressing emotion of shame and increase the pro-social emotion of guilt. This study provided evidence that negative family experiences and healthy peer relationships predict guilt-proneness. It is possible that growth fostering, authentic, empowering, and engaging relationship lead to the five good things (zest; capacity to act; greater understanding of the self, other, and relationship; a sense of worth; a desire for more connection) which help individuals approach their partners as opposed to engaging in

strategies of disconnection. This may allow individuals to be more focused on behavior and reparative action as opposed to attacking the self and isolating the self.

Findings are also valuable for those working with couples and families, as they provide evidence that growth fostering, empowering, engaging, and authentic relationships allow for prosocial emotions and guard against distressing emotions, such as shame. Mental health providers can use this information in their treatment to help clients make the prosocial shift toward guilt (and away from shame) by improving their close relationships. To do this, mental health providers can help individuals challenge their negative relational images by helping them recognize and engage in positive relational interactions with others in their lives. Relationships with mental health providers can serve as relational models by providing an experience of empathetic, empowering, engaging, and authentic relational connection. This emphasizes the importance of mental health providers being authentic in their connection with their clients. Having difficult conversations with clients about interpersonal reactions during sessions may be beneficial in helping the client understand their influence on others and any strategies of disconnection they may be using. Similarly, being open to and encouraging honest feedback from the client and reacting in a genuine and engaging way may be helpful in allowing the client to recognize that difficult conversations do not have to result in disconnection and shame. Counselors could, for example, demonstrate and role play conflict resolution with clients. In addition, therapy groups or couple's and family therapy may be a way for clients to practice having authentic, engaging, and empowering relationships with others. These modalities could allow clients to process real world relational disconnection under the guidance of a therapist

who can facilitate and model authenticity, engagement, and empowerment. In this setting, clients can receive feedback from others with whom they are in relation and process any interpersonal difficulties and/or feelings of shame and guilt as they arise. As Lloyd et al. (2017) demonstrated, groups that promote empowerment are effective in reducing shame prone reactions. Therefore, groups that promote empowerment, authenticity, and engagement will likely be effective at increasing relational health and reducing shame and other psychological distress.

Last, the findings from this study can be useful for those working with individuals who may be struggling with negative family experiences, as it provides evidence that negative family experiences do not prevent individuals from developing strong and healthy relationships, which can ultimately lead to changes in shame proneness and an increase in the ability to engage in reparative action. It is important that parents, teachers, mental health providers, and other adults in leadership roles stress healthy peer and community relationships at an early age to increase relational understanding and awareness. Perhaps if the development and maintenance of healthy relationships are stressed early, the negative emotions of shame will not be as persistent in life.

Limitations and Future Research

Strengths of this study are that it is grounded in theory and there was an adequate sample size. However, all studies have limitations. One limitation of this study is that the majority of the participants were White, heterosexual females. Also, a majority had a bachelor's level of education, were middle income or higher, and grew up with their married biological parents. This suggests caution in generalizing to other

populations. Particularly, the impact of negative family experiences and trauma could potentially be different if there were more individuals with varied family backgrounds. Future research is needed to explore these findings.

It would be beneficial for future researchers to do similar studies with more diverse populations, including populations with varied family configurations. Additionally, as it was found that age was a significant predictor of increased guilt proneness, future research should explore this demographic and the potential reasons behind this finding. It would be interesting to complete a longitudinal study on guilt and shame proneness using relational health as a predictor from adolescence through adulthood.

Further, the study was completed via self-report measures. As Tangney and Dearing (2002) and Brown (2007) suggested, today's society is a shame-phobic one. Individuals do not enjoy thinking about events that cause uncomfortable emotions, particularly shame. Therefore, it is possible that this dynamic impacted responses to the survey. Of note, however, Tangney and Dearing reported one of the strengths of the TOSCA-3 is that it is a scenario based measure that does not actually mention guilt and shame, which may reduce priming effects and decrease defensive responding.

While the hierarchical regressions produced only small-to-medium effect sizes, the regressions were run with and without shame and guilt as control variables to control for overlap. This allowed the researcher to more clearly determine the individual contribution each variable provided. However, this study was correlational, which prevents causation from being determined.

Conclusion

While guilt can be seen as adaptive since it focuses on behaviors and promotes reparative actions, shame has been linked to maladaptive emotions and psychological distress, including depression, aggression, and hostility (Velotti, Garofalo, Bottazzi, & Caretti, 2017; Tangney & Dearing, 2002; Tangney, Wagner, Hill-Barlow, Marschall, & Gramzow, 1996). As shame and guilt are so closely tied, they were found to be significant individual predictors of each other. Although shame and guilt overlap, there were distinct predictive patterns that supported Relational Cultural Theory in demonstrating that healthy relationships reduce shame proneness and increase guilt proneness.

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Appendix A: Survey

Predictors of Guilt and Shame: Relational Health, Trauma, and Family Experiences

If you are between the ages of 18 and 65-years-old, you may be eligible to participate in a 20-minute research survey to help me complete my dissertation and finish my Ph.D. in counseling psychology at the University of Oklahoma. To complete the 20-minute research survey, please follow the link provided below. If you would like to share this survey with friends who would like to participate, please feel free to do so. Please contact the primary investigator, Deni Napier (deninapier@ou.edu), for more information or if you have any questions. The University of Oklahoma is an equal opportunity institution.

I am Deni Napier from the Counseling Psychology, Ph.D. program in the Educational Psychology department and I invite you to participate in my research project entitled Predictors of Guilt and Shame: Relational Health, Family Experiences, and Trauma. This research is being conducted at The University of Oklahoma Norman Campus. You were selected as a possible participant because you are 18 years old or older. You must be at least 18 years of age to participate in this study. Please read this document and contact me to ask any questions that you may have BEFORE agreeing to take part in my research. **What is the purpose of this research?** The purpose of this research is to determine predictive factors of guilt and shame proneness. **How many participants will be in this research?** About 300 people will take part in this research. **What will I be asked to do?** If you agree to be in this research, you will proceed with the following survey. **How long will this take?** Your participation will take approximately 20 minutes. **What are the risks and/or benefits if I participate?** There are no direct benefits to participation in this survey. There is little risk in the participation of this survey; however, it is possible that one may feel emotional discomfort while answering questions about how likely they are to react in certain situations, family experiences, trauma history, and relationships. There is a chance that demographic information gathered could lead to identification; however, the demographic information will be reported via statistics and due to the large number of participants being recruited, the likelihood of information being identifiable is low. Individual demographic information will not be reported. If you feel discomfort, you are free to discontinue the survey. If you have a negative experience while taking this survey, visit one of the following counseling resources. Find a counselor near you through the American Counseling Association website http://www.counseling.org/aca-community/learn-about-counseling/what-is-counseling. If you are experiencing suicidal thoughts or thoughts of harming yourself, please visit the nearest emergency room and/or call the National Suicide Prevention Lifeline 1 (800) 273-8255. For confidential support services by sexual assault service providers, please contact the National Sexual Assault Hotline 1 (800) 656-HOPE. **Will I be compensated for participating?** You will not be reimbursed for your time and participation in this research. **Who will see my information?** No personally identifiable information will be recorded. In research reports, there will be no information that will make it possible to identify you. Research records will be stored securely and only approved researchers and the OU Institutional

Review Board will have access to the records. Data are collected via an online survey system that has its own privacy and security policies for keeping your information confidential. Please note no assurance can be made as to the use of the data you provide for purposes other than this research. **Do I have to participate?** No. If you do not participate, you will not be penalized or lose benefits or services unrelated to the research. If you decide to participate, you don't have to answer any question and can stop participating at any time. **Who do I contact with questions, concerns or complaints?** If you have questions, concerns or complaints about the research or have experienced a research-related injury, contact me at deninapier@ou.edu or 405-325-2914 via Dr. Frey (melissa.frey-1@ou.edu), my research advisor. You can also contact the University of Oklahoma – Norman Campus Institutional Review Board (OU-NC IRB) at 405-325-8110 or irb@ou.edu if you have questions about your rights as a research participant, concerns, or complaints about the research and wish to talk to someone other than the researcher(s) or if you cannot reach the researcher(s). Please print this document for your records. By providing information to the researcher(s), I am agreeing to participate in this research

This study has been approved by the University of Oklahoma, Norman Campus IRB. IRB Number: 8193 Approval date: 06/20/2017

❍ I agree to participate (click should connect to survey) (1)
❍ I decline (click should send to a Thank You for your consideration page) (2)

Condition: I decline (click should sen... Is Selected. Skip To: End of Survey.

The following questions are from Tangney & Dearing, 2002.
Below are situations that people are likely to encounter in day-to-day life, followed by two common reactions to those situations. As you read each scenario, try to imagine yourself in that situation. Then indicate how likely you would be to react in EACH of the ways described. We ask you to rate ALL responses because people may feel or react more than one way to the same situation, or they may react different ways at different times. As you can see in the example below, each response was rated:

You wake up early one Saturday Morning. It is cold and rainy outside.
You would telephone a friend to catch up on news. X 1 __2 __ 3 __ 4 __5
You would feel disappointed that it's raining __1 __2 X_ 3 __4 __5

Please rate how likely you would be to react in EACH of the ways described for each scenario.

You make plans to meet a friend for lunch. At 5 o'clock, you realize you stood him up.

	Not Likely (1)	Somewhat Likely (2)	Likely (3)	More than Likely (4)	Very Likely (5)
You would think: "I'm inconsiderate." (1)	❍	❍	❍	❍	❍
You'd think you should make it up to him as soon as possible (2)	❍	❍	❍	❍	❍

You break something at work and then hide it.

	Not Likely (1)	Somewhat Likely (2)	Likely (3)	More than Likely (4)	Very Likely (5)
You would think: "This is making me anxious. I need to either fix it or get someone else to." (1)	❍	❍	❍	❍	❍
You would think about quitting (2)	❍	❍	❍	❍	❍

You are out with friends one evening, and you're feeling especially witty and attractive. Your best friend's spouse seems to particularly enjoy your company.

	Not Likely (1)	Somewhat Likely (2)	Likely (3)	More than Likely (4)	Very Likely (5)
You would think: "I should have been aware of what my best friend is feeling." (1)	❍	❍	❍	❍	❍
You would probably avoid eye-contact for a long time. (2)	❍	❍	❍	❍	❍

At work, you wait until the last minute to plan a project, and it turns out badly.

	Not Likely (1)	Somewhat Likely (2)	Likely (3)	More than Likely (4)	Very Likely (5)
You would feel incompetent (1)	❍	❍	❍	❍	❍
You would feel: "I deserve to be reprimanded for mismanaging the project (2)	❍	❍	❍	❍	❍

You make a mistake at work and find out a co-worker is blamed for the error.

	Not Likely (1)	Somewhat Likely (2)	Likely (3)	More than Likely (4)	Very Likely (5)
You would keep quiet and avoid the co-worker. (1)	❍	❍	❍	❍	❍
You would feel unhappy and eager to correct the situation. (2)	❍	❍	❍	❍	❍

For several days you put off making a difficult phone call. At the last minute you make the call and are able to manipulate the conversation so that all goes well.

	Not Likely (1)	Somewhat Likely (2)	Likely (3)	More than Likely (4)	Very Likely (5)
You would regret that you put it off. (1)	❍	❍	❍	❍	❍
You would feel like a coward. (2)	❍	❍	❍	❍	❍

While playing around, you throw a ball and it hits your friend in the face.

	Not Likely (1)	Somewhat Likely (2)	Likely (3)	More than Likely (4)	Very Likely (5)
You would feel inadequate that you can't even throw a ball. (1)	❍	❍	❍	❍	❍
You would apologize and make sure your friend feels better. (2)	❍	❍	❍	❍	❍

You have recently moved away from your family, and everyone has been very helpful. A few times you needed to borrow money, but you paid it back as soon as you could.

	Not Likely (1)	Somewhat Likely (2)	Likely (3)	More than Likely (4)	Very Likely (5)
You would feel immature. (1)	❍	❍	❍	❍	❍
You would return the favor as quickly as you could. (2)	❍	❍	❍	❍	❍

You are driving down the road, and you hit a small animal.

	Not Likely (1)	Somewhat Likely (2)	Likely (3)	More than Likely (4)	Very Likely (5)
You would think: "I'm terrible." (1)	❍	❍	❍	❍	❍
You'd feel bad you hadn't been more alert. (2)	❍	❍	❍	❍	❍

You walk out of an exam thinking you did extremely well. Then you find out you did poorly.

	Not Likely (1)	Somewhat Likely (2)	Likely (3)	More than Likely (4)	Very Likely (5)
You would think: "I should have studied harder." (1)	❍	❍	❍	❍	❍
You would feel stupid. (2)	❍	❍	❍	❍	❍

You and a group of co-workers worked very hard on a project. Your boss singles you out for a bonus because the project was such a success.

	Not Likely (1)	Somewhat Likely (2)	Likely (3)	More than Likely (4)	Very Likely (5)
You would feel alone and apart from your colleagues. (1)	❍	❍	❍	❍	❍
You would feel you should not accept it. (2)	❍	❍	❍	❍	❍

While out with a group of friends, you make fun of a friend who's not there.

	Not Likely (1)	Somewhat Likely (2)	Likely (3)	More than Likely (4)	Very Likely (5)
You would feel small... Like a rat. (1)	❍	❍	❍	❍	❍
You would apologize and talk about that person's good points. (2)	❍	❍	❍	❍	❍

You make a big mistake on an important project at work. People were depending on you, and your boss criticizes you.

	Not Likely (1)	Somewhat Likely (2)	Likely (3)	More than Likely (4)	Very Likely (5)
You would feel like you wanted to hide. (1)	❍	❍	❍	❍	❍
You would think: "I should have recognized the problem and done a better job." (2)	❍	❍	❍	❍	❍

You volunteer to help with the local Special Olympics for handicapped children. It turns out to be frustrating and time-consuming work. You think seriously about quitting, but then you see how happy the kids are.

	Not Likely (1)	Somewhat Likely (2)	Likely (3)	More than Likely (4)	Very Likely (5)
You would feel selfish and you'd think you are basically lazy. (1)	❍	❍	❍	❍	❍
You would think: "I should be more concerned about people who are less fortunate." (2)	❍	❍	❍	❍	❍

You are taking care of your friend's dog while they are on vacation and the dog runs away.

	Not Likely (1)	Somewhat Likely (2)	Likely (3)	More than Likely (4)	Very Likely (5)
You would think, "I am irresponsible and incompetent." (1)	❍	❍	❍	❍	❍
You would vow to be more careful next time. (2)	❍	❍	❍	❍	❍

You attend your co-worker's house warming party and you spill red wine on their new cream-colored carpet, but you think no one notices.

	Not Likely (1)	Somewhat Likely (2)	Likely (3)	More than Likely (4)	Very Likely (5)
You would stay late to help clean up the stain after the party. (1)	❍	❍	❍	❍	❍
You would wish you were anywhere but at the party. (2)	❍	❍	❍	❍	❍

The following questions are from Draper et al., 2002.Instructions:
Below is a list of experiences which may occur in families. Read each experience carefully. Some of these may have been true at one point in your life but not true at another point. Think about your childhood and your adolescence. If the experience happened in your family during either of these periods, please fill in the oval labeled "Yes." It is important to remember family can have a large number of meanings. Therefore, if these experiences happened to you while living or staying with a group you consider family (i.e. foster, adoption, biological, blended families), please fill in the oval labeled "Yes." If the experience never happened in your family, please fill in the oval labeled "No."

	Yes (1)	No (2)
Parents divorced or permanently separated before you were 18 (1)	❍	❍
Family frequently moved (2)	❍	❍
Parents unemployed for an extended period of time (3)	❍	❍
Frequent, hostile arguing among family members (4)	❍	❍
Death of parent(s) before you were 18 (5)	❍	❍
Parent(s) with a drinking problem (6)	❍	❍
Parent(s) with a drug problem (7)	❍	❍
Parent(s) with a gambling problem (8)	❍	❍
Physical abuse within your family (9)	❍	❍
Sexual abuse within your family (10)	❍	❍
Rape/Sexual assault of yourself or family member (11)	❍	❍
Family member hospitalized for emotional problems (12)	❍	❍
Family member diagnosed with a mental disorder (13)	❍	❍
Family member attempted suicide (14)	❍	❍
Family member committed suicide (15)	❍	❍
Family member with a debilitating illness, injury, or handicap (16)	❍	❍
Family member prosecuted for criminal activity (17)	❍	❍
Family member with an eating problem (18)	❍	❍

The following questions are from Briere, 2001.
Instructions: At any time in your life, including your childhood, have any of the following happened to you? Please indicate Yes or No for each item.

	Yes (1)	No (2)
An accident or crash involving a car, motorcycle, plane, boat, or other vehicle, when you were seriously hurt or were afraid you would be hurt or killed? (1)	❍	❍
A hurricane, tornado, flood, earthquake, explosion, or fire, when you were seriously hurt or were afraid you would be hurt or killed? (2)	❍	❍
An accident at work or at home, when you were seriously hurt or were afraid you would be hurt or killed? (3)	❍	❍
Someone hitting, chocking, or beating you (including someone you lived with or were married to), when you were seriously hurt or were afraid you would be hurt or killed (at anytime in your life, including your childhood)? (4)	❍	❍
Someone threatening to injure you or do something sexual to you against your will, although they didn't actually do anything to you, when you were afraid you would be hurt or killed? (5)	❍	❍
Someone shooting or stabbing you, or trying to shoot or stab you, when you were seriously hurt or were afraid you would be hurt or killed? (6)	❍	❍
Being in a war, when you were seriously hurt or were	❍	❍

afraid you would be hurt or killed? (7)		
Being held-up, robbed, or mugged, when you were seriously hurt or were afraid you would be hurt or killed? (8)	❍	❍
Someone doing something sexual to you against your will (for example, rape, sexual assault, or unwanted sexual contact), or making you do something sexual, that caused you to be seriously hurt or afraid you would be hurt or killed? (9)	❍	❍
Someone doing something sexual to you agaist your will (even if you were not hurt or afraid you would be hurt) or making you do something sexual before you were 16 years old. (10)	❍	❍
Some other experience that caused you to be seriously hurt or made you fear that you might be seriously hurt or killed? (11)	❍	❍
Seeing someone else get seriously hurt or killed? (12)	❍	❍

The following questions are from Lang, Tracy, Taylor, & Williams, 2002.
PEER: Next to each statement below, please indicate the choice that best applies to your relationship with a close friend.

	Never (1)	Seldom (2)	Sometimes (3)	Often (4)	Always (5)
Even when I have difficult things to share, I can be honest and real with my friend. (1)	❍	❍	❍	❍	❍

After a conversation with my friend, I feel uplifted. (2)	❍	❍	❍	❍	❍
The more time I spend with my friend, the closer I feel to him/her. (3)	❍	❍	❍	❍	❍
I feel understood by my friend. (4)	❍	❍	❍	❍	❍
It is important to us to make our friendship grow. (5)	❍	❍	❍	❍	❍
I can talk to my friend about our disagreements without feeling judged. (6)	❍	❍	❍	❍	❍
My friendship inspires me to seek other friendships like this one. (7)	❍	❍	❍	❍	❍
I am uncomfortable sharing my deepest feelings and thoughts with my friend. (8)	❍	❍	❍	❍	❍
I have a greater sense of self-worth through my relationship with my friend. (9)	❍	❍	❍	❍	❍

I feel positively changed by my friend. (10)	❍	❍	❍	❍	❍
I can tell my friend when he/she has hurt my feelings. (11)	❍	❍	❍	❍	❍
My friendship causes me to grow in important ways. (12)	❍	❍	❍	❍	❍

The following questions are from Lang, Tracy, Taylor, & Williams, 2002.
COMMUNITY: Next to each statement below, please indicate the choice that best applies to your relationship with or involvement in your community.

	Never (1)	Seldom (2)	Sometime (3)	Often (4)	Always (5)
I feel a sense of belonging to this community. (1)	❍	❍	❍	❍	❍
I feel better about myself after my interactions with this community. (2)	❍	❍	❍	❍	❍
If members of this community know something is bothering me they ask me about it. (3)	❍	❍	❍	❍	❍
Members of this community are not free to just be	❍	❍	❍	❍	❍

themselves (4)					
I feel understood by members of this community. (5)	❍	❍	❍	❍	❍
I feel mobilized to personal action after meetings within this community. (6)	❍	❍	❍	❍	❍
There are parts of myself I feel I must hide from this community. (7)	❍	❍	❍	❍	❍
It seems as if people in this community really like me as a person. (8)	❍	❍	❍	❍	❍
There is a lot of backbiting and gossiping in this community. (9)	❍	❍	❍	❍	❍
Members of this community are very competitive with each other. (10)	❍	❍	❍	❍	❍
I have a greater sense of self-worth	❍	❍	❍	❍	❍

through my connection with this community. (11)					
My connections with this community are so inspiring that they motivate me to pursue relationships with other people outside this community. (12)	❍	❍	❍	❍	❍
This community has shaped my identity in many ways. (13)	❍	❍	❍	❍	❍
This community provides me with emotional support. (14)	❍	❍	❍	❍	❍

About You...
What is your gender identity

- ❍ Woman/Female (1)
- ❍ Man/Male (2)
- ❍ Transgender Man to Woman (3)
- ❍ Transgender Woman to Man (4)
- ❍ Gender Fluid (5)
- ❍ Agender (6)
- ❍ Gender Queer/Nonbinary (7)
- ❍ Please Specify: (8) _____

What is your sexuality orientation

- ❍ Lesbian or Gay (1)
- ❍ Heterosexual (2)
- ❍ Bisexual (3)
- ❍ Asexual (4)
- ❍ Please Specify (5) _____

What is your age?
What is your ethnicity

- ❍ Bi-Racial (Please Specifiy) (1) _____
- ❍ European American or White (2)
- ❍ African American or Black (3)
- ❍ Hispanic or Latino (4)
- ❍ Asian American (5)
- ❍ Native American or Alaska Native (6)
- ❍ Native Hawaiian or Pacific Islander (7)
- ❍ Please Specify (8) _____

What is your highest degree of education?

- ❍ No High School Degree or GED (1)
- ❍ GED (2)
- ❍ High School Diploma (3)
- ❍ Trade School (4)
- ❍ Associates Degree (5)
- ❍ Bachelors Degree (6)
- ❍ Masters Degree (7)
- ❍ Professional Degree (8)
- ❍ Medical Degree (9)

Have you ever been in fostercare?

- ❍ Yes (1)

❍ No (2)

Are you adopted? If so please specify whether your adoptive parents are biologically related to you.

❍ Yes (1) _____
❍ No (2)

Who did you live with the majority of your childhood and adolescence?

❍ Biological Parents (1)
❍ Foster Parents (2)
❍ Non-Biologically Related Adoptive Parents (3)
❍ Biologically Related Adoptive Parents (4)
❍ Please Specify (5) _____

The majority of your life, were your parents/guardians

❍ Married (1)
❍ Divorced (2)
❍ Separated (3)
❍ Never married (4)
❍ Widowed (5)
❍ Please Specify (6) _____

The majority of your childhood and adolescence, did you live with

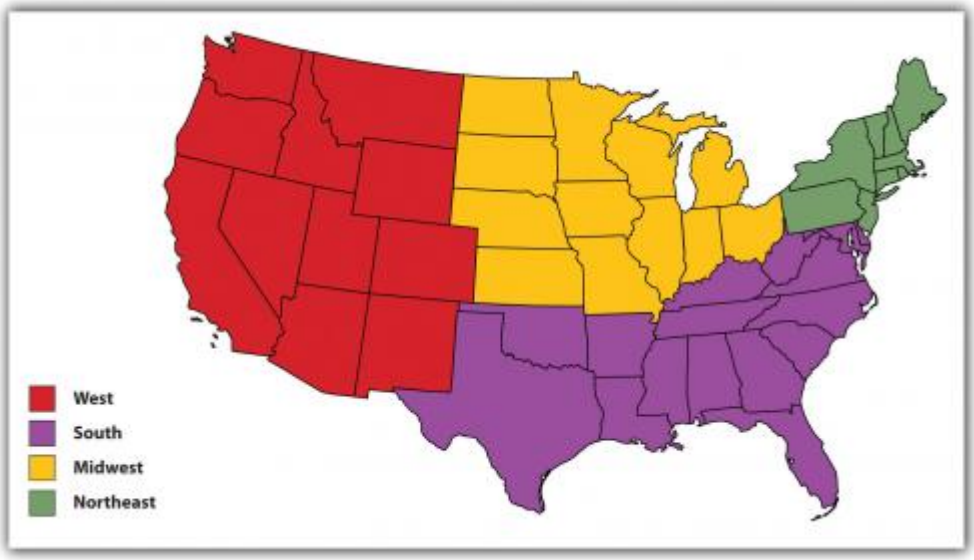
❍ two parents/guardians in the same home (1)
❍ two parents/guardians in different homes (2)
❍ a single parent/guardian (3)
❍ Please Specify (4) _____

How many siblings do you have

What is your current socio-economic status?

❍ Low: below $32,500 (1)
❍ Lower middle $32,500 - $60,000 (2)
❍ Middle middle $60,000 - $100,000 (3)
❍ Upper Middle $100,000 - $150,000 (4)
❍ Upper $200,000 or more (5)

According to the picture, which geographic location did you spend the majority of your childhood



- West (1)
- South (2)
- Midwest (3)
- Northeast (4)

Thank you for your participation! If you have had a negative experience while taking this survey, we encourage you to contact the researchers or visit one of the following counseling resources. Find a counselor near you through the American Counseling Association website http://www.counseling.org/aca-community/learn-about-counseling/what-is-counseling. If you are experiencing suicidal thoughts or thoughts of harming yourself, please visit the nearest emergency room and/or call the National Suicide Prevention Lifeline 1 (800) 273-8255. For confidential support services by sexual assault service providers, please contact the National Sexual Assault Hotline 1 (800) 656-HOPE.

Table 1

Means, Standard Deviations, Alphas, and Intercorrelations Among Measured Variables

Variable	*M*	*SD*	*a*	1	2	3	4	5	6	7
1. Age	35.88	11.55		--	.064	.056	-.011	.009	-.113	.188**
2. FEQ	21.58	3.44			--	.569**	.011	.016	.190**	.195**
3. DAPS-RTE	14.30	2.65				--	.076	.063	.204**	.113
4. RHI-P	44.77	8.44	.91				--	.364**	-.105	.254**
5.RFI-C	41.89	9.82	.87					--	-.192**	.059
6. Shame	44.89	12.16	.86						--	.40**
7. Guilt	59.64	10.20	.84							--

Note. Age = age of the participant. FEQ = Family Experiences Questionnaire; higher scores indicate more negative family experiences. DAPS-RTE = Detailed Assessment of Posttraumatic Stress – Relative Trauma Exposure section; higher scores indicate more traumatic exposures. RHI-P = Relational Health Inventory-Peer; higher scores indicate higher peer relational health quality (range 12-60). RHI-C = Relational Health Inventory-Community; higher scores indicate higher community relational health quality (range 14-70). Shame = TOSCA-3 Shame Subscale; higher scores indicate more shame prone emotional experiences (range 16-80). Guilt = TOSCA-3 Guilt Subscale; higher scores indicate more guilt prone emotional experiences (range 16-80).
*p < .05. **p < .01. ***p < .001

Table 2

Hierarchical Multiple Regression 1: Shame

Independent Variable	Step	R^2	ΔR^2	*F Change*	*df*	*B*	*SE B*	*β*
FEQ	1	.050	.050**	6.115	(2, 234)	.357	.269	.101
DAPS-RTE	1					.745	.351	.162*
RHI-C	2	.093	.043**	5.547	(2, 233)	-.229	.083	-.185**
RHI-P	2					-.073	.097	-.051

Note. FEQ = Family Experiences Questionnaire. DAPS-RTE = Detailed Assessment of Posttraumatic Stress – Relative Trauma Exposure section. RHI-P = Relational Health Inventory-Peer. RHI-C = Relational Health Inventory-Community.

*p < .05. **p < .01. ***p < .001

Table 3

Hierarchical Multiple Regression 2: Shame controlling for Guilt

Independent Variable	Step	R^2	ΔR^2	*F Change*	*df*	*B*	*SE B*	*β*
Guilt	1	.16	.160***	44.64	(1, 235)	.512	.071	.430***
FEQ	2	.186	.026*	3.78	(2, 233)	.046	.248	.013
DAPS-RTE	2					.787	.318	.171*
RHI-C	3	.259	.072***	11.26	(2, 231)	-.208	.075	-.168**
RHI-P	3					-.239	.091	-.166**

Note. Guilt = TOSCA-3 Guilt Subscale. FEQ = Family Experiences Questionnaire. DAPS-RTE = Detailed Assessment of Posttraumatic Stress – Relative Trauma Exposure

section. RHI-P = Relational Health Inventory-Peer. RHI-C = Relational Health Inventory-Community.
*p < .05. **p < .01. ***p < .001

Table 4

Hierarchical Multiple Regression 3: Guilt

Independent Variable	Step	R^2	ΔR^2	*F Change*	*df*	*B*	*SE B*	*β*
Age	1	.035	.035**	8.42	(1, 231)	.160	.055	*.180***
FEQ	2	.068	4.06*	4.06	(2, 229)	.596	.224	.201**
DAPS-RTE	2					-.140	.292	-.036
RHI-C	3	.136	8.90**	8.90	(2,227)	-.054	.069	-.052
EHI-P	3					.332	.080	.276**

Note. Age = age of participants. FEQ = Family Experiences Questionnaire. DAPS-RTE = Detailed Assessment of Posttraumatic Stress – Relative Trauma Exposure section.

RHI-P = Relational Health Inventory-Peer. RHI-C = Relational Health Inventory-Community.
*p < .05. **p < .01. ***p < .001

Table 5

Hierarchical Multiple Regression 4: Guilt Controlling for Shame

Independent Variable	Step	R^2	ΔR^2	*F Change*	*df*	*B*	*SE B*	*β*
Shame	1	.172	.172***	48.11	(1, 231)	.402	.048	.477***
Age	2	.228	.056***	16.56	(1, 230)	.214	.049	.241***
FEQ	3	.241	.013	2.01	(2, 228)	.456	.197	.154*
DAPS-RTE	3					-.473	.259	-.123
RHI-C	4	.339	.097***	16.65	(2, 226)	.030	.062	.029
RHI-P	4					.367	.070	.305***

Note. Shame = TOSCA-3 Shame Subscale. Age = age of participants. FEQ = Family Experiences Questionnaire. DAPS-RTE = Detailed Assessment of Posttraumatic Stress

– Relative Trauma Exposure section. RHI-P = Relational Health Inventory-Peer. RHI-C = Relational Health Inventory-Community.
*p < .05. **p < .01. ***p < .001