

Suicide: A dying shame

A literature review of the therapeutic relationship

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Dissertation

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The words of grief kill none.

Dumb silence is what kills.

Speaking, we live;

Speechless, we die.

Listen, then, to my voice -

a paltry flame that lights up

the walls of our cave.

'There is no one here,

there is nothing to fear

as long as the world exists

and the flame is lit.

Olof Lagercrantz

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Attestation of authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements.

Susan P. Goldstiver

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*Dedicated to Chris,
for giving me my life,
thank you.*

Abstract

The purpose of this dissertation was to investigate the role that shame plays in suicidality. Shame is an emotion that is not easily communicated or identified and suicidal ideation is often taboo. Given that shame and suicide can both be hidden and silent, how does a psychotherapist work with clients who experience chronic shame and who are potentially suicidal? The case of Kurt Cobain is used as an illustrative example. A modified systematic literature review was the method used to ensure a thorough investigation of the psychological literature available on this topic. It was found that shame is present in many attempted and completed suicides. This dissertation raises the possibility of a fundamental connection between suicide and shame but further research is required, as other emotions were not reviewed for their connection with suicidality. Clinical implications are highlighted for the practicing psychotherapist.

Chapter One: Introduction

From the beginning of our lives, we endeavor to be understood, to be loved and to love. Feeling loved, having a sense of belonging, being respected and needed by others and an awareness of one's own worth is vital to all human beings. People are first and foremost relational beings. Donald Winnicott (1987, p. 88) stated, "if you set out to describe a baby you will find that you are describing a baby and someone. A baby cannot exist alone, but is essentially part of a relationship".

The primary relationship between a mother and her newborn begins with the mutual gazing that takes place after the birth. Ideally, this gaze is reciprocated whenever the mother is touching, holding or feeding her baby. What happens for the baby internally when this gaze is not reciprocated, or when this gaze is pensive, vacant or full of hatred? What happens when the mother is withdrawn, depressed, envious, misattuned or empty? What happens to the baby when the mother does not see her baby and when she does not give her baby a reflection of itself?

This dissertation will demonstrate an answer to these questions. I speculate that a core sense of shame about one's self develops: shame about the essence of one's self, about one's very being. The child learns to adapt the self to meet the mother, and associated with that is an anxiety. A false self develops to hide the supposed bad, flawed and ugly true self that the child believes himself or herself to be. Alice Miller (1983, p. 30) writes of the child's fear of being their true self: "What would have happened if I had appeared before you, bad, ugly, angry, jealous, lazy, dirty, smelly? Where would your love have been then?"

It is important to acknowledge that some shame feelings are useful (Scheff, 1990). Gaylin (1979, p. 76) suggests that "shame is indeed companion to virtue. [It guides] us to our better selves and ensure[s] our safety supporting the group on which we all ultimately depend for our survival". Crowe (2004b, p. 336) states that "an ability to feel shame could be regarded as healthy and important in maintaining social connectedness, but excessive shame could be experienced as physically paralyzing and anxiety producing." Pattison (2000, p. 130) writes that he finds it difficult to "attribute any positive, useful role to chronic shame. It seems to maintain people in a

state of social isolation and diminished social and personal existence". Chronic shame leaves a distinctive imprint upon people in adult life. Influenced by early shame experiences, it is unlikely that individuals who suffer chronic shame will have a solid sense who they are, experiencing little self-worth and self-esteem. These people may struggle with their own boundaries, as well as those of others, and will perceive themselves to be bad, inferior, defective, and a failure.

Feelings of shame, resulting from a misattunement as a child, are often overwhelming and if they remain unrepaired can be the beginning of an attachment pattern based on fears. Fears such as fear of losing the love or approval of the other and fear of being unlovable for example can be a reality for these people.

Suicide is everyone's concern; directly or indirectly, it has touched many people at some stage of their life. It would be fair to say that suicide is in all of us to differing degree's; life is optional and pain and suffering visit us all (Heckler, 1994). However, most people have no desire to kill themselves and have multiple reasons not to take or risk their lives (Linehan, Goodstein, Nielsen, & Chiles, 1983). Conversely, there is something different going on for those with suicidal ideation. I propose that this is the connection between chronic, core shame and suicide.

A shame-suicide connection is seldom considered and it is for this reason that I am going to concentrate on shame in suicide. From personal discussions with other psychotherapists, guidance counsellors within the secondary school system and clinicians within the mental health sector, it seems that little conscious thought is given to this connection. This seems dangerous to me because of the potential fatal consequences. This and my growing awareness from my own personal experience, are what motivate me to write this dissertation. My desire is to make a difference to the ways in which psychotherapists, counsellors and medical clinicians perceive individuals with suicidal intentions, by providing knowledge on the impact that shame feelings have on the internal and external experience of a person and how this may lead them to suicide.

Chapter Two: Methods

Theoretical perspective

This literature review is a modified systematic review in that it does not strictly adhere to Dickson's (1999) definition which states that systematic reviews “locate, appraise and synthesize evidence from scientific studies in order to provide informative, empirical answers to scientific research questions” (p. 42). Most writing in psychotherapy is qualitative rather than quantitative. Mohammed (2002, p. 44) points out that "psychotherapy is an intervention that combines both scientific and artistic principles: it focuses on the intricacies of practice". By necessity contemporary sciences such as psychotherapy, have their own research methodology (Leuzinger-Bohleber, 2002) due to the subjective nature of the clinical work as experienced and understood by both the client and the therapist. It is the work within the relationship that produces change and therefore is difficult to measure quantitatively (Hinshelwood, 2002). This dissertation explores and explains the relationship between shame and suicide as presented by many authors who use a qualitative research framework.

The research questions

- 1) What is the role of shame in suicidality?
- 2) What are the clinical implications?

My process

As I began reviewing the literature on shame and attachment I noticed that suicide was frequently mentioned. Given my own relationship to both shame feelings and suicide, my interest was immediately sparked and that began this dissertation. Had I known then how difficult this would be in terms of my countertransference and identification I would not have pursued this but then again how could I not? Countertransference, transference, parallel processes and identification were all intensely present for me whilst reading for and writing this dissertation. Because this

is my lived experience, I often found myself depersonalized. I was anxious about feeling exposed and not being good enough to complete this work. And as is often experienced by people with chronic shame, my cognitive process often froze; the ability to form words coming from a shame experience was occasionally impossible. It is little wonder that this work has taken two years to complete. It has been even harder to include myself in the writing, as I have wanted to hide. Having said all of this, I have learnt so much about shame concepts, suicide and my work with clients and ultimately about myself. I have lived the process!

Selection and synthesis of material

I used key psychology and psychotherapy databases (refer Appendix 1 to view the databases and search words used) for searching. There is a massive supply of psychotherapeutic literature. My search criteria included all the articles that specifically related to suicide and shame in a psychotherapeutic context for individuals. Articles that focused on group therapy, or specific disorders were read for relevance but often excluded, as they did not meet search criteria. Articles that focused on child psychotherapy, suicide bombings, suicide due to terminal illness and those not written in English, were also excluded. From these abstracts, articles were selected and if not available online from AUT, were ordered via interloan. I also hand-searched journals and books in the AUT library. Many valuable leads came from references listed in the main articles and from books on the topics. I was also alerted to articles and authors by my supervisors, colleagues, and peers who were researching their own dissertations.

Due to the nature of my narrowed search an obvious limitation of this study is that I specifically focussed only on shame and suicide connections and relationships. I did not refer to articles specifically relating to guilt and suicide, depression and suicide or anger and suicide to name but a few of the multitude of emotions that exist in this complex topic. This is the particular slant of this dissertation, as I wanted to highlight that there is a significant correlation between shame and suicide.

Given that I have not had the experience of a client having suicided, I gained permission from the School of Psychotherapy to use Kurt Cobain as an example to demonstrate what I believe to be the connection between shame and suicide.

Chapter Three: The case of Kurt Cobain

There are many examples in the literature that illustrates the subtle and hidden connection between shame and suicide. I have chosen the experience of Kurt Cobain to demonstrate the link. As he was a well-known figure, much has been written about him and his suicide experience. Furthermore his own published journals, the songs he wrote, interviews with him as well as his suicide note were available to analyze.

The fault, the blame, the shame

Kurt Cobain was the lead singer of the successful grunge rock band "Nirvana". On April 8th, 1994 he completed suicide, aged 27 using a gun (Manchip, 1994). It is generally thought that "All Apologies" (1993a), being the last song he wrote for his last album, was his suicide song; it describes in part his shameful feelings about himself.

All Apologies

What else should I be

All apologies

What else could I say

Everyone is gay

What else could I write

I don't have the right

What else should I be

All apologies

In the sun

In the sun I feel as one

In the sun

In the sun

I'm married

buried

I wish I was like you

Easily amused

Find my nest of salt

*Everything is my fault
I'll take all the blame
Aqua seafoam shame
Sunburn with freezerburn
Choking on the ashes of her enemy
All in all is all we all are*

It is possible that Kurt Cobain developed a core sense of shame from an early age. Kurt's lack of interest in anything macho caused his father to beat him and treat him with humiliation (Wright, 1994). Preoccupied as a parent, his father bottled up his emotions and then inevitably frustrated, he would erupt at his family. He would "shame Kurt verbally and often slap or rap him on the head. Nothing the boy ever did was quite good enough for him. Kurt just did not measure up" (p. 57). Wright mentions that Kurt's precocious perceptions as a child "frightened" (p. 56) his mother. It must have been very frightening and disturbing for the young Kurt to know that he was frightening to his mother.

As a child Kurt was diagnosed as hyperactive and given Ritalin (Jobes, Berman, O Carroll, Eastgard, & Knickmeyer, 1996) during the day and sedatives to sleep during the night, creating within himself the belief that he was a problem child who needed drugs. At the age of eight (Jobes et al., 1996; Manchip, 1994), Kurt's parents divorced and fought over the custody of their children, Kurt being the eldest (Jobes et al., 1996). He began to noticeably "withdraw; his mood turned sullen" (Wright, 1994, p. 57). Becoming increasingly angry he lived with his mother for a year and then, unable to deal with Kurt, she sent him to his father where he was made to participate in wrestling, baseball and hunting, none of which Kurt wanted to do. "Feelings of shame and unworthiness engulfed him, never to disappear entirely. He got angry and stayed angry" (Wright, 1994, p. 57). Eventually his father gave up on him too, and Kurt was sent to live with a succession of aunts and uncles. In adolescence he became a drug addict (Jobes et al., 1996).

It appears that Kurt's father rejected who he fundamentally was as a person, and he felt he was abandoned by his mother and important others when he didn't measure up. The questions Kurt poses in his song "All Apologies" (Cobain, 1993a) suggest

that this wounding was never resolved for him. "What else should I be ... what else could I say ... what else could I write?" all reflect on his core sense of a shamed self. Trying to please everyone else, he was unable to please himself, never feeling good enough (e.g. "I wish I was like you"), never knowing who he was. Ambivalence haunted him and his talent was seen as either "a blessing or a curse" (Wright, 1994, p. 55). He experienced the public interest in himself as an intrusion, "the psychic equivalent of rape" (p. 56) and the demands of fame caused Kurt to become more isolated.

Raging anger was always with him and this was most often expressed in his lyrics, his singing style and his voice. The rage he experienced from childhood protected his vulnerable core and masked his sense of shame, serving both as a manic and a depressive defense. Broucek states that (1991, p. 5) "shame is also intimately involved in complex affective states such as rage, envy, despair, hopelessness, contempt, vanity, conceit, ambition, pride, and ruthlessness. Shame and defenses against shame have been implicated as playing crucial roles in various conditions as depression, manic-depressive illness". Interestingly, Kurt had an undiagnosed chronic stomach complaint (Jobes et al., 1996; Manchip, 1994), which may have been a psychosomatic symptom of his rage. His suicide note (see Appendix 2) reflected his anger with himself (e.g. "The sad little, sensitive, unappreciative, Pisces, Jesus man. Why don't you just enjoy it? I don't know") and with others (e.g. "I've become hateful towards all humans in general").

Drugged with heroin and valium (Jobes et al., 1996) at the time of the suicide, his anger and ambivalence is again apparent as he writes in his suicide note of both his hate and love for humans (e.g. "only because I love and feel sorry for people too much I guess"). His despair and thoughts of suicide seem to arise from an endless spiral of unacknowledged shame and rage. The words in "All Apologies" "aqua seafoam shame" reflect the sense that he is covered with shame, just as the turbulent sea is covered with foam; both the sea and he were unable to remove either the foam or the shame.

In his note, he wrote of being unable to experience his success as 100% fun, and of feeling unable to fool people anymore and unable to fake it. This describes the experience of someone with a core sense of shame who has to hide their real self from others eyes, believing that they can only be accepted by adapting to what others need them to be. It's as if Kurt no longer had the energy to hide and his terror of being found out, maybe of Kurt finding out what is wrong with himself too, was overwhelming. "At 27 years old, Kurt Cobain wanted to disappear, to erase himself, to become nothing" (DeCurtis, 1994, p. 30).

Kurt's daughter reminded him of his innocent days and he seemed terrified that his shame was contagious. He writes, "I can't stand the thought of Frances becoming the miserable, self-destructive, death rocker that I've become," and also "Please keep going Courtney [his wife], for Frances. For her life, which will be so much happier without me". DeCurtis (1994, p. 30) wrote, "He sought purpose in fatherhood. He wanted to soothe in his daughter, Frances Bean, his own primal fears of abandonment. He managed, finally, only to perpetuate them".

Written accounts of Kurt Cobain's life mention attempts at drug rehabilitation (which he stayed at for two days (Jobes et al., 1996)) but there is no mention of any professional psychiatric help in his later years. There is very little mention of his depression (Manchip, 1994). It is tragic that Kurt found through his music an ability to voice his anger, depression, despair and shame and even his suicidal ideation, yet he was still unable to accept the help he needed. The agony and pain that he must have felt with the experience exposing himself yet still not being heard and seen seems intolerable. Kurt once described himself in a MTV interview as "a man tortured with a private, internal pain" (Muto, 1995, p. 74). He had already made a suicide attempt less than a month before his death on March 14th using champagne and tranquilizers (Jobes et al., 1996). This was reported as an accident to the public. Then two days later he locked himself in a room with guns and the police were called (Jobes et al., 1996). His songs screamed his pain. How loud did he have to be?

Wright (1994, p. 63) states that,

From the very beginning, the external circumstances of Kurt's life predisposed him toward this path, if only as a survival tactic to try to retain even the meanest sense of self ... finally, when his own ground became too painfully untenable, he said no to his wife, to his daughter, to life itself.

Suicide is a subject that is developed in many things Kurt wrote and it becomes an obvious theme in his song "I Hate Myself and I Want to Die" (recorded but not included on any album). Fish (1995) states that whilst Kurt publicly stated this was a satirical song, "analysis of the lyrics reveals so many references to violence in general, and suicide in particular that perhaps this statement was closer to the truth than Cobain led his listeners to believe" (p. 92). In his song "Milk It" (Cobain, 1993b) Kurt writes that "on the bright side there is suicide", giving a sense that suicide was always a solution to escape the inner torment. Three of Kurt's uncles had also suicided (Manchip, 1994). Rather than the perceived choice suicide seemed, I suggest that suicide became for Kurt the only solution for getting rid of an unbearable, irreparable sense of a bad, shamed self, the ultimate hide-away from the public eyes.

Jobes et al. (1996, p.264) conclude their article stating "his suicide forces us to wonder how we can better reach and intervene successfully in the lives of these suicides-about-to-happen. His death continues to describe our failures".

These questions motivate this dissertation too. The next chapters provide a theoretical foundation on both shame and suicide. The literature that links the shame and suicide connection is reviewed, and clinical implications are considered. Had Kurt been able to accept the help offered, how might a psychotherapist have worked with him and what would they need to be aware of?

Chapter Four: Shame - towards a definition.

This chapter introduces the concept of shame. First shame is described phenomenologically. Second the important differences between concepts of shame and guilt are discussed, as they should not be used interchangeably. Third, a brief developmental history of concepts of shame follows and finally definitions from various authors are presented culminating in a working definition for this dissertation. This is provided as a basis for Chapter Six that systematically reviews the literature that exists on the relationship between feeling shame and feeling suicidal.

Phenomenology

Shame is a difficult phenomenon to describe given that it is often an experience in which cognitive ability becomes confused, a person becomes disorientated, their behaviour is disrupted (Crowe, 2004a; Lewis, 1992) and continuity and coherence are sacrificed (Pines, 1995). Kaufman (1980) describes how language is lost when shame is unmasked, "exposure ... eradicates the words, thereby causing shame to be almost incommunicable to others ... however much we long to approach, to voice the inner pain and need, we feel immobilized, trapped, and alone in the ambivalence of shame" (p. 9). Shame forms from the exposure of difference and implies judgement and exclusion (Crowe, 2004a).

Shame is more often observed by behaviour rather than words. Typically the head is hung down, eyes are averted as sustained eye contact is intolerable and spontaneous movement is interrupted, speech is silenced, and blushing can occur. Kaufman (1980, p. 12) states that "to live with shame is to feel alienated and defeated, never quite good enough to belong...the deficiency lies within ourselves alone".

Mollon (2002, p. 23) depicts shame as:

A hole where our connection to others should be ... and in the deepest depths of shame we fall into a limbo where there are no words but only silence. In this no-place there are no eyes to see us, for the others have averted their gaze - no-one wishes to see the dread that has no name.

When others find shame aversive to witness, this of course redoubles one's isolation.

With shame there is a strong urge to hide, a desire to escape. There is a need to protect the self from the feeling of profound shame-induced inadequacy and its subsequent exposure, either to the self or to others. Shame can become all-consuming, taking over the senses and resulting in the inability to take in new information (Hastings, Northman, & Tangney, 2000; Lewis, 1992; Pines, 1995; Underland-Rosow, 1995).

The distinction between shame and guilt

The terms 'shame' and 'guilt' have been inconsistently used historically, and are sometimes used interchangeably in psychological literature. This makes the two emotions indistinguishable. The well-known psychoanalytic dictionary by Laplanche & Pontalis (1973) does not even separate shame from guilt; rather it includes shame within a definition of guilt.

It is important to distinguish between the two, as they are not synonymous.

The experience of shame is directly about the *self*, which is the focus of evaluation. In guilt, the self is not the central object of negative evaluation, but rather the *thing* done or undone is the focus. In guilt, the self is negatively evaluated in connection with something but is not itself the focus of the experience. (Lewis, 1971, p. 30)

Recent research (Tangney, Wagner, & Gramzow, 1992; Tangney, 1996) which studied shame and guilt has made explicit an important distinction between the two. They found that shame, not guilt, was related to a wide range of psychopathology indicators (including depression, anxiety and hostility). Table 1 usefully shows the important similarities and differences between them.

Table 1:

Key similarities and differences between shame and guilt

Features shared by shame and guilt		
• Both fall into the class of "moral" emotions		
• Both are "self-conscious", self-referential emotions		
• Both are negatively valanced emotions		
• Both involve internal attributions of one sort or another		
• Both are typically experienced in interpersonal contexts		
• The negative events that give rise to shame and guilt are highly similar (frequently involving moral failures or transgressions)		
Key dimensions on which shame and guilt differ		
	Shame	Guilt
Focus of evaluation	Global self: " <i>I</i> did that horrible thing"	Specific behavior: " <i>I did</i> that horrible <i>thing</i> "
Degree of distress	Generally more painful than guilt	Generally less painful than shame
Phenomenological experience	Shrinking, feeling small, feeling worthless, powerless	Tension, remorse, regret
Operation of 'self'	Self 'split' into observing and observed selves	Unified self intact
Impact on 'self'	Self impaired by global devaluation	Self unimpaired by global devaluation
Concern vis-à-vis the other	Concern with others' evaluation of self	Concern with one's effect on others
Counterfactual processes	Mentally undoing some aspect of the self	Mentally undoing some aspect of behavior
Motivational features	Desire to hide, escape or strike back	Desire to confess, apologize, or repair

Tangney and Dearing (2002, p. 25).

Historical overview

The subject of shame has received surprisingly late attention in the psychotherapeutic world (Archer, 2002; Broucek, 1991; Kaufman, 1989). Only in the last 20 years has research and theory grown on this topic (Gilbert & Andrews, 1998). The following is a brief summary of the history of shame as a concept.

Let me begin with Darwin's (1873) account of shame. He wrote that involuntary act of blushing cannot be caused by an action of the body, rather it is the mind that is affected. Darwin describes how he noticed blushing in a one-year-old infant, and how women blush more than men do. He states:

The habit of turning away, or lowering his eyes, or restlessly moving them from side to side, so general with every one who feels ashamed, probably follows from the conviction that he is being intently regarded; and he endeavours, by not looking at those present, and especially not at their eyes, momentarily to escape from this painful conviction. (Darwin, 1873p. 159)

Freud describes shame as "fear of other people knowing about it" (1886-1899, p. 224). In 1905 he believed that a person's fundamental state is shameless and that shame is "reactive, inhibitory, and prohibitive and in opposition to the pleasure principle" (Broucek, 1991, p. 11).

Erikson described shame and self-doubt as the negative emotional outcome that occurs when a child (aged between 18 months and 3 years) sense of autonomy is damaged during the second phase of development (Erikson, 1965). This phase, if unsuccessfully completed, can lead to the development of shame and doubt because an integral developmental task "is the ability to perceive oneself as an object that involves having consciousness of the way one's own person is received from an outside perspective" (Crowe, 2004a, p. 330).

The reemergence of shame as a "central focus of psychoanalytic thinking" (Lansky, 1995, p. 1081) was led by H.B. Lewis in 1971 who uses experimental

studies to understand how shame is different from guilt. An important contribution that Lewis made was to distinguish between overt acknowledged shame, overt unidentified shame and bypassed shame. In overt unidentified shame a person might be in a state of self-hatred but does not acknowledge the affect of shame, and in bypassed shame the person is not overwhelmed in shame feeling but is clearly dealing with shaming events (Broucek, 1991). Lewis says that the shame affect is a "relatively wordless state" (Lewis, 1971, p. 37) and describes how the subject of shame is either engulfed wordlessly by the experience of shame, or else evades the affective side by taking up an observer position, thus protecting the self.

An argument for shame developing early in life came from Broucek (1991). Self-objectification emerges between the 18th and 24th month of life and Broucek sees it as fundamental precondition for the experience of shame. Miller (1989) states that Broucek linked facial recognition of the mother to shame, stating that the shame experience is dependent on the internal disturbance experienced when the communication-ready infant finds that the mother does not warmly respond to his or her affect. This is equivalent to feeling disregarded, rejected, and devalued. It might be that the mother does not actively seek to shame her child; rather she might not meet the child because she is depressed for example. Mollon (2002, p. 124) states that "even when the creation of shame was not the intention, we can feel this through the failures of connection and empathic attunement in our childhood interactions with parents or other care-givers".

Lewis (1992), a developmental psychologist, drawing on the attachment theory of Bowlby, sees shame as a secondary emotion because it involves self-reference (as opposed to primary emotions which do not). This capacity emerges in the second year of life.

Similarly, Schore (1991) argues that shame arises from "early child-parent interactions in which the child experience's a failure in parental attunement. Instead of finding shared joy in the experience of achievement, the child experience's the parent as a deflating stimulus/object" (Gilbert, Pehl, & Allan, 1994, p. 24).

More recently, Ayers (2003) writes of "the eyes of shame", stating that the world is full of eyes and the point of anguish and despair in the inner world of shame is this element of exposure. She describes absolute shame as evolving from an experience of mother's eyes during the holding phase of psychological development and as a result she identifies shame as a core affect in psychotic anxieties. Eye contact that is hollow, dead, mechanical or envious at an infant's earliest stage forms the internal object relationship that generates pathological shame.

In their classic monograph Piers & Singer (1953) study the difference between shame and guilt. They suggest that shame reflected a reaction to the conflict between ego and ego-ideal. They observed that shame was to do with failure and the unconscious threat of abandonment (Broucek, 1991; Seidler, 2000; Tangney & Dearing, 2002).

Morrison (1989) expands on the ideas of Piers & Singer and translates these ideas into self-psychology language. He writes of a 'self' experiencing itself as deficient and inadequate that is central to the manifestation of shame (Seidler, 2000). Shame reflects severe tension between the self and the ideal self (Broucek, 1991). Kohut (1971; 1978) proposes that shame-proneness originates from serious defects in the self-structure that prevents a firm sense of cohesiveness and self-esteem. Shame and rage conflicts arise following an empathic break or failure in self-object functioning when infantile grandiosity has emerged in an attempt to gain affirming and admiring responses. This is to offset developmental failure in the area of ideals and standards (Lansky, 1995) where there is conflict between the ideal self-image and the apparent self noted by introspection and observation (Kinston, 1983, p. 214).

Tomkins (1963) was one of the first modern theorists to propose that shame was an innate affect with its own facial display pattern (Gilbert & Andrews, 1998)..He based this on a theory of affects, rather than on a drive theory. Tomkins stated that "shame operates only after interest or enjoyment has been activated; it inhibits one, or the other or, both" (Tomkins, 1963, p. 143). Levin (1967) too proposed that shame is a signal affect that serves as a protective function from rejection that might come when the self is overexposed (Broucek, 1991).

Kaufman (1989) developed Tomkins' affect theory. For Kaufman, the shame affect manifests itself when an 'interpersonal' bridge is broken. He views this experience as both alienating and rupturing, being difficult to express in words. Seidler states that Kaufman views the shame affect as "fundamental to an understanding of repression mechanisms" (2000, p. 105) in that the concept of defense mechanisms are replaced with 'defending scripts', organized around the shame affect, functioning to "predict and control scenes of shame" (1989, p. 104).

Nathanson (1987, 1992), also influenced by Tomkins affect theory, rejects the concept of drives and views shame as the "polar opposite" of pride, stating that "where pride allows us to affiliate with others, shame makes us isolate ourselves from them" (Nathanson, 1992, p. 86). Nathanson suggests that the painfulness felt in the shame affect is proportional to the pleasure felt by the positive affect it has disturbed.

Wurmser (1981) approached shame empirically, differentiating it by how it related to time: shame anxiety, in anticipation of something imminent; shame proper, as a reaction to something that has already happened; and shame attitude, a reaction formation designed to prevent the other two. Wurmser notes that the conflict underlying the shame constellation is related to power and powerlessness because "shame guards the boundary of privacy and intimacy while guilt limits the expansion of power" (Kaufman, 1989, p. 11).

Tangney (1991) found that shame-prone individuals had more pervasive difficulties in interpersonal relations, such as impaired empathy, externalizing blame, and frequent bursts of anger and hostility (Lester, 1997).

A working definition of shame

Having described what shame feels like and how the concept developed, various definitions from the literature follow, and I will conclude with an overarching definition of shame that will be applied throughout the remainder of the study. Defining shame is complex and there is enormous diversity as it is often implicitly assumed that shame means the same thing to everyone (Pattison, 2000; Seidler, 2000).

The word shame derives from notions of covering and concealing:

The word shame is derived from a Germanic root *skam/skem* ... with the meaning 'sense of shame, being shamed, disgrace (Schande).' It is traced back to the Indo-European root *kam/kem*: 'to cover, to veil, to hide.' The prefixed *s* (*skam*) adds the reflexive meaning 'to cover oneself.' The notion of *hiding* is intrinsic to and inseparable from the concept of shame. (Wurmser, 1981, p. 29)

A psychoanalytic view of shame is offered by Lansky (1995, p. 6) who states that it can be a mixture of:

shame as signal of danger to the sense of self among others (the superego anxiety), shame as defense (modesty or humility, the obverse of shamelessness), and shame as the searing anguish resulting from exposure as having failed or as being unlovable and deserving rejection or inferior status (the emotion).

Similarly for Pattison (2000, p. 181-182) there are different types of shame. He describes six different types of shame. The first is "ontological" which relates to being human, limited and mortal. The second is "healthy" shame, which helps to mark and maintain boundaries. The third is "acute" shame, which is short-lived and acts as a warning or communication to self and others. The fourth is "chronic" shame, which can be dysfunctional. "Social" shame is the fifth type, which can be engendered socially, and finally "psychological" shame, which is experienced as a condition of individual psychological emotion. Pattison best understands shame to be "toxic unwantedness" (p. 181).

Shreve & Kunkel (1991) again differentiate shame but for them it is between primary shame and secondary shame. Primary shame involves:

(a) experiencing or anticipating a painful awareness of oneself as an object of observation by others, (b) relating this awareness to a self-perceived shortcoming of the self ... (c) believing that others have or will have a negative reaction to what is exposed, and (d) a consequent wishing to withdraw or hide oneself. (p. 307)

Secondary shame specifically relates to a person's awareness of their tendency to experience shame and "derivatives such as shyness, grandiosity, and social withdrawal" (Shreve & Kunkel, 1991, p. 307).

For Kaufman (1980, p. 8) it is the magnitude of shame that he highlights. He states that shame is "the affect of indignity, of defeat, of transgression, of inferiority, and of alienation . . . shame is felt as an inner torment, a sickness of the soul". According to Kaufman shame begins primarily in significant early relationships and then becomes internalized within the self so that even without an interpersonal event, shame can be activated. He states that "shame lies hidden behind inaccurate words, symbols that fail to grasp the inner experience of the self" (1980, p. 7).

Finally, shame is considered to be a developmentally younger emotion than guilt (Lester, 1997) that unfolds in the second year, a time when a sense of self is being formed (Crowe, 2004a). Lacan describes "the mirror-stage [where] the infant realizes that she or he is a separate person and begins to understand emotional messages sent to him and learns to feel shamed when others are displeased" (cited in Crowe, 2004a, p. 330). Mollon (2002) describes a fundamental sense of inadequacy which may be felt by the small child who fails to evoke an empathic response from the mother. When an expected facial response is absent this can be disturbing and bring about a primitive shame response.

The working definition used in this dissertation is that shame is an experience of wanting to hide, of feeling worthless, alienated and isolated which has early developmental origins (Ayers, 2003; Crowe, 2004b; Erikson, 1965; Fonagy, 2001; Lewis, 1992; Spiegel, Severino, & Morrison, 2000). Unlike guilt, with which it is often confused, shame is about perceived defects of one's self rather than about one's acts. Shame is difficult to articulate, and is hard to bear and to witness; it can play a malignant role in a person's life.

I have deliberately spent some time elaborating shame precisely because it is an emotion that tends to hide its face. The following chapter introduces suicide, sometimes the final consequence of shame.

Chapter Five: Suicide

Having developed a working definition of shame it is now pertinent to briefly examine suicide. Four theorists are discussed and the Ministry of Health guidelines are included depicting what the New Zealand government believe the causes of suicide to be. New Zealand suicide statistics are presented in Appendix 3.

Understanding suicide is complicated, the "answer is neither simple nor singular" (Mokros, 1995, p. 2). Each suicidal attempt and death is a diverse event that encompasses biological, biochemical, and cultural, sociological, interpersonal, intrapsychic, logical, philosophical, conscious, and unconscious elements. Culturally, suicidal ideation remains a taboo subject (Shea, 2004). It has been the "taboo subtext to our successes and our happiness" (Shneidman, 1996, p. 3). Today, suicide is associated with shame, uneasiness and guilt for all concerned, making it difficult to address the problem openly and scientifically (Wasserman, 2001). Difficult feelings of fear and aversion are common and understandable for family and friends as well as health professionals. These feelings create a desire to avoid the complex and often tortuous inner world of pain and suffering. Therefore, aversion towards these feelings means that people become "distanced from aspects of other people's lives that we don't understand, but reject those parts of our own lives as well" (Heckler, 1994, p. xxv).

Wasserman (2001) presents suicide as being caused by feelings not facts. People may think that suicide is an expression of control, yet most suicidal acts occur when a situation makes life seem unbearable and everything is understood to be out of reach of the individual's control. Some people who are emotionally distressed can know that suicide is an option but never go beyond that contemplation. For others, however, suicide becomes a viable option to put a stop to the level of distress they are experiencing. These people experience the "penetrating hopelessness - the loss of faith - that leads one to suicide" (Heckler, 1994, p. xxii).

Philosophically, it could be debated that there is an alternate choice or option in suicide and suicide is controlling, yet experientially it does not feel like this for the suicidal person. Options and choices narrow and fall away until it feels as if there is nothing else left for that person to do. The suicidal person already feels dead inside and death may just be the physical solution.

Alternatively, people with a chronic sense of shame who believe that they are fundamentally bad, may consider suicide because they do not want to live; they experience their life as a mistake. Whilst there is always the aspect of ending pain it may be not so much about this but more a matter of putting things right and healing oneself.

There are alternative perspectives that suicide can be about facts, a way of making social or political statements or protests not connected to shame. However, this dissertation only focuses on the potential link between shame and suicide.

I will now briefly review the social integration hypothesis of Durkheim (1897). An overview of a later sociological theory proposed by Henry & Short (1954) is given. Freud's (1916-1917) contribution is acknowledged and finally Shneidman's (1996) definition of 'psychache' is presented.

Social integration hypothesis

The work of Emile Durkheim in the late 1800s began a long tradition of sociological and epidemiological studies on suicidal behaviour, directly linking social exclusion and suicide. According to Durkheim (1897), people need moral regulation from society to manage their own needs and aspirations. Anomie, a sense of normlessness, lack of social control, and alienation can lead to suicide when basic social needs are not met. He showed that suicide rates are highest among people who are not well integrated into society as a whole. He thought there were four types of suicide - altruistic, egoistic, anomic, and fatalistic. He referred to feelings of shame as a contributor to 'anomic' suicide. Hastings, Northman, & Tangney (2000, p. 70) define this as "a result from a sudden and unexpected change (typically a negative change) in social position with which the individual was unable to cope".

I notice that this literature is more than 100 years old. It needs to be said that society as a whole has changed, an exploration of which exceeds the scope of this study. However, it should equally be noted that the theory of social regulation still appears valid.

A sociological theory of suicide

Baumeister (1990) and Lester (2003) both discuss a sociological theory of suicide proposed by Henry & Short (1954). Henry & Short assumed that the basic and primary response to frustration is aggression towards the other rather than the self. When there is an external event and restraint for which responsibility can be attributed and shared other-orientated aggression is justified. When the "external restraints are weak, the self must bear responsibility for the frustration generated, and other-orientated aggression is not legitimized" (Lester, 2003, p. 1165). Studies by Lester supported the hypothesis that,

when external conditions are bad, we have a clear source to blame for our own misery and this directs anger outward rather than inward.

When times are good, there is no clear external source of blame for our misery and so we are more likely to direct our anger inward.

(Lester, 2003, p. 1165)

Research shows increased suicide rates after war, after winter and after divorce. (Baumeister, 1990; Lester, 2003) Thus, Baumeister and Lester attribute suicide to internalisation rather than to external motives.

Freud

Freud (1916-1917) in describing a melancholic person, stated that their "propensity to suicide is made more intelligible if we consider that the patient's embitterment strikes with a single blow at his own ego and at the loved and hated object" (p. 427). Mokros (1995, p. 10) interprets this to mean,

in killing one's self, one is killing the punishing humiliating other.

Suicide is only possible, according to Freud, if one can treat one's self

as an object, an object against which it can direct the hostility it holds toward objects in the world.

Psychache

Shneidman (1996) argues that suicide is caused by a psychological pain he calls "*psychache*. Furthermore, this psychache stems from thwarted or distorted psychological *needs*" (p. 4). He defines psychache as the

hurt, anguish, or ache that takes hold in the mind. It is intrinsically psychological - the pain of excessively felt shame, guilt, fear, anxiety, loneliness, angst, dread of growing old or of dying badly. When psychache occurs, its introspective reality is undeniable. (p. 13)

Ministry of Health guidelines

Because of the complex nature of suicide, I have included what the New Zealand government believes to be the contributing factors as a background to the main review. Suicide statistics are presented in Appendix 3.

The New Zealand Ministry of Health report (2003, p.18) states that research has shown that several factors contribute to suicide:

1. Mental disorder, most commonly depression, appears to be the most important risk factor for suicide and suicide attempts.
2. Research from the Canterbury Suicide Project in Christchurch has found that young people who have died by suicide, or who have made a serious suicide attempt, often have shared circumstances, such as:
 - they have some underlying psychological distress or mental illness
 - they display some recognisable mental health or adjustment difficulty before the suicide attempt
 - immediately before the suicide attempt they may face a severe stress or life crisis that often centers around the breakdown of an emotional or supportive relationship

- they tend to come from disturbed or unhappy family and childhood backgrounds
 - They tend to come from socially and educationally disadvantaged backgrounds.
3. Research from this study also found that approximately 90 percent of people who die by suicide or make suicide attempts will have one or more recognisable psychiatric disorders at the time. The most common of these are: depression, substance-use disorders (alcohol, cannabis and other drug abuse) and significant behavioural problems.

Interestingly, it seems that from this report that people either suicide for an understandable outside event, or that they are mentally ill. It is important to note that the research in New Zealand is most often statistical, and suicide is usually approached from a medical model in which depression is most commonly attributed to be the cause. The psychodynamics of why a person is depressed receives little attention, and because shame is a feeling rather than a diagnosis, the relationship between shame and suicide is not even considered; it remains hidden.

Women attempt suicide more, men complete suicide more. Evidence suggests that this is about methods used (Ministry of Health, 2003) however I wonder if suicide and suicidality involve different character dynamics e.g. a suicide attempt could be an expression of anger and not be fatally intentional, or vice versa. In this study nonetheless suicide and suicidality have been conflated.

Whilst acknowledging the multifaceted elements in any suicide this dissertation considers that the feeling of shame is a pervasive contributing component of suicide. This systematic literature review will examine the existing literature on the connection between shame and suicide.

Chapter Six: The connection between shame and suicide.

Psychological distress can involve many internally generated emotions. The one I am choosing to examine is the feeling of shame. This chapter reviews the literature that links shame and suicide and arranges it according to the following themes: failure, family systems, bypassed shame, escape, the social bond, shame as the motivating dynamic, traumatic loss, loneliness, morbid and chronic shame.

Failure

In a study from 1954 to 1963 Breed (1972) interviewed survivors (family, friends and co-workers) of 264 completed suicides. Breed began to frame a series of questions that attempted to understand psychologically and sociologically what happened for people who committed suicide. He asked "what kind of people were they; what were their relationships with others; how did they relate to the society and its values; and why did they commit suicide?" (p. 6).

Over several years, he identified a five component syndrome that he believed was significantly correlated with the decision to commit suicide. The five components are a) commitment, b) rigidity, c) failure, d) shame, and e) isolation.

Breed defined shame as "response to failure in a major role" (p. 7). Again, on page 14, Breed states "failure clearly precedes shame". This varies substantially from my working definition of shame, pointedly in it's reference to discrete external events as a trigger for the experience of shame and then suicide; as opposed to the self potentially developing with a core sense of shame, being more susceptible to suicide. It seems that Breed's definitions of the other components cohere with aspects of my working model of shame, rather than requiring separation into independent components.

For example, Breed talks about the importance of self-esteem, and feelings of worthlessness under "commitment" (p. 7), stigma and self-exposure under "isolation" (p.8), and under "failure" talks about an inability for the individual to handle the negative reactions of others (p.6).

Breed states it was a problem attempting to accurately code the affect of those who suicided due to relying on other people's reports. For example, in examining the shame component, there was difficulty in coding item 18, because subjects were not "convinced they could discern such a private feeling as shame, even as to its 'possible' presence" (p.13). See Table 2.

Table 2:

Presence of "Basic Suicide Syndrome" Characteristics in 137 New Orleans Suicides, by Sex (Presented in Percentages)

Item	Shame	Male (N=52)	Female (N=85)
15	Low self-esteem (grades 3 & 4 on 4-point scale)	83	81
16	Depressed and felt worthless	83	78
17	Felt others 'labeled' him as failure, "took the attitude of the other"	64	44
18	Felt shame, from failure	37	32
19	Goals lost their meaning	98	37
20	Loss of hope	83	70

This highlights the complication that exists in identifying shame. It is as if felt shame is invisible, hidden and hard to see. Regardless, Breed concluded that suicide is the outcome of a negative progression of developing interpretations of self, as well as events, which slowly lead individuals to make a decision to commit suicide. Breed's findings are focused more on the external events preceding suicide. I suggest that shame is present in each of Breed's components, but this is not acknowledged.

Family systems perspective

Lansky (1991) examines shame dynamics in suicidal behaviour by viewing it from within a family systems perspective, arguing that this method is the beginning towards an "understanding of what the patient is fundamentally ashamed of, and why

the patient's narrative usually tends to be skewed toward a minimization of shame" (p. 232). This perspective views the suicidal person as someone whose significant attachment to an intimate other/s has been put in jeopardy. Thus, suicidal crises often result from exposure (or fear of exposure) of an individual's inability to form close relationships, or of feeling either over-controlled or abandoned by supportive significant others. Shame results from the "exposure ... of aspects of one's own makeup, that renders the patient for internal, not external, reasons feeling unlovable, destructive, unable to have or tolerate close relationships" (p. 232).

According to Lansky, emotional states such as depression, guilt, psychic pain, and anger are all secondary to the primary emotional state of shame. They are however often mistaken for being the primary states due to the hidden nature of shame.

Lansky states that suicidality results from feelings of shame over a depressive preoccupation rather than depression itself. "Patients are ashamed about being in a relationship burdened by their depression, very often because such a depression could not be tolerated early in life" (p. 233). Lewis (1992) also commented that whilst suicide is often attributed to depression, it can be a direct result of shame or an indirect consequence of rage turned inward. Guilt, according to Lansky, is often easier to conceptualize than shame and in a therapeutic setting shame is "a constant and real risk ... because formulations based solely on guilt tend to attribute more cohesion to the personality of the suicidal patient than is usually warranted" (1991, p. 233). Both Lansky and Shneidman refer to psychic pain, however Lansky proposes that, "the more common situation is that self absorption, defective ego strength, or failure to perform a generative family role produces shame that leads to suicidal feelings" (p. 233).

Finally, anger is frequently thought to be a source of suicidality. Closer examination uncovers that the "suicidal person is ashamed of dependent attachments and of being revealed and exposed as highly dependent on the person at whom he or she is so angry...[therefore] shame precedes the rage" (Lansky, 1991, p. 233).

This is reminiscent of Kohut's (1972) concept of narcissistic injury which then leads to narcissistic rage. Likewise, Trumbull (2003) addresses how shame ignited by

narcissistic injury can mobilize aggressive behaviour toward others, motivated by a need to restore the self.

Bypassed shame

Often feelings of shame are unacknowledged and bypassed by the suicidal person. Bypassed shame occurs when a person fails to acknowledge or feel their shame but rather responds with an "incessant, obsessive ideation about the role of the self in the shaming event" (Broucek, 1991, p. 7).

If shame is bypassed in an early infantile relationship, there is a predisposition towards a need to "require more coercive and more infantile bond formation in adulthood" (Lansky, 1991, p. 234). Shame occurs when these infantile methods of relationship, which develop to avoid shame, are exposed and become overwhelming. The bond then becomes more precarious and suicidality can result. It seems to me that Lansky highlights the vicious cycle where bypassed shame leads to conscious shame which can ultimately result in suicide if the shame is not attended to.

Lewis (1992) states that much of the effect of shame in psychic life occurs because of unacknowledged, repressed or bypassed shame, therefore the feeling of shame is "unavailable as an explanation for individuals attempting to account for their behaviour either to themselves or to others with whom they interact" (p. 120). One reaction to bypassed shame is the loss of self because shame can cause memory loss, due to cognitive failure. However, Scheff (1997) suggests that when shame is bypassed there is little feeling; rather the feeling is taken over by excessive thought or speech, and that the reverse is true for overt shame where there are lots of feeling and very little thought.

Lansky (1991, p. 234) warns us of two important treatment difficulties:

Firstly, whatever is repressed in the narrative is likely to be acted out in the treatment situation. And secondly, unacknowledged shame generated by the intensely ambivalent dependency within the treatment situation is likely to generate rageful or envious attack on the supportive relationship.

Escape

Suicide can be seen as an ultimate step in the effort to escape.

1. Escaping psychological distress

Shneidman (1996) asserts the presence of five clusters of unmet psychological needs, reflecting different kinds of psychological pain involved in suicide. These are thwarted love, fractured control, avoidance of shame, ruptured key relationships and the associated grief, and excessive anger, rage and hostility. He describes shame as coming from the frustrated needs of affiliation, defendance, and shame-avoidance, which assault the self-image. Avoidance of shame and associated feelings of defeat, humiliation and disgrace results in psychological pain. He argues that these five clusters all connect to the feelings generated by shame.

Viewing suicide as a function of social and psychological factors Shneidman (1968) claims that there are three types of suicide (egotic, dyadic and ageneratic). Shame feelings that predispose one to suicide are most common in dyadic suicides due to "interpersonal events that triggered deep-seated, unfulfilled wishes and needs ... which sparked strong negative reactions such as rage, rejection, shame and guilt" (Hastings et al., 2000, p. 71). Shneidman wrote that a highly suicidal state "is characterized by its transient quality, its pervasive ambivalence, and its dyadic nature" (1985, p. 234). Lester states that Shneidman defines the relationship between shame and suicide as the process of avoiding "humiliation. To quit embarrassing situations or to avoid conditions which may lead to belittlement, scorn, derision, or indifference of others" (1997, p. 178).

Shneidman (1996) believes that the goal of suicide is to achieve a "peace of mindlessness" (p. 159). He says that suicide is not about hostility, rage, destruction, withdrawal or depression. He believes, like Freud that it is rather a communication of intention. These "verbal and behavioural communications are often indirect, but audible if one has the ears and wits to hear them" (p. 135). It seems that a conflict exists where sharing the feelings of shame would help ease the pain except that the

nature of shame means others are avoided, and secondary shame, i.e. shame about shame, entrenches this avoidance of the topic.

Mokros (1995) believed that when feelings of shame become dysfunctional the meaningful experience of self is one of "desperate preoccupation with one's identity, one's sense of place, within a milieu of deeply experienced, at times intolerable, psychic pain. Suicide provides one solution by which a person perceives the possibility of escape from this condition of the self" (p. 7).

2. Escape from self

Baumeister (1990) elaborates on the 'escape theory' developed by Baechler (1979) stating that suicide is about an escape from the self; escaping "meaningful awareness of certain symbolic interpretations or implications about the self" (p. 33). He identifies six steps in a causal chain, beginning when events fall seriously short of standards and expectations. Negative affect is then generated when awareness is heightened of the self's inadequacies internally and the individual wants to escape from self-awareness and the associated affect. Cognitive deconstruction (constricted temporal focus, concrete thinking, immediate or proximal goals, cognitive rigidity, and rejection of meaning) is sought to help prevent meaningful self-awareness and emotion. "The deconstructed state brings irrationality and disinhibition, making drastic measures seem acceptable" (Baumeister, 1990, p. 2).

The main appeal of suicide, according to escape theory is that it offers oblivion. Death may seem preferable to the emotional suffering which may seem indefinite, and from the painful awareness of the self as deficient. "The long term implications of death have ceased to be considered because of the extreme short-term focus" (Baumeister, 1990, p. 8). Baumeister states that suicidal rates have been clearly associated with personal failure and inadequacies. Furthermore, awareness of inadequacy prevents self-love from providing a deterrent, hence: "termination of the self would ... be a much less valuable loss to the suicidal person, whose self is devalued, than to the normal person. The future is no precious treasure, and neither is the self" (1990, p. 34).

Shreve & Kunkel (1991) concur with the "escape" motivation for suicide. They report that mental health professionals are frequently finding that suicide, attempted suicide and suicidal ideation are thought of and acted upon as a method to escape the profound sense of shame; more so than the "traditional loss-depression-anger models of suicidal behaviour" (p. 307). They provide a conceptual framework utilizing a self-psychology perspective to understand the dynamics of adolescent suicide, using the four pathological syndromes of self-development identified by Kohut and Wolf (1978). These are 1) the understimulated self, 2) the fragmenting self, 3) the overstimulated self, and 4) the overburdened self. In each "shame is a possible result of the failure of defensive or compensatory maneuvers" (Shreve & Kunkel, 1991p. 308). People in all four groups fear exposure and all experience debilitating amounts of shame when exposed. For example, the understimulated self fears of the inner sense of emptiness, the fragmenting self fears of exposure of their lack of cohesion, the overstimulated self fears of exposure of their need for distance and the overburdened self fears of exposure of their inability to maintain internal emotional equilibrium.

Suicidal behaviour is viewed as an attempt to

cope with a perceived psychological loss and the resultant blow to the integrity and cohesiveness of the self ... [suicidal behavior] may be considered manifestations of integral feelings of shame, 'maladaptive' efforts to ameliorate the feelings of shame and prevent further deterioration of the sense of self, or as a last-ditch effort to defend against being overwhelmed by unwanted emotions. (Shreve & Kunkel, 1991, p. 309)

The social bond

Scheff (1990; 1997) and Retzinger (1991) developed the concept of the "social bond" (p. 4) based on the concept of attunement, mutual identification and understanding. A secure social bond means that the individuals involved identify with and understand each other" (Scheff, 1997, p. 76). There is balance between the viewpoint of self and other. Bonds are continually tested in interaction - being built,

maintained, repaired or damaged. Two threats to the social bond are when either the bond is too tight, meaning that relationships are engulfed or the bond is too loose, meaning that relationships are isolated. Engulfed relationships are when one person understands and embraces the view of the other at the expense of themselves. When the relationship is isolated there is mutual misunderstanding, or rejection. Scheff thought that suicide was a tragic conclusion to the disruptive influence of shame on social bonds and the attachment system.

On the same path, Mokros' (1995) study states that the preservation of secure social bonds is the central aim of human motivation. These bonds provide a sense of place, a sense of identity and are always "embedded within and concerned with the qualities of the social bond and the qualities of the self ... this investment of the self, in meaning making ... is first and foremost an affective, not cognitive experience" (p. 5). Mokros said that shame feelings help to regulate an awareness of "one's place and responsibility to the social bond" (p. 6) because of the experience of separation and distance from others and the need to socially reintegrate when shamed. For Mokros, the link of shame to suicide needs to be considered in relation to the regulatory function of shame and how when shame becomes dysfunctional "the individual experience's no sense of social place" (p. 7).

Mokros examined the general theory of human motivation proposed by Scheff (1990) who suggested a causal model of suicide in which there are three conditions that if met are likely to result in suicide. They are:

1. Experience of deep humiliation
2. The experience of the humiliation is not acknowledged by the self
3. There is no-one to turn to in adversity (i.e. no secure social bond)

Results from Mokros' study of two suicide notes indicated that another two conditions exist which need to be recognised. These are that:

1. The third stage of Scheff's model be expanded to include the self as unavailable to itself.

- By attending to identity it can be seen that for the suicidal person "suicide is a meaningful act that is capable of resolving the confused relationally grounded meaning of the self" (p11).
2. The psychological availability of suicide as a meaningful solution and the physical availability of a means to suicide.
- By recognizing that suicide is a means of escape from the inner turmoil and if the means to escape are locally available, "the context within which suicide is possible is complete" (p.11).

However, Lester (1997) critiqued Mokros's analysis stating that firstly it is not clear that shame motivated suicides involve the suppression and repression of shame. For example Lester says those who react with anger when humiliated and shamed are less inclined to attack the self in a suicidal act. Secondly, he states that viewing suicide as simply an escape from the self is not enough; it must be viewed as an escape from the other too. It should also be noted that two suicide notes do not provide the basis for generalisability, more evidence would be useful.

Shame as a motivating dynamic

Lester has published more than 1,900 (2003, p. 1170) scholarly articles and notes primarily on suicide and murder. Whilst he has no formal theory or conclusions to offer, he states that "shame has been implicated as the motivating dynamic for suicide in many groups and in many situations" (1997, p.4) and provides examples of groups such as unemployed, adolescents, those in prison, and gender differences. Lester also acknowledges cultural differences such as those in Japan, and he recognizes *whakamaa*, a New Zealand Maori concept that includes shame within its definition.

A case study written by Kalafat & Lester (2000) builds on Lester's (1997) review. 'Sarah' attempted suicide when she found that she was the last to know of her recently deceased husband's long term affair with another woman in the community. She had strong feelings of betrayal and anger, which masked her shame feelings. One important therapeutic goal included "a positive relationship that would provide a safe environment for dealing with the client's pain (shame) and loss" (2000, p. 159). Kalafat & Lester state that "for the therapist working with suicidal clients, the

uncovering of the role of shame may pose greater difficulty than uncovering the role of guilt. Shame seeks secrecy, and a failure to notice the client's shame may result in 'unexpected' suicidal behavior" (2000, p. 161).

Johnson, Danko, Huang, Park, Johnson, & Nagoshi, (1987) claim that shame, but not guilt, is associated with neuroticism. This was extended by Lester (1998) who applied identical measures in a study to examine whether shame and guilt are associated with suicidality. 38 male and 78 female undergraduate students (mean age of 21.9) completed the Johnson et al. shame and guilt scales as well as the Beck Depression Inventory, which has one measure of suicidality. In addition the participants were asked if they had ever contemplated or attempted suicide. Lester found that the association between shame and current suicidality was present for men but not for women and that guilt was not associated with current suicidality for either gender. Lester concluded that the "propensity for feelings of shame was a stronger correlate of suicidality than was propensity for feelings of guilt" (Lester, 1998, p. 2).

Hastings et al. (2000) examined the implications of shame and guilt for suicidal ideation by using data from two independent studies of college undergraduates, replicating the above analysis by Lester (1998). They found that a "dispositional tendency to experience shame across a range of situations was reliably linked to suicidal ideation as well as to overall depression scores" (2000, p. 73). They found little evidence for guilt, and stated that if anything, people with "shame-free guilt ... are less inclined toward suicidal thoughts and behaviors than their peers" (p.74).

So, both Lester (1998) and Hastings et al. (2000) found a correlation between shame and suicide. The studies differ in that Hastings et al. had a high number of women in their sample whereas Lester only found it to be true for men.

Another study using the Johnson et al. scale was conducted by Gilbert, Pehl, & Allan (1994). They explore the relation of shame and guilt to phenomenological experiences; to investigate the relation of shame to submissive behaviour; and to explore the relation of shame, guilt and submissive behaviour to measures of social anxiety and depression. Results confirmed that feelings of helplessness, anger at other, anger at self, inferiority and self-consciousness are "significantly correlated

with shame; self-consciousness being particularly high" (p. 31). It highlighted that shame is related to a variety of affects and cognition's. Gilbert et al. was surprised to find that total shame, which was measured with the Johnson et al. scale, did not correlate with depression, indicating perhaps that the scale is less sensitive to measures of psychopathology than shame scales used in other studies. They feel that from a clinical point of view, being aware of shame and distinguishing it from guilt is "important for treatment and transference relationships. The transference is likely to be different in shame-based difficulties" (p. 34).

In a study by Gilbert, Allan, & Goss (1996) the concept of affectionless-control i.e. low care and high control by the parent is studied. They state that in numerous studies the association between this concept and vulnerability to adolescent suicide has been linked. They note that there is growing evidence indicating that depression, social anxiety and other symptoms of psychological disturbance are related to problems associated with shame, often beginning in early childhood where parents, siblings and significant others "treated you as weak, incapable, unattractive, or bad" (p. 25).

A recent study examined 42 suicide notes. Finding that 74% of the suicide notes contained apology and shame themes, the authors suggest that the deceased may have welcomed alternative solutions to suicide for their problems (Foster, 2003).

One unanswered query is whether shame could have emerged as a primary response *to* the act of suicide, rather than as a motivating factor. Several of these studies could be subject to this same critique, as the evidence of suicide notes is subject to interpretation and complicated by the extreme affect that is possibly aroused prior to suicide.

Traumatic loss, extreme family dysfunction, and alienation

Whilst Heckler (1994) does not directly link the feeling of shame to suicidality in his writing, shame can be seen in the language he and the participants of his research use. Using participatory research he examined the events and experiences of "about fifty" (p. xvi) people who have recovered from a suicide attempt. Early unresolved pain compounded by present adversity was identified as a chief precursor to suicide.

Many of the participants link their early, unmourned experiences of loss and trauma (such as the death of a parent or sexual abuse) to their suicidality. Heckler (1994) defines the withdrawal of subjects from others, and the creation of a façade to cloak their suffering, a gradual withdrawal into the trance¹, as critical to subsequent suicidality. Shame would seem to be involved in the need for people to employ such a withdrawal, although anger could equally be implicated.

Many of the participant's accounts indicate that no-one was available who could see beneath the adaptive coping patterns to attend to the suffering being defended against. And, if such a person was available the suicidal person could not recognize this. Withdrawal, used as a form of protection, has two components. The first is either the flooding or numbing of emotion and physical sensation. The second involves a separation from the environment. The withdrawal (e.g. acting out, less communicative) or moving away makes them "become more removed, hiding their vulnerability and pain" (p. 37). I suggest that this withdrawal is a defense against the feeling of shame. Heckler states that signs of withdrawal can be as simple as little things being left unsaid and eyes which do not look up to meet your gaze - as we have seen, this is a common feature of shame. The following verbatim demonstrates the core experience of shame being described using other words e.g. hiding:

I had gone to a counsellor. One of the things he said to me - and this was very frightening to me - was that I had to learn to tell my own truth, no matter what the consequences. I felt an incredible amount of fear about saying or doing what I thought and felt and letting the chips fall where they may. It was terror. I was so afraid that if someone knew who I was I'd be left alone...I would see the two people I had become; the person I showed in therapy, in tremendous pain, but honest about it; and the person I showed to the world - pleasant, attending to others. Hiding. Every day, I would feel the real chasm between the two. Coming out of hiding meant facing the pain

¹ Heckler (1994, p. 50) defines the trance as "the moment at which the world becomes devoid of all possibilities except one: suicide". He claims that despite differences in details, everyone who attempts suicide enters into the suicidal trance.

throughout my life, and I just didn't want to go through it. (Heckler, 1994p. 40)

Following on from the withdrawal phase, the unaddressed turmoil intensifies and silent suffering is hidden by the projection of the image an individual portrays; "that image becomes a façade: a mask designed to hide the pain" (p. 44). Another verbatim demonstrates hidden shame and the mask:

There was something inside me that was just horrible or bad or needy or painful, and it didn't match the outside, because I'd always been so extroverted and everybody thought I was happy and normal and well-adjusted. (p. 43)

Hastings, Northman & Tangney (2000) claim that feelings of shame are more likely to result in suicidality than feelings of guilt. From a self-psychology point of view, suicidal behaviour results as a way of coping with the "perceived psychological loss inherent in shame and the resulting destruction to an individual's integrity and cohesiveness of the self" (Hastings et al., 2000, p. 70). They comment that the lack of research in this field may reflect how difficult it is to investigate shame when an individual has completed suicide.

Loneliness

Hassan (1995) reviewed 176 cases of suicide, defining eleven categories of affective experience, of which shame and guilt were one. This was defined as "a failure to meet obligations and or social expectations that result in a sense of disgrace" (Hastings et al., 2000, p. 74). Shame and guilt were found to be the main precipitant of 7% of the suicides, the majority of this group being middle aged men and older women. Other categories including 'sense of failure in life' and 'loneliness' were separate. According to Hassan, the most common cause of suicide was "a sense of failure in life" (p. 133). I suggest, based on the reading summarized above, that these latter categories could be accurately subsumed under the rubric of shame.

In Moir's (2001) book about New Zealanders and suicide, a central theme of loneliness and not belonging is highlighted. According to Moir "because suicidal people don't believe that anyone else experiences that gut-gnawing loneliness, they

don't share those feelings. Like suicide, loneliness is a taboo subject, something to be ashamed of" (2001, p.122).

Morbid shame

Feeling unloved and unappreciated and unable to live up to self imposed high standards and ideals creates a sense of what Wasserman (2001) refers to as 'morbid shame' in suicidal people. Even when suicidal people are loved, successful and good at what they do they may feel plagued by shame stemming from early self-esteem failures. Shame pervades their personality and arises when "their 'shortcomings' are laid bare by a situation of loss and/or offence" (p. 120). Wasserman states that this shame makes people want to be different and if it becomes impossible to reinvent themselves, suicidal impulses can become stronger as the desperate urge to wipe out part of the bad self, a finding strikingly similar to Breed (1972). Her research focuses on an interdisciplinary approach that elucidates psychodynamic, psychiatric and genetic aspects of suicidal behaviour. Wasserman states that the essence is how a person perceives a negative life event, rather than the occurrence of the event itself. With a limited problem solving capacity, certain people tend to react to such events with feelings of shame and hopelessness as well as guilt, hurt and anger. She too, strongly supports the concept of loss as a major stressor to suicide, as well as changes in life situation and trauma.

McWilliams (1994) writes of the defense "undoing" which means "the unconscious effort to counterbalance some affect - usually guilt or shame - with an attitude or behavior that will magically erase it" (p. 127). This is similar to the research findings of Wasserman (2001). It seems that a failure to be able to undo seems to be a prevalent disappointment.

Mollon (2002) notes that depressed clients often suffer from hidden shame. Suicidal preoccupations symbolize a desire to assert autonomy - "to retake possession of one's life by ending it" (p. 51). He describes a female client of his who was chronically depressed. Having never managed to separate from her mother she felt all her life that she had to be something for other people. Within the transference, his client felt that to become dependant on him would mean that she would be taken

over, losing autonomy. She viewed suicide as one way to avoid the hold of the other, maintaining her own self by asserting that her life belonged to her and she made several suicidal plans. In order to stop others from seeing her private life when she was dead she would destroy all her personal letters, possessions and anything with emotional meaning. Mollon interpreted this to mean "she wished to avoid the sense of shame associated with violation of her core self, even after death. She was engaged in a lifelong struggle to emerge from the shame-ridden state of being an object for the other" (p. 44). Alternatively, this could be seen as an *inability* to move away from primary symbiosis, since fantasized death could be experienced as a return to primary merger.

Chronic shame

Crowe (2004a) argued that shame is an "integral but neglected feature in the experiences of mental distress" (p. 335). She challenges the borderline personality disorder diagnosis believing it to be better described as a chronic shame response where the person feels that they will never be good enough in relation to others. Shame is difficult to verbalize because of the developmental period in which it develops, it is often experienced and revealed through the body and may "underlie ... actions of self-harm that are usually directed at the body" (p. 331). Suicidality, according to Crowe, occurs when "the other is needed for self-coherence. Abandonment means the re-internalization of the intolerable self-image and consequent destruction of the self. Suicide represents the fantasized destruction of this self-image" (2004a, p. 332).

Attachment

A brief word on attachment. Insecure attachment can arise when the importance of relatedness is denied because of the overwhelming fear of feeling shame. The self that is ruptured is preoccupied with painful shame feelings whilst at the same time being overwhelmed with concern about the other as "one who controls the self experience and well-being" (Spiegel et al., 2000, p. 3).

Security is paramount above all other psychological needs and the attachment bond is seen as "the starting point for survival" (Holmes, 2001, p. xii). Basic needs

when missing lead to adaptive coping skills. For some people, often those with a "secure attachment" (Karen, 1994), negative life events are difficult but a solid sense of self usually enables them to ask for help if needed. For others, those who experience chronic shame and are "insecurely attached" (Karen, 1994), negative life events prevent the satisfaction of these basic needs and may bring some people closer to suicide (Wasserman, 2001). I believe that this needs to be further researched.

Summary

This chapter is a modified systematic review of the literature pertaining to shame and suicide. I have established that a link exists and have highlighted its importance theoretically. A discussion follows which will draw this connection together. The following chapter will also cover clinical implications for those clients with chronic shame who may be suicidal.

Chapter Seven: Discussion and clinical implications

An overview of the findings of this study is discussed. Thereafter, a section is included giving a summary of the clinical implications. This chapter cannot be a complete guide to healing shame so I have chosen to highlight what I believe to be the most important aspects to consider and hold when working with clients who experience chronic shame and who may be at risk of suicide. Research recommendations are provided, concluding with a personal reflection.

Discussion

Feelings of shame can help to guide us to live moral and ethical lives. But core shame feelings are not useful when they become chronic, limiting one's essence and life force; it shapes a way of being and of relating to the self and to others that is dysfunctional. Chronic shame can become malignant, sometimes resulting in a premature death by suicide, as in the case of Kurt Cobain.

In psychotherapy the importance of shame has been relatively neglected until recently. An extensive amount of literature now exists on both suicide and shame but fewer articles link shame as a motivating dynamic in suicide. To some extent this can be understood because shame is often difficult to detect, shame has been and is often confused with guilt, and because it is so shameful to talk and write about shame. Of course it could also be argued that it is because the link is questionable. However, I do believe that this dissertation raises the distinct possibility, and provides substantial empirical and observational evidence that a link exists. The heart of the matter is the defective self implied in shame and the extinguishing of the self in suicide.

An early preverbal experience, there often can be no words to describe the shame experience and it remains hidden and silenced. A vicious cycle takes place where to alleviate the painful shame feelings requires identifying and talking about them yet to do so means exposure of vulnerability and risk of further shame feelings. Shame experiences are often not described specifically but are referred to metaphorically or symbolically; i.e.: "I just wish the ground would open up and swallow me" for

example and nonverbally such as with blushing, and a lowering of eyes and head. The emphasis is placed on the need to listen with the "third ear" (Reik, 1948).

Suicide too is a sensitive and taboo subject; to feel suicidal can in itself be shameful and so these ideations remain undisclosed. In many cases it is only after the suicide event that people even know that something was wrong and are left wondering what it was about. Rose (2004, p.1) writes that suicide is rarely the "singular, definitive act it appears to be". The difficulty, of course, in researching suicide is that people cannot be interviewed after they are dead. However there are always suicide notes and survivor narratives that seem to vividly depict scenes of shame.

My review of the existing literature goes further and shows that shame plays a key role in many suicides. Indeed, several authors referred to shame being a direct cause of suicide and if one were to analyze the terms used to describe the other causes, shame can be seen to contribute in the decision to commit suicide.

Unacknowledged and bypassed shame can be acted out in adult relationships, jeopardizing intimate relationships. Emotions such as rage and depression are secondary to shame, serving as defense mechanisms to bypass shame feelings, as these are so painful to feel. Fearing exposure of an empty, internal self, and of then being further shamed; one could suicide as a means of avoiding humiliation and embarrassment. This also enhances the feelings of loneliness.

Suicide can sometimes be merely the method of physically killing what is already experienced as dead inside. When death becomes preferable to the seemingly reality of endless suffering it is referred to as escaping from the self. Self love is what protects one from committing suicide, but for the suicidal person suffering from chronic shame there is no self-love, rather a feeling of despising and hating the self and all of its inadequacies.

Social bonds help us to understand the significance of being attuned to, understood and mutually identified with. When this has not been experienced enough, a chronic feeling of shame can result, with suicide bringing to an end the intolerable psychic pain. Freud (1886-1899) and others talk of not only killing oneself but the

introjected object as well because of a hatred for that object. It can be a hateful experience being constantly misattuned, unseen and unheard, suffering in silence.

Interestingly, empirical research supports the link between shame and suicidality, and not between guilt and suicide. So, it may be that when an external reason, which may provide meaning making, is not identifiable, suicide becomes one way of ameliorating bad and shameful feelings, of fixing the bad self.

Morbid shame, chronic shame, and toxic shame are terms that all relate to a childhood experience of feeling unloved and never good enough, fearing abandonment, loneliness and alienation. Shame can be misdiagnosed as depression, anxiety and borderline personality disorder, being recurrently neglected as a feature in mental illness. Suicide becomes a manifestation of a fantasy, where destruction of the negative self-image becomes the ultimate way to wipe out the bad self. Heckler (1994) warns us of the trance that preoccupies the suicidal person in the last days and hours when all that can be heard is the inner voice of death calling.

Clients who experience chronic shame rarely present in therapy stating that it is feelings of shame that impede on their intrapsychic and interpersonal relationships and create their difficulties in living. Bypassed and embedded in the anxious, false self they have become, the client is unable to recognize shame for what it is. Once a "real relationship" (Clarkson, 1995) has been established (which in itself may take years), the therapist gently introduces the concept of shame to them, providing a possibility of what their experience might be about. Psycho-education is useful here; it helps to provide a language to talk about these very difficult feelings. Knowledge can provide a cognitive and emotional reassurance for clients that they are not crazy. The therapist needs to acknowledge with clients that to talk about shame is shaming and that the therapist too can feel shamed. The importance must be emphasized that by going to these hard places healing will take place. Feelings of shame will never go away, given that the memory remains in the body and given that it is a key signal for human survival. However the literature surveyed in this dissertation suggests that an understanding and acceptance of this emotion detoxifies shame. As in Annie Lennox's (1992) song which states: "take this gilded cage of pain and set me free, take this overcoat of shame, it never did belong to me". So much energy is used

fighting against shame - being able to locate these feelings earlier means that a client will recover equilibrium more quickly, returning to a more solid sense of self and reality.

Clinical implications

Some feelings of shame are healthy in that they guide people to live within the moral standards and boundaries of our society, however it is the chronic shame experience which becomes pathological that I refer to when discussing clinical implications for the psychotherapist. Chronic shame is not easy to heal and being more vulnerable to psychological problems these clients are more likely to need long-term therapeutic treatment.

The heart of the healing will take place in the real therapeutic relationship with another vulnerable human being. Sometimes the client who experiences chronic shame will experience analytical interpretations, empathy or adequate mirroring as causing more shame (Ayers, 2003). Although it will be difficult, it is vital for the therapist to build a relationship of basic trust and this may take a long time because of the inherent mistrust and fear of exposure felt by people with chronic shame. This relationship needs to develop before beginning the work on the roots of shame (Pattison, 2000). What the client most needs at a core level is a real relationship where the importance of what "she feels, thinks, perceives or intuits ... become[s] real [so as] to exist in the face of another" (Ayers, 2003, p . 222).

Shame is a prominent, yet often hidden feeling for those people with suicidal ideation. Suicidal ideation is in itself a difficult and delicate issue to talk of, consequently shame and suicide together can be a ticking time bomb which could go off with very little warning if the psychotherapist does not facilitate a therapeutic environment in which it is safe for the client to disclose their feelings. Obviously, a therapist must attend to the suicidal thoughts and plans of a client first, paying attention to safety foremost. The key processes of engagement - forming a relationship and making a human connection, conveying acceptance and tolerance, and hearing and understanding (Cutcliffe & Barker, 2002) need to be activated.

However, once a client is no longer actively suicidal, exploring the sources of shame, as well as related low self-esteem and self-doubt, will be helpful for the individual in overcoming chronic shame (Hastings et al., 2000).

Morrison (1989, p. 191) states that an intervention should include

inquiry about, and identification of, shame and its manifestations (such as hidden secrets) and should be directed at uncovering and sharing the details of shame in the patient's immediate circumstances. Such an inquiry should form a part of the evaluation of suicide risk and, once that connection is established, concentration on shame should be part of the acute treatment of the suicidal patient.

Sometimes cognitive-behavioural approaches are helpful in treating suicidal clients who experience shame (Foster, 2003; Hastings et al., 2000). Identifying distortions in thinking (regarding global and intense self-blame), educating the client on the concept of generalization, and helping the client distinguish between judgments made regarding behaviour and self might make up part of the treatment plan.

Hastings, et al. (2000) state that considering shame as a predictor of suicide is only useful if this understanding can be applied to helping the suicidal client. Attention must be paid to examining underlying shame, often masked by depression, and rage. For suicidal clients experiencing intense shame Morrison (1996) suggests that reassurance is limited in its usefulness. He recommends a direct, problem-solving approach, with a specific focus on alternative plans, goals, lifestyles, and friendships - giving immediate tangible changes that offer hope and help. It is helpful for the therapist to draw attention to strengths and assets, reminding clients of past and present personal successes.

Identifying shame

Identifying shame has its own unique difficulties because it is often concealed, there is a paralysis of words because shame is often primitive and pre-verbal, it is

frequently assimilated and confused with guilt, and there is a tendency for the observer of shame to turn away from it.

Morrison (1989) believes that within clinical practice, suicide resulting as manifestation of shame, is still not appreciated as the danger that it is. He claims that the centrality of shame has been ignored, and proposes that by providing more attention to shame in the therapeutic work, suicide prevention may be more effective. Morrison stated that "where shame is deep and pronounced, especially when coupled with other indices of identified suicidal risk, the danger of suicide is strong" (p. 190). He believes that shame is solitary and internal, causing a need to "go into hiding, in order to wipe out their sense of unworthiness and disgrace" (p. 190).

Crowe (2004b, p. 337) identifies five behaviours or interactions that might indicate signs of shame:

- Descriptions of self are permeated with negative global evaluations.
- In the presence of others who might be evaluating them, a person may feel the need to hide or withdraw.
- Unreasonable hostility may be expressed towards others regarded as evaluating them. This is because the internal hostility might be so unbearable that it and blame are projected onto others.
- Expressions of a sense of powerlessness or worthlessness.
- Sensitive to the opinions of others.

Pattison (2000) highlights words that might be used by those with unacknowledged shame. For example those that relate to feeling alienated (e.g. dumped, estranged, deserted, rejected, rebuffed), feeling confused (e.g. stunned, empty, lost, aloof), feeling ridiculous (e.g. foolish, absurd, stupid, bizarre), feeling inadequate (e.g. helpless, weak, small, failure, worthless, impotent, oppressed), and feeling uncomfortable (e.g. tense, nervous, restless), or feeling hurt (e.g. wounded, tortured, dejected, defeated).

Sometimes shame needs to be named specifically by the therapist because it is often felt by the client who has no words to describe the experience, and avoidance

and denial can defend shame. It is not possible to address shame if its presence is unrecognized (Pattison, 2000). The therapist needs to understand the language of shame and to attend with their "third ear" (Reik, 1948) for words which may describe these feelings, listening and looking for non-verbal behaviour that may indicate the client's shame. For example,

there may be an abrupt interruption in a client's account of previous events, accompanied by signs of discomfort or agitation, nervous laughter, and/or downcast eyes. Other potential clues ... include gaze aversion, face touching, lip manipulation, and a slumped posture ... In addition the client may have difficulty articulating his or her experience of the moment. (Tangney & Dearing, 2002, p. 175)

Transference

This section by no means attempts to discuss all likely transference dynamics; rather it provides a brief overview.

A key to the therapeutic work with clients is to understand the transference (Pattison, 2000). Negative transference is likely to be scornful and humiliating of the therapist whilst the positive transference is one of idealizing the therapist and remaining in an inferior position to him or her. Clients may try to avoid a sense of shame by becoming more analytical than the therapist (Broucek, 1991). It is also important to distinguish between shame and guilt transference's as they are likely to be different: "shame involves more experiences of helplessness, inferiority, self-consciousness ... and possibly motivates more concealment and fear of negative evaluation from the therapist" (Gilbert et al., 1994, p. 34).

Commencing therapy is a experience that can easily in itself bring about increased shame (Broucek, 1991; Mollon, 2002; Pattison, 2000). Clients may feel awkward and ashamed about needing therapeutic help and it can be difficult for the client knowing that successful therapy will often require disclosure.

Therapist's own shame and countertransference

The "transferential/countertransferential relationship is the experience of unconscious wishes and fears transferred onto or into the therapeutic relationship" (Clarkson, 1995, p. 62). Countertransference reactions are an intrinsic process in psychotherapy and negative reactions can be subtle. Unrecognized shame reactions can be critical to the therapeutic relationship, inducing a desire from within the therapist to "deny these negative feelings, blame the client, or withdraw (emotionally or physically) from the therapeutic process" (Tangney & Dearing, 2002, p. 178). Being alert to their own transference and countertransference feelings of shame allows a therapist to be more effective in recognizing and working through feelings of shame with their client.

There are at least three ways in which 'therapist shame' presents itself. Firstly, therapists are vulnerable to their own painful experience's of shame, especially when their professional identity is generally regarded as being "warm, empathic, wise and effective" (Tangney & Dearing, 2002, p. 177). This may be questioned every session by clients who might be angry with their therapists in many shame-inducing ways. Therapists may feel shame at their own response, which for example might be to feel shame and/or anger - when they are presumably meant to feel positive regard.

Secondly, when confronted with therapeutic failure, feelings of shame may emerge. Shame feelings may be aroused by not being able to help the client, and by feeling that they are intruding into the client's privacy (Pattison, 2000). Shame-related symptoms may actually get worse by a lack of diagnosis (Lewis, 1971; Pattison, 2000). The "ultimate failure" (Tangney & Dearing, 2002, p. 179) is when a client suicides. Tangney & Dearing estimate that 15-51% of therapists have lost a client to suicide. Given that the skill of the therapist is judged by client progress; when outcomes are unfavorable, therapists may blame themselves.

As an aside, 'negative therapeutic reaction' is the term used for when clients fail to progress. Hahn (2004) addresses the role of shame in these reactions, stating that it is due to early interpersonal relationships where emotional misconnection frequently occurred. A need to conceal longing for emotional understanding and moderating a

sense of intrusive condemnation both serve as self-protective functions against being further shamed by the therapist. Negative therapeutic reactions express a sense of control and autonomy, yet this only enhances a sense of separateness when it is the affective attunement they most long for.

Defenses

It is important for the therapist to recognize chronic shame defense patterns since shame can be difficult to identify due to its hidden nature. Part of the therapeutic work is to help dismantle the defenses that have been built against recognizing the shame, commonly defended against because of its painful affect. Recognizing, of course, that defenses are not to be smashed down - they have served a protective function for many years. Amongst the use of many defenses involved in shamed clients, the following are named as most prominent. Pattison (2000, p. 156) states that

with defenses against further humiliation and rejection in place, any attempt to build interpersonal or social bridges may itself be perceived and treated as a threat to such sense of personhood and self-respect that an individual may still possess.

Nathanson (1992) and Pattison (2000) suggest that there are four common shame defense mechanisms: withdrawal, avoidance, attack of self and attack of others. 'Attack of self' if habitual can be destructive and distressing to observe. Pattison (2000, p. 111) states that the chronic 'attack self' response can be related to masochism and understood as "a creative solution to the infantile problem of trying to relate to a needed and powerful other". Wurmser (1981, p. xviii) understands masochism to be a form of acting out and says that it is "the need, usually compulsive, to seek suffering and pain in order to obtain love and respect, and to sabotage one's chances and success".

Of the four, attacking the self most relates to suicide so I will concentrate on this defense mechanism. It can be seen in various forms such as self-ridicule, putting down of the self, being constantly angry with the self as well as rejecting self, with the extreme rejection being suicide. Having introjected a critical, hostile and

punishing parent², a child learns that pain is one way to experience intimacy. Self-humiliation and masochism preempt the power of others to humiliate, and trying to gain and manage love this way "alleviates the shame and powerlessness and insignificance" (Pattison, 2000, p. 112).

Kaufman (1980) states that defenses enable a person to adapt and survive, escape and avoid paralyzing shame. "Following internalization of shame within the personality, each succeeding shame experience must be defended against, compensated for, or transferred interpersonally because exposure has become so acutely intolerable" (p. 97). Defenses used to predict and avoid shame include rage, contempt, striving for perfection to eliminate the inner sense of blemish, striving for power and control to avoid powerlessness and unexpected shame, transferring blame outside the self, and internal withdrawal, as well as humor and denial of shame. He specified self-blame, comparison making and self contempt as three distinctive identity scripts, shaped as a response to shame and all of which turn the self against itself.

In addition, Kinston (1983) highlights the significance of mortification. This is literally the process of deadening or putting down the self and aims to kill the offending, inadequate self and therefore kill the shame. The outcome could be the death of a person through suicide.

Interventions

Crowe (2004b, p. 335) argues that the characteristics of borderline personality disorder can also be expressions of chronic shame: identity disturbance, affective instability and impulsivity, suicidality, self-harm, dissociation and emptiness. She provides an approach that assists the client experiencing shame to develop alternative positions. The interventions focus on

encouraging awareness of how the person positions her or his self in relation to others, and the communication patterns that perpetuate feelings of shame. It also involves helping the person to integrate an

² That's not to say that the person actually had such a parent. Equally, the parent may have been emotionally unavailable or negligent.

ideal image of her or his self with subject positions that are more flexible. (p. 337)

Tangney & Dearing (2002, p. 175 -177) list five effective interventions which fit very well with all that this dissertation has shown about the nature of shame.

1. Helping the client to verbalize events and associated experiences causing the shame reaction often alleviates the feeling of shame. Translation and naming of the preverbal, global shame reaction creates a more logical thought process, enabling the client to re-evaluate the shaming episode.
2. The therapist can aid the client in making these cognitive reevaluations by taking an active role in helping the client to move back and reconsider their reaction in context.
3. Not realizing that behaviour-focused feelings of guilt are an option is a common experience for shame-prone clients. Making a reevaluation in context can be made by explicitly educating the client about the difference between shame and guilt.
4. The therapist can foster an accepting and understanding supportive relationship with the client so that when they disclose their "secret shame-eliciting fears, flaws, and foibles over the course of treatment, the therapists reaction provides ... an alternative to the self-disgust and self-disdain inherent in the shame experience" (p. 176).
5. Use of light-hearted humor³ is thought to normalize individual shortcomings, providing a more realistic perspective and helping to dispel the ugly feeling of shame, although, the therapist must make sure the client experiences this as laughing with rather than at them.

To summarize, unlike guilt, there is no reparation with shame. This dissertation has highlighted what I have found to be the crucial elements in this work. Not unexpectedly, it is the relationship between therapist and client that is critical:

³ Laughter as a means of escaping shame feelings has also been recognised by Darwin (1873), Lynd (1958), Nathanson (1987), Retzinger (1991), Scheff (1990) and Pattison (2000). They argue that when people laugh self-consciousness is left behind, shame is dissolved and at least for a temporary moment self-unification and solidarity is felt (Pattison, 2000).

creating an emotionally safe environment where secrets are encouraged to come out of hiding and be named. It is vital that the client's reality be affirmed, as this experience was so often missing before. Identifying shame has its own unique difficulties and some suggestions are offered. Suicide and shame are a dangerous combination and the therapist needs to be alert to the transference and countertransference dynamics, including their own feelings of shame, as these will provide key unspoken communication. Typical shame defense patterns, and interventions are suggested that assist the client to move from reactivity or suppression to intentionality.

Recommendations for future research

- 1) This review has addressed shame and suicide on an individual level, within individual therapy. Further research into the presence of shame in groups, and shame on a social and political level is recommended. Within institutions these factors can create and exploit an unhelpful sense of shame and alienation (e.g. schools, mental health, church) and communities.
- 2) Attachment has been briefly discussed within this dissertation but it has not directly considered any link between attachment styles and suicidality. I suspect from my review that there is a positive correlation. Research into this area would be pertinent.
- 3) This dissertation has concentrated on literature drawn from white, middle-class populations such as England and the United States, Australia and New Zealand. Within New Zealand we have many different cultures. I wonder what effect the presence of shame and the meaning it has within different ethnic and cultural groups when one is suicidal. The *whakamaa* connection could also be considered as clinical implications may differ. I believe that this would be a valuable exploration.
- 4) Because psychotherapy with this client group can be lengthy and demanding, it is costly. Some District Health Boards would prefer to use brief therapies for their clients. However, in-depth psychotherapy does have its place with suicidal clients. Maybe a tool could be devised to screen both suicide and shame, as the

tragic nature of suicide for the individual and those affected around them will cost more than long-term psychotherapy ultimately.

Personal reflection

This dissertation has deepened my knowledge about the impact that the shame experience has had, not only in my life but also in the lives of my clients and others around me. I am able to better understand and to be more sensitive to the material my clients bring. I am alert to the transference and countertransference dynamics that operate, taking to supervision issues that arise around shame. I fully appreciate the ability to have language with which to talk about shame and about suicide. This allows me to better contain my clients by staying closer to their material. I have found that working within the real relationship, and being attuned to shame moments, and simply being able to speak openly about shame brings relief, acceptance and recognition for clients, especially those with chronic shame. When words such as shame, humiliation, feeling bad and hateful, disgusting and undesirable for example are used honestly and tactfully they help to establish a stronger therapeutic alliance.

I have experienced satisfaction in being able to better understand and to help clients with chronic shame. What is more, because of the work that has gone into this dissertation I am more able to accept and love myself. Ultimately, as a psychotherapist I am better able to hold the hope for my clients so that eventually they might be able to experience relationships and intimacy where they are able to be fully present and true to themselves.

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Appendix 1: Data collection

Databases used, and search words entered

	SEARCH WORDS USED	PSYCINFO	PSYCARICLE	PROQUEST	CINAHL	MEDLINE	PEP
1	Psychotherapy	40454	6804	9210	2532		
2	Shame	3651	2166	40	368		1000
3	Chronic and shame	87	595		13		
4	Core and shame	91	449		7		
5	Suicide	19832	6187	42700	3480		1000
6	Suicide attempts	2934	1101		193		
7	Suicide ideology	7	1		0		
8	Kurt Cobain	6	8	179	1		1
9	Attachment	12527	9229		1098		
10	1&2&5&9	0	38		0		
11	1&2&5&6	1	28	3	0		
12	Shame and suicide	130	323	3	12	72	565
13	Shame & suicide & attachment	4	57		0		
14	Shame and neglect	51	254		2		
15	Shame and trauma	229	415		13		
16	Shame & sexual abuse	206	260		23		
17	Shame & physical abuse	51	140		4		
18	Shame & emotional abuse	33	49		1		
19	5&6&14&15&16&17&18	0	7		0		
20	Embarrassment	938	2104		237		
21	Shame & transference	97	148		1		
22	Shame & counter-transference	102	94		3		

Appendix 2: Kurt Cobain suicide note

To Boddah:

Speaking from the tongue of an experienced simpleton who obviously would rather be an emasculated, infantile complainer. This note should be pretty easy to understand.

All the warnings from the punk rock 101 courses over the years, since my first introduction to the, shall we say, ethics involved with independence and the embracement of your community had proven to be very true. I haven't felt the excitement of listening to as well as creating music along with reading and writing for too many years now. I feel guilty beyond words about these things.

For example, when we're backstage and the lights go out and the manic roar of the crowds begin, it doesn't affect me the way in which it did for Freddie Mercury, who seemed to love, relish in the love and adoration from the crowd which is something I totally admire and envy. The fact is, I can't fool you, any one of you. It simply isn't fair to you or me. The worst crime I can think of would be to rip people off by faking it and pretending as if I'm having 100% fun.

Sometimes I feel as if I should have a punch-in time clock before I walk out on stage. I've tried everything within my power to appreciate it (and I do, God, believe me I do, but it's not enough). I appreciate the fact that I and we have affected and entertained a lot of people. It must be one of those narcissists who only appreciate things when they're gone. I'm too sensitive. I need to be slightly numb in order to regain the enthusiasms I once had as a child.

On our last 3 tours, I've had a much better appreciation for all the people I've known personally, and as fans of our music, but I still can't get over the frustration, the guilt and empathy I have for everyone. There's good in all of us and I think I simply love people too much, so much that it makes me feel too ****ing sad. The sad little, sensitive, unappreciative, Pisces, Jesus man. Why don't you just enjoy it? I don't know!

I have a goddess of a wife who sweats ambition and empathy and

a daughter who reminds me too much of what I used to be, full of love and joy, kissing every person she meets because everyone is good and will do her no harm. And that terrifies me to the point to where I can barely function. I can't stand the thought of Frances becoming the miserable, self-destructive, death rocker that I've become.

I have it good, very good, and I'm grateful, but since the age of seven, I've become hateful towards all humans in general. Only because it seems so easy for people to get along that have empathy. Only because I love and feel sorry for people too much, I guess.

Thank you all from the pit of my burning, nauseous stomach for your letters and concern during the past years. I'm too much of an erratic, moody baby! I don't have the passion anymore, and so remember, it's better to burn out than to fade away.

Peace, love, empathy,

Kurt Cobain

Frances and Courtney, I'll be at your altar.
Please keep going Courtney, for Frances.
For her life, which will be so much happier without me.

I love you, I love you!

(Cobain, 1994){PRIVATE "TYPE=PICT;ALT="}

Appendix 3: Suicide statistics

Suicide rates in New Zealand and international ranking : ⁴

Comparatively, New Zealand's 2000 suicide rates are high for all-age males (4th among selected OECD countries⁵), and particularly youth aged 15-24 (2nd). New

⁴ Only when an official coroner's inquiry is completed will a death be deemed as suicide.

⁵ Includes Norway, Japan, Finland, Sweden, Australia, Canada, Netherlands, France, USA, Germany and the United Kingdom

Zealand ranked 10th among the selected OECD countries for female all-age suicide rates, but ranked 4th for 15-24 year old females. However, comparing international rates is "inherently problematic as countries may have different evidentiary standards when ascertaining whether a death was a suicide" (Ministry of Health, 2003:17).

Suicide rates⁶ and gender

According to the latest New Zealand provisional statistics (Ministry of Health, 2003) for the year 2000 (provisional because a small number of deaths are still subject to coroners' findings) 375 males and 83 females (totaling 458) died by suicide. The age-standardized rate⁷ of suicide for the total population was 11.2 per 100,000 in 2000 compared to 12.1 per 100,000 in 1990. As high as New Zealand suicidal rates are, in 2000, males had the lowest suicide rate since 1993 (18.7 per 100,000), and during the same period females also had the lowest rate since 1961 (4.0 per 100,000).

Suicide rates and age

Young people in New Zealand retain high rates of suicide although this has been decreasing for 5 consecutive years with 18.1 deaths per 100,000 in 2000 for the 15-24 year age group (males 29.9, females 5.8) compared to 22.5 per 100,000 in 1990. The highest rate of suicide now occurs in the 25-29 year age group (45.0 per 100,000 for male and 9.5 per 100,000 for female in 2000).

Suicide rate and ethnicity

In 2000, the rate of suicide in Maori was 13.1 per 100,000. This compares with 10.7 per 100,000 in non-Maori. Whilst I could not find data for comparable rates, it is worth noting that 12 Pacific people and 21 Asian people died by suicide in 2000.

Rates of attempted suicide

The rate of hospitalisation for intentional self-harm in 2000/2001 was 129.2 per 100,000. For men the rate was 91.7 per 100,000 and for women the rate was 167.4 per 100,000. It is not possible to compare this rate with previous years as the definition has changed to include cases not previously included. It is thought that

⁶ The age-specific rate of suicide is the frequency with which it occurs relative to the number of people in a defined population.

⁷ Age-standardized rates are rates that have been adjusted to take account of differences in the age distribution of the population over time (Ministry of Health, 2003).

more females are hospitalised for intentional self-harm than males because they more commonly choose methods such as self-poisoning that are generally not fatal but serious enough to require hospitalisation. Caution should be exercised when interpreting attempted suicide data. Often people do not seek medical attention when they attempt suicide, or they see only their general practitioner. Records are only kept for those admitted to hospital as inpatients or day-patients.