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Abstract: *The purpose of this concept analysis is to explore the concept of shame and examine its implications for nursing. Walker and Avant's method is used to identify shame's antecedents, consequences, defining attributes, and empirical referents. Shame is well documented in the literature as having both positive and negative effects on the well-being of individuals and families. Research literature almost exclusively focuses on the negative effects and consequences of shame. Consequently, it is imperative for advance practice nurses to contribute to research that establishes a nuanced concept of shame as part of the discipline of nursing.*

Key Words: *Shame, childhood sexual abuse, child maltreatment, post traumatic stress disorder (PTSD), concept analysis.*

Shame: Concept Analysis

Who has not experienced *shame* at some point in life? What person has not heard the expressions "you should be ashamed of yourself" or "*shame* on you?" Shame is a concept known by all and documented since early biblical times. The Bible refers to *shame* in Genesis with Adam and Eve's first sin. Later in the same book of the Bible, the story of Lot, whose wife turns to salt, tells of Lot's two daughters becoming pregnant with their father's children. Lot's family incest introduces the concept of family *shame* (Kutz, 2005). Hawthorne's classic novel, *The Scarlet Letter,* presents shaming as a punishment for a woman's sexual transgression; she is forced to wear a visible symbol of the indiscretion on her chest.

Shame may have both positive and negative outcomes in an individual's development and abilities to function. Zupancic and Kreidler (1998) conclude that the positive outcome of *shame* protects a person's humanity through societal parameters. According to Kaufman (1996), *shame* plays an important role in the development of conscience, dignity, and identity and disrupts the natural functioning of the self. Cleary (1992) states that too much shaming in early development can yield internalization of *shame,* a harmful emotion. Erikson (1963) views *shame* as the negative ramification of the second stage of development autonomy versus *shame* and doubt. Wiginton (1999) refers to the role of *shame* and its negative effects in development of psychosocial disorders and self-destructive coping behaviors.

Kaufman (1996) writes that due to a significant degree of *shame about shame* and the taboo surrounding *shame, shame* has been neglected in scientific psychology. Kaufman states "another reason for the neglect of *shame* concerns the lack of an adequate language with which to accurately perceive, describe, and so bring into meaningful relationship this most elusive of human affects" (p. 4). The documentation of *shame* is apparent in the current literature; however, current research is limited on the concept of *shame.* An analysis of the concept and further research on *shame* will provide a better understanding of this concept and its implications.

Purpose

The purpose of this concept analysis is to explore the concept of *shame* and examine its implications for nursing. Walker and Avant's (2005) 8-step process of concept analysis is used to explore the concept of *shame.* A literature review identifies uses of the concept and determines the defining attributes of *shame.* This article also provides case presentations, antecedents and consequences, empirical referents, and implications for practice to clarify the concept of *shame.*

Review of Literature

Definitions, attributes, and use of the concept of *shame* were derived from a review of the disciplines of nursing, psychology, psychiatry, and religion during the last decade plus Erikson's (1963) work from the 1950s. Computer search using the keyword *shame* produced results in these disciplines and research associated with the concept of *shame.*

Definitions of the Concept

According to the Merriam-Webster dictionary (2009), *shame* as defined in is a painful emotion caused by consciousness of shortcomings, guilt, or impropriety. Bradshaw (1998) states *shame* is difficult to define but comes in two forms: Healthy, nourishing *shame* and toxic/life-destroying *shame.* Most sources, however, define *shame* as a negative experience. Kaufman (1996) writes that *shame* is the source of feelings of inferiority, and the inner experience of *shame* is like a sickness of the soul. Stuewig and McCloskey (2005) refer to *shame* as a negative emotion focusing on evaluation of the entire self against internalized standards. Similarly, Lewis (1992) and Tangney (1995) describe *shame* as a negative experience involving feelings of self-condemnation and the desire to hide from others. Lewis (2000) states that *shame* is a self-conscious emotion requiring cognition of self and the ability to evaluate one's behavior against a standard and recognize one's failure. Miller (2006) describes the experience of *shame* as an "inner, critical voice that judges a person's actions as wrong, inferior, or worthless" (p. 2).

Related concepts. Terms and concepts similar to *shame* include guilt, embarrassment, and humiliation. Shame and guilt although often used interchangeably to describe a person's feelings have important conceptual differences (Cleary, 1992; Stuewig & McCloskey, 2005). According to Stuewig and McCloskey (2005), the major difference between *shame* and guilt concerns the distinction between *the self* and *behavior.* Experienced guilt motivates a person to make amends for the behavior while experienced *shame* makes a person feel awful about one's self and can be debilitating. According to Feiring and Taska (2005), guilt con-

cerns one's action while *shame* concerns one's entire being. Guilt, an emotion that motivates productive behavior, differs from *shame* because *shame* is a nonproductive and often incapacitating emotion (Deblinger & Runyon, 2005).

Humiliation is a person's perception of being degraded, ridiculed, belittled, or criticized at the hands of another while concurrently holding a negative attribution of blame to that person (Stuewig & McCloskey, 2005). Keltner and Buswell (1997) state that embarrassment shares some attributes with *shame* but differs from *shame* because the latter reflects violations of a deeper moral standard, whereas the former is generally less intense and associated with social transgressions. Kaufman (1996) indicates the essential quality of embarrassment is a person seen as socially inappropriate who is *shamed* before an audience.

Negative outcomes. Research on *shame* relates to the negative outcomes of experiencing *shame* in relationship to an antecedent of *shame*, child maltreatment. Harper and Arias (2004) studied the role of *shame* in predicting adult depression and anger in victims of child maltreatment. Rahm, Renck, and Ringsberg (2006) explored whether and how women who had been sexually abused during childhood verbally expressed unacknowledged overt and covert *shame* when interviewed about the abuse, mental and physical health, and relationships with family and friends. Bennett, Sullivan, and Lewis (2005) examined a model in which *shame* mediates the possible relation between maltreatment and anger, and anger mediates the possible relation between *shame* and behavior problems.

Stuewig and McCloskey (2005) studied how maltreatment might influence the development of *shame*-proneness and guilt-proneness and how these predispositions relate to depression and delinquency. Feiring and Taska (2005) investigated abuse-related *shame*, particularly Childhood Sexual Abuse (CSA) during a 6-year period, and their findings suggest that *shame* as a consequence of childhood sexual abuse should be a focus of treatment. Negrao, Bonanno, Putnam, and Trickett (2005) explored the contributions of *shame*, anger, embarrassment, and humiliation by examining the relationship between emotional coherence, disclosure of childhood sexual abuse, and trauma. The journal *Child Maltreatment* (Berliner, 2005) devoted a special section to research on the concept of *shame* in an effort to explain the contribution of *shame* to child abuse consequences. Berliner concludes that research increases knowledge of abuse consequences but leaves unanswered questions about clinical implications.

Beyond shame. The review of literature in the domain of nursing is limited and focuses primarily on the discipline of psychology and psychiatry. Kaufman (1996) states the appropriate environment to address the issues of *shame* as well as its relationship to self-destructive and other destructive behavior patterns is in postsecondary psychological health education. Zupancic and Kreidler (1998) conclude that a crucial aspect of healing *shame*-based feelings and behaviors is managing symptoms, redesigning cognitive distortions, and improving self-care strategies. Rahm, et al. (2006) state that an important clinical implication for health-care professionals and psychiatric services is to acknowledge both sexual abuse and *shame* in order for patients to work through the trauma of their abuse and their *shame* to improve psychological well-being.

Uses of the Concept

Shame appears in varied contexts in the literature. Barrett (1995) refers to *shame* as a social emotion because it arises in interpersonal contexts. According to Kroll and Egan (2004) *shame*, guilt, remorse, and regret are the most often referenced moral emotions. Shame-based syndromes, conceptualized by Kaufman (1996), describe how excessive internalized *shame* relates to many dysfunctional behaviors.

Zupancic and Kreidler (1998) state, "Pathological or toxic *shame* is presented as debilitating and restrictive in the expression of appropriate feelings" (p. 30). Pines (1995) observes that reactions to or interactions with others precipitates toxic *shame*. Bradshaw (1998) and Kaufman (1996) refer to individuals who magnify *shame* as *shame*-bound and label this excessive internalized *shame* as toxic.

Lewis (1971) distinguishes that overt *shame* exists when a person feels embarrassed for a brief duration, whereas covert *shame* (formerly referred to as by-passed *shame*) is a constant state of being *shamed*. Rahm et al. (2006) regard covert *shame* as a person's not feeling the mental pain of *shame* but being identified by others through gestures, choice of words, and body language. *Shame*, specifically covert *shame*, can affect a person's life in different ways such as in social relations (Rahm et al.). According to Bennett et al. (2005), shame proneness is associated with both externalizing and internalizing problems observed in child maltreatment. Scholars use the concept of *shame* to reflect the predominance of negative connotations typically associated with the concept.

Defining Attributes

Defining attributes are the characteristics of a concept repeatedly appearing in reference to the concept and providing the broadest insight into the phenomenon (Walker & Avant, 2005). The defining attributes of *shame* appearing consistently in the literature are specific physical expressions, feelings of worthlessness, low self-esteem, and alienation.

Physical expressions of *shame* consist of several behaviors occurring when a person experiences *shame*. Kaufman (1996) states that the facial signs of *shame* include lowering or averting eye contact, blushing, and hanging the head. Wiginton (1999) describes the physical expressions of *shame* as blushing, diverted eyes, or lowered head. Rahm et al. (2005) state that *shame* is physically expressed by blushing, breaking eye contact, putting one's hands in front of one's face, and other hiding behaviors. Bennett et al. (2005) indicate body collapse, eyes lowered, and corners of the mouth turned downward are physical expressions of *shame*. Feiring and Taska (2005) describe *shame* posture as head down, shoulders hunched, and nonverbal behaviors as avoiding eye contact, covering the face, head down, body collapsed, and body hidden by coat or object. Harper and Arias (2004) indicate external responses to *shame* include avoiding eye contact and wanting to hide or escape. Bonanno, Noll, Trickett et al. (2002) conclude that survivors of CSA who did not voluntarily disclose prior CSA showed the greatest facial *shame* and non-Duchenne smiles. A non-Duchenne smile lacks spontaneity; it is a grin only smile that excludes cheek and eye movement. Bonnanno et al. indicate non-Duchenne smiles tend to occur when hiding negative emotions, expressions of *shame*.

Worthlessness or feelings of being inadequate, unworthy, and powerless is a defining attribute of *shame*. Deblinger and Runyon (2005) state that individuals suffering feelings of *shame* may see themselves as damaged or unworthy. Kroll, Eagan, Erickson, Carey, and Johnson (2004) indicate that *shame* leaves a person powerless to change in response to diminishing the person. Possum and Mason (1986) describe *shame* as a person's inner sense of being completely diminished or insufficient, robbed of one's dignity, and exposed as inadequate, bad, or worthy of rejection. The participants in Rahm's et al. (2006) research revealed significant signs of *shame* as feelings of inadequacy, powerlessness, worthlessness, and unworthiness. Toxic *shame* is a central issue in women sexually abused as children; the consequence of this *shame* disables women and prevents the appropriate expression of feelings in adulthood (Zupancic & Kreidler, 1998).

Low self-esteem is diminished belief in one's self and relates to feelings of worthlessness, self-doubt, or inadequacy. It is a defining attribute of *shame*. Zupancic and Kreidler (1998) state the "affect of *shame*" is a source of low self-esteem, poor body image, self-doubt, and insecurity. Kroll et al. (2004) describe *shame* as a negative emotion that diminishes one's sense of self-esteem and worth. Ferguson (2005) adjusts Leary's (1999) analysis of

self-esteem to illustrate the association of *shame* with a person's self-esteem. Ferguson's adjustment indicates that in an effort to preserve self-esteem, a person avoids *shame.*

Alienation is expressed as feeling alone, feeling like an outsider, and feeling betrayed (Rahm et al., 2006). Among sexually abused women, expression of feeling betrayed is related to being misused or mistreated by a person on whom the child was dependent and the loss of trust and love of this person (Rahm et al.). Younger (1995) describes alienation of the sufferer and the role *shame* plays in the feelings of alienation. When a person experiences *shame,* he or she feels unattached, not only to a particular person involved in the *shame* but also from all others.

Case Presentations

Model Case

A model case is an actual or realistic example of a concept demonstrating all of its defining attributes (Walker & Avant, 2005). The following is a model case for the concept of *shame.* AB is a 31-year-old, white, married, female, mother of two children, and employed as a receptionist. Although AB completed more than four years of college, she earned an associate's degree because she frequently changed her major due intense feelings of inadequacy and a fear of failure. AB often finds herself feeling irritable with her children, husband, and co-workers and is frequently absent from work. She received a written warning that termination of her employment is imminent if the absences persist.
AB seeks psychological counseling for alcohol abuse and depression related to *shame*ful and intense desires to have sexual relations with a man other than her husband. AB experiences feelings of worthlessness and powerlessness over her desires. She feels that she can no longer tolerate or contain these feelings and begins weekly sessions of cognitive behavioral and exposure therapy with a psychologist.

During the weekly sessions, AB admits her father sexually molested her for several months when she was 13 years old. She also reveals being sexually molested by her uncle, six years her senior, at approximately age 10. Both of her parents are alcoholics; her father is verbally abusive, and her mother is emotionally *absent* as a parent. The psychologist indicates that AB suffers from depression and exhibits low self-esteem and physical behaviors of poor eye contact, lowering head, and covering eyes when talking about the abuse. AB also expresses feelings of worthlessness, being inadequate and powerless over these feelings. AB frequently diets and obsesses over her size, often dressing in loose, baggy clothing. She expresses feelings of betrayal by her father, mother, and uncle. She feels alone and says she has no one to talk to about these feelings. The psychologist works with AB to discover specific triggers resulting in internalized shaming events that cause AB to experience the initial shaming of sexual and verbal abuse repeatedly. After several months of individual therapy, the psychologist introduces group therapy; however, AB fears feeling the emotions of the sexual abuse. This fear hampers her ability to benefit from therapy. AB continues to have little contact with her family of origin and does not have relationships or friendships with anyone other than her husband. She continued to engage in psychotherapy intermittently for several years; however, her issues of *shame persist,* and she frequently experiences the effects of internalized shame at work and in her daily life.

Discussion and interpretation. In this model case, AB exhibits all of the defining attributes of *shame.* Infrequent eye contact, lowering head, and covering eyes when talking, represent critical physical behavioral indices of *shame.* AB's expression of unworthiness, inadequacy, powerlessness, and self-doubt along with poor body image demonstrate the defining attributes of worthlessness and low self-esteem. The limited relationships and friendships, and the infrequent contact with her family of origin represent the defining attribute of alienation. Despite engaging in psychotherapy, AB continues to experience the negative consequences of *shame.* She struggles with depression and frequently experiences the effects of internalized shame in her life. This case demonstrates the concept of *shame* and all its defining attributes.

Borderline Case

The following *borderline case* is an example of the manifestation of *shame,* including some, but not all, of the defining attributes. The borderline case helps clarify an individual's thinking about the defining attributes of the concept (Walker & Avant 2005).

KR is a 24-year-old female, attending a local university, but has yet to select a college major. She experiences episodes of depression resulting in missed work and school. A friend suggests the name of a psychiatric-mental health nurse practitioner and KR makes an appointment. During the first few sessions, KR is willing to talk with the therapist about her past. Her eye contact is frequent but her posture remains closed.

KR reveals that her father was physically and verbally abusive to her and her siblings throughout her childhood and adolescence. She states her mother did not intervene on behalf of the children and often criticized KR and her siblings. According to KR, both of her parents are alcoholics who were inconsistent in their child-rearing practices and discipline.
KR states she frequently feels unworthy and hears her parents' voices telling her how she is "bad" and "worthless". She expresses feelings of inadequacy and relates this to her delay in completing a college degree. KR is an average sized female but repeatedly states she is fat and unattractive. KR does not have contact with her parents and speaks infrequently to her siblings. She has only one close friend and has not had a lasting relationship with a male.

The therapist helped KR lessen the *shame* through cognitive behavioral therapy and authentic relationship building. After a year of therapy, KR's depression subsided and she developed skills that enabled her to change her thinking to a positive self image and worth. She learned to recognize that her parents' behavior and the abuse was not her fault. She attends family functions on a limited basis and begins to develop a relationship with her siblings. KR completed her bachelor's degree and has received admittance to a graduate program at prestigious university

Discussion and interpretation. In the absence of sexual abuse and its devastating effects, this borderline case demonstrated three of the four defining attributes of *shame.* KR exhibits the defining attribute of worthlessness when she expresses feeling unworthy and hearing her parents' critical voices. The poor body image and no contact with family delineate the defining attributes of low self-esteem and alienation. These attributes diminished after therapeutic intervention. This borderline case does not present unequivocal evidence of the attribute, physical expression or behavior. KR maintained a socially appropriate level of eye contact with the therapist throughout the therapy. Although she maintained a closed posture, KR did not exhibit the lowered head in a downward position or covering of eyes or face characterizing the social humiliation of shame.

Related Case

A related case is an example of instances where the concept is similar but does not contain all the defining attributes (Walker & Avant, 2005). When closely examined related cases clarify what is significant as defining attributes of a concept and what is not significant.

CS is a 17-year-old, white female who lives with her parents and is active in her high school. She is a bright, above average student who has many friends. Recently her parents noticed a change in her attitude about school and her friends. She presents to a psychologist after admitting to her parents episodes of purging after eating meals for approximately two months. CS expresses feelings of dissatisfaction with her body (poor body image) and feeling

hurt by comments made by her classmates. CS makes appropriate eye contact and maintains an upright posture except when she talks about the purging episodes and the comments made by her peers. CS states that she is a*shame*d of her behavior and wants to stop. She believes peer pressure and hurtful comments about her size prompted her to lose weight by purging.

CS attends a class on eating disorders and completes the recommended counseling sessions. CS recognizes that purging is an unhealthy method of losing weight. Upon completion of counseling, CS has no further episodes of purging, begins to exercise, and begins to understand that she is in control of how she responds to the comments her peers make.

Discussion and interpretation. In this related case, CS experienced a *shaming* event of peers making negative comments about her body. She then felt *shame* in her behaviors of purging. However, CS did not exhibit all the defining attributes of *shame.* She did not present with any of the physical behaviors as she makes appropriate eye contact and maintains an upright posture. She did not demonstrate the defining attribute of worthlessness. She exhibited some low self-esteem as indicated by her poor body image. CS demonstrated some alienation when her attitude toward school and friends changed and when she did not immediately share her concerns and feelings with her parents. CS sought help from her parents and experienced no lasting effects of *shame* after completing therapy. Eating disorders are both an antecedent to *shame* and a consequence of *shame.* The *shame* experienced by CS demonstrates some of the defining attributes but more clearly demonstrates an antecedent and consequence of *shame* rather the actual concept of *shame.*

Contrary Case

Contrary cases have none of the defining attributes and are clear examples of what the concept is not (Walker & Avant, 2005). SJ is a 12-year-old, African American female who lives with her parents, attends grade school, and is active in sports, particularly soccer. At a soccer game, SJ attempts to make a header shot for the goal but misses the ball totally and falls flat on her face. She is not hurt physically but a little embarrassed by this event. SJ picks herself up and goes to the bench to have a bandage applied to a scrap on her face that is bleeding. She returns to the game and scores on the next offensive drive. SJ laughs about her fall when the team goes out for pizza after they win the game.

Discussion and interpretation. In this contrary case, SJ did not exhibit any of the defining attributes of physical behavior, worthlessness, low-self-esteem, or alienation associated with *shame.* She experienced embarrassment when she missed the ball and fell flat on her face. This event did not result in any negative, long-term consequences for SJ. She returned to game, scored a goal, and at the end of the day laughed about what happened.

Antecedents and Consequences

Antecedents are incidents or events that must precede occurrence of the concept (Walker & Avant, 2005). Although some antecedents do not affect normal functioning, most antecedents of *shame* affect the normal functioning of individuals. Individuals experience *shame* associated with inadequate reading skills affecting their health literacy (Speros, 2005). People diagnosed with bulimia or nocturnal sleep-related eating disorder may experience *shame* following binges (Muscari, 2002; Montgomery & Haynes, 2001). Nurses may experience the emotional effects of *shame* in a whistle-blowing event (McDonald & Ahern, 2002). Survivors of suicide may experience *shame* (Barlow & Morrison, 2002). Alcoholics feel *shame* about being an alcoholic and an alcoholic's family experiences *shame* because of the shared membership in an alcoholic family (Bennett, 1995). Family members of an individual under psychiatric care for a mental illness may be blamed for the disease and experience *shame* (Sjöblom, Pejlert, & Asplund, 2005). Adults and children who stutter (Daniels & Gabel, 2004) or nurses disciplined for unprofessional conduct (Johnstone & Kanitsaki, 2005) may feel incapacitating *shame,* or their *shame* may motivate behavior change. Vulnerable patients experience a sense of *shame* because of the disease they have or the stigma associated with the disease (Saylor, Yoder & Mann, 2002).

The literature repeatedly illuminates adverse effects of child maltreatment on children, adolescents, and adults. Child maltreatment involves violations of moral standards for behavior that is socially and legally acceptable (Feiring, 2005). These violations include neglect, physical abuse, emotional abuse, or sexual abuse (Bennett et al., 2005). Harsh parenting of criticizing, rejecting, and shaming behavior is linked to higher *shame*-prone emotional style in adolescents (Stuewig & McCloskey, 2005). Researchers need to focus on *shame* and its varied outcomes and roles in adaptation to experiences of child maltreatment (Feiring, 2005). Ritualized abuse and extreme trauma are endured by others populations. For instance, survivors of torture often feel *shame* about the torture they experienced. Because these survivors fear what others will think, they must be assured of confidentiality during treatment (McCullough-Zander & Larson, 2004).

Consequences are incidents or events existing because a concept occurs (Walker & Avant, 2005). The consequences of *shame* include depression, anger, fear of feeling negative emotions, posttraumatic stress disorder (PSTD), addictive disorders, eating disorders, behavior problems, and spiritual pain. Stuewig and McCloskey (2005) relate *shame* to many forms of psychopathology, including PSTD, depression, anxiety, and obsessive-compulsive disorder. *Shame* plays a role in PSTD and social phobia (Zayfert, Deviva & Hofmann, 2005). The fear of feeling of shame as a long-term repercussion of toxic *shame* and women sexually abused as children (Zupancic & Kreidler, 1998). The *shame* associated with this abuse disables women and prevents appropriate expressions of feelings of adulthood. *Shame* is correlated with depression in women and with anger in men (Harper & Arias, 2004). Addictive disorders result from a person's attempt to avoid further *shame* and become a substitute for interpersonal relationships (Wiginton, 1999). Eating disorders have a relationship to the covert messages of *shame* and excessive internalized shame (Kutz, 2001; Cleary, 1992). Research findings show a direct correlation between *shame,* anger, and maltreatment and between maltreatment, anger and behavior problems in children (Bennett et al., 2005). According to Satterly (2001), the foundation of spiritual pain is in the emotion of *shame* and all its potentially harmful consequences.

Empirical Referents

Empirical referents "are classes or categories of actual phenomena that by their existence or presence demonstrate the occurrence of the concept itself" (Walker & Avant, 2005, p. 73). Empirical referents provide nursing and other disciplines with observable phenomena by which to measure *shame* in an individual. The Test of Self-Conscious Affect (TOSCA) for adults and TOSCA-A for adolescents is used to assess *shame,* guilt, detachment, externalization, alpha pride (pride in self) and beta pride (pride in behavior) (Harper & Arias, 2004; Stuewig & McCloskey, 2005). The *shame* subscale has a test-retest reliability coefficient of .85. It consists of 15 items with possible scores of 15-75 with higher scores indicating greater proneness for *shame* (Harper & Arias, 2004).

The Adolescent Shame Measure (ASM), modeled after the TOSCA-A, focuses on *shame* and guilt (Stuewig & McCloskey, 2005).The ASM is composed of 13 scenarios followed by 4 emotional responses including *shame* and guilt statements. Participants are asked to rate the likelihood of experiencing an emotional response using a 5-point Likert-type scale.

Ekman and Friesen's Facial Action Coding Systems (FACS) (cited in Negrao et al., 2005) codes facial muscle movements into facial expressions of anger, embarrassment, and *shame.* Two coders

rate facial muscle movement using a 5-point scale and a calculated ratio of agreement ensures inter-coder reliability.

Implications for Nursing

Although a review of the literature is limited in the domain of nursing, there are implications for the discipline of nursing from this concept analysis of *shame*. Box 1 outlines the attributes, antecedents, consequences, and empirical referents of *shame*.

Shame can affect individuals in a variety of situations and circumstances, resulting in mild to extreme dysfunction. It is important that nurses recognize that feelings of *shame* can have deleterious effects on their patients. Early identification of the antecedents and the presence of defining attributes of *shame* provide the nurse with the knowledge necessary to approach the patient in the most effective, therapeutic way. Doing so can enhance the nurse's ability to identify patients at risk for suffering the consequences of *shame* that impact their care in the clinical setting.

Nursing Practice

Child maltreatment is a prevalent antecedent to *shame*, requiring disclosure of the events to diminish the effects of *shame* on an individual. Providing a *shame*-free environment is vital to establishing a trusting relationship with patients. Only after health practitioners establish a rapport and trust should they ask about abusive situations Leserman (2005). This knowledge is vital to mental health nurses and advanced practice mental health nurses in caring for children, adolescents, and adults who have survived physical or sexual abuse or torture. Zupancic and Kreidler (1998) state that "advanced practice nurses must help women deal with the core issue of *shame*, not just the more obvious developmental lags" (p. 30).

To enhance feelings of validation and self-acceptance, nurses must actively listen, reflect back patients' worries and concerns, and answer questions and concerns about bodily *shame* thoughtfully and in the context of a medical examination (Steuwig & McCloskey, 2005). Deblinger and Runyon (2005)state that nurses must be aware that a child may negatively perceive repeated questioning by health-care providers as disbelief, which may reinforce feelings of *shame* and concern. Deblinger and Runyon stress the importance of the mental health nurse's educating both mother and daughter that the sexual abuse is not the daughter's fault and does not occur because of the child's appearance or behaviors, but is the inappropriate action of an adult.

Zupancic and Kreidler (1998) indicate group therapy facilitated by advance practice nurses for women who experience toxic *shame* should include repatterning of cognitive processes to include self-talk to affirm positive coping and new ways of thinking and self-care strategies to decrease symptoms. Stone (1992) states that acknowledging *shame* is an integral part of therapy; as one means to recover from PSTD, it gives power and effectiveness to most therapeutic approaches. Stone stresses the importance of naming *shame*, recognizing the *shame*-related aspects of the initial trauma, and increasing the patient's understanding of the role of *shame* in order to structure a foundation for healing.

Nursing Education

Wiginton (1999) stresses the importance for health educators to address *shame* as a key element in several self-destructive behavior patterns. Mental health nursing curricula should include the antecedents, defining attributes, and consequences of *shame*. Warne and McAndrew (2005) conclude that mental health nurses are ill-prepared to work with patients who have experienced CSA. Curricula should reflect the skills, knowledge, and attitudes related to CSA and sexual health and illness (Warne & McAndrew, 2005). Cleary (1992) believes mental health curricula should contain 5 components, one of which is *shame*-related stress. It is important for psychiatric nurses to have knowledge of families, including their contribution or potential hindrance in the therapeutic process in order to provide quality care to the psychiatric patient (Sjöblom et al., 2005).

Mental health nursing curricula should reflect current research findings on the effects of *shame* and effective treatments. Stuewig and McCloskey (2005) advocate the need to target *shame* in treatment, intervention, and prevention programs to reduce psychopathology among adolescents. Bennett et al. (2005) conclude that there are gender differences that need to be considered in therapy, particularly the fact that girls exhibit more *shame* than boys. Cognitive behavioral therapy provides greater improvement than other modalities in the treatment of *shame*, PTSD, depression, abuse-related attributions, and behavior problems in abused children and adolescents (Caffo, Forresi, & Lievers, 2005).

Nurses should take an active role in community health services to provide public education on child maltreatment and the impact *shame* can have on children, adolescents, and adults. Because the prevalence of sexual abuse in childhood may be under-reported specifically because the subject is taboo (Heise, Ellsberg & Gottmoeller, 2002), nurses have a pivotal role to play in educating the public and other health-care providers of the importance of being alert to the possibility of sexual abuse (Rahm et al., 2006).

Nursing Research

Research addressing *shame* is largely limited to the domain of psychology/psychiatry. Advance practice nurses and psychiatric mental health may appropriately and uniquely address this critical gap. Nurses working in acute clinical settings may provide important research data on the impact of *shame* on hospitalized pa-

Box 1. Findings of concepts analysis: Shame

Attributes
- Physical behaviors
  - Blushing
  - Breaking eye contact, diverting eyes
  - Head lowered, down
  - Covering eyes, head, or face
- Worthlessness
  - Unworthiness
  - Inadequacy
  - Powerlessness
- Low self-esteem
  - Poor body image
  - Self-doubt
  - Diminished self
- Alienation
  - Feeling alone
  - Feeling betrayed
  - Feeling like an outsider

Antecedents
- Child maltreatment
- Eating disorders
- Physical and mental disabilities
- Torture/extreme trauma

Consequences
- Depression (women)
- Anger (men)
- Fear of feeling negative emotion
- Posttraumatic Stress Disorder
- Eating disorders
- Behavior Problems

Empirical Referents
- Adolescent Shame Measure (ASM)
- Test of Self-Conscious Affect for Adolescents (TOSCA-A)
- Test of Self-Conscious Affect (TOSCA) - Adults

tients. Immediate practical applications of research are not always required because research is a building block to more complex understanding of a concept or phenomenon (Bennett, Sullivan, & Lewis, 2005). Nonetheless, further basic and applied research is needed to clarify the defining attributes and consequences of *shame*. Nurses' participation in this research will help establish the concept of *shame* as part of the discipline of nursing and enhance nursing knowledge of this concept. Nurses are in a prime position to catapult translational research and develop interdisciplinary policies, which address antecedents, defining attributes and consequences of *shame* and facilitate implementation of effective evidence-based interventions.

Conclusion

Shame is a complex concept. The most recent research focuses on the relationships among abuse experiences, *shame*, and outcomes or consequences. The defining attributes of *shame* are still evolving and warrant further research to clarify the concept of *shame*. Because the defining attributes are evolving, empirical referents are subject to change as research reveals new findings or refines previous findings.

The purpose of this concept analysis was to explore the concept of *shame*, clarify ambiguities associated with this concept, and examine its implications to the discipline of nursing. Concept analysis promotes a consistent use of a concept in nursing language and research. This concept analysis revealed the defining attributes, antecedents, consequences, and empirical referents associated with the concept of *shame*. Identifying antecedents and attributes of *shame* early will enhance the therapeutic relationship between the client and therapist or mental health nurse.

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