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The role of shame in posttraumatic stress disorder: A proposal for a socio-emotional model for DSM-V☆

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ABSTRACT

Posttraumatic stress disorder (PTSD) is one of the emblematic psychiatric conditions in contemporary public consciousness, indexing not only disordered minds, but also disordered human relations. With efforts currently mounting to refine criteria for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V), an important task is to re-examine the emotional foundations of trauma and their elaboration in social context. A body of clinical research on psychological trauma indicates that the emotion *shame* is central to the development and course of PTSD. However, current diagnostic criteria and bio-behavioral research do not account for these findings. In light of an emerging understanding of PTSD as a disturbance of affect systems (Stone, 1992), this paper proposes a novel theoretical model that describes how shame underlies peri-traumatic and posttraumatic experiences of threats to the *social self*. It first presents a rationale for investigating traumatic shame that draws on affect theory and current findings in PTSD research. Next, it discusses the foundations of shame in perceptions of *status inferiority* and *failure to conform to normative expectations* and their elaboration in PTSD. Then it describes psychological, social, and cultural domains that are critical for contextualizing shame meanings and expressions. Finally, it recommends revisions to the diagnostic criteria for PTSD in DSM-V.

Introduction

Since its inception into the DSM-III (American Psychiatric Association [APA], 1980), the clinical category PTSD has spawned a voluminous literature. A PsychINFO database search of keywords "posttraumatic stress disorder" *or* "PTSD" yielded 16,272 entries between 1980 and May 2009. This corpus encompasses a wide array of observations, theories, and debates about the disorder. Current diagnostic criteria in the DSM-IV-Text Revision (TR) and animal research models implicate *fear*, resulting from encounters with physical threats of injury and death, as the affective basis of traumatic stress response and PTSD etiology (APA, 2000; Kirmayer, Lemelson, & Barad, 2007). Other emotions are taken to play only peripheral roles. However, literature in clinical psychology addresses the role of shame in all the major categories of trauma associated with the disorder. These include gender violence, child abuse, accidents and injury, combat exposure, and political violence and dislocation.

The goal of this paper is to propose an account of the organizing structure of trauma-related shame and its social, psychocultural, and biological concomitants. Anthropologists have made important contributions to clinical efforts by emphasizing the social embedding of trauma-related distress and psychopathology. Yet, to date, there exists no systematic analysis of the shame-trauma-PTSD relationship in medical anthropology or in adjacent disciplines that could corroborate clinical findings through cross-cultural exegesis. This paper addresses this lacuna by bridging disciplinary literatures and advancing a novel theoretical model of *traumatic shame*.

At its core, this model posits that shame 1) mediates peri-traumatic injuries (i.e., occurring at the time of the stressful events) that threaten and damage the social self and 2) orchestrates many of the posttraumatic sequelae that unfold in the field of social relations and collective meanings. The social self is defined as the symbolic and subjective sense of a stable, core identity and the integrity of that identity structure in relation to the social environment (Hallowell, 1955; Lewis, 1990). The discussion focuses on conceptualizing the mechanisms of shame-based responses to *social threats* and on identifying key socio-cultural domains in which shame is elaborated. The proposed model accounts for

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universal and culturally variant features of shame as well as its individual and collective orientations and their relevance to PTSD symptoms. This paper contributes a synthetic perspective on shame to our developing understanding of trauma and post-traumatic syndromes and makes recommendations for incorporating this framework into revisions of PTSD criteria in DSM-V.

Controversies

Despite the proliferation of research on PTSD, the validity of the clinical construct remains controversial. Scholarship in anthropology and psychology has interrogated the historicity, ontological status, construct validity, and cross-cultural applicability of the clinical label and the DSM framework (e.g., Bracken, Giller, & Summerfield, 1995; Kleinman, 1987; Rosen & Lilienfeld, 2008; Summerfield, 1999; Wilson, 1993; Zur, 1996). For example, Rosen and Lilienfeld (2008) reveal that many core assumptions about PTSD's etiology, mechanisms, and distinctive presentation lack compelling and consistent empirical support. Nevertheless, they contend that the clinical category should be revised for DSM-V rather than rejected because it retains considerable heuristic value for expanding knowledge of the impacts of traumatic events, related idioms of distress, and the factors contributing to pathogenesis and pathology. Examining the category through a more historical lens, Young (1995) asserts that of greater significance than whether PTSD is "really real" is *how it has been made real* over time, and how, as a social fact, it imparts real-life consequences for survivors of trauma, their families, and their caregivers. PTSD, like all diagnostic categories, is a dynamic construct; the current DSM revision cycle is another attempt at its re-making. This paper is a small contribution to this endeavor.

PTSD: a disturbance of affect systems

The prevailing understanding of PTSD is that its pathological nucleus lies in the splitting of intensely stressful experiences away from normal metabolization in memory and linguistic schemas, leading to the characteristic physiological, psychological, and behavioral symptoms (Brewin & Holmes, 2003; van der Kolk, 1994). DSM-IV-TR (APA, 2000) defines these stressors as *the experience, witnessing or confrontation with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others* (Criterion A1), and *the person's subjective response involving intense fear, helplessness, or horror* (Criterion A2). The core symptom criteria of PTSD are grouped into three categories: *re-experiencing symptoms and intrusive emotional memories* (Criterion B), *emotional numbing and stimulus avoidance* (Criterion C), and *hyper-arousal* (Criterion D). In order to confirm a diagnosis, some cluster of these symptoms must persist beyond one month (Criterion E) and cause clinically significant impairment in social, occupational, or other important areas of functioning (Criterion F). The casual link of symptoms to prior history of trauma has come to imply a certain burden of proof required for diagnosing PTSD that does not exist for any other psychiatric disorder (Young, 1995). However, empirical evidence has not consistently supported this assumption or the view that stressor criteria (A) sufficiently predict PTSD pathogenesis (Rosen & Lilienfeld, 2008). Rather, the vast majority of individuals meeting stressor criteria do not develop PTSD. For example in a meta-analysis, Ozer et al. (2003) found that even with a 60% trauma exposure rate in the U.S.-based sample population, only around 10% developed PTSD. Other large-scale U.S. and cross-national studies have shown similar patterns, and reveal that PTSD has approximately twice the prevalence rate in women despite lower documented rates of traumatic exposure compared to men (Breslau, Davis, & Andreski, 1995; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Lai, Chang, Conner, Lee, & Davidson, 2004). Epidemiological studies and meta-analysis also indicate that negatively perceived social support in the aftermath of traumatic injury is the strongest predictor of PTSD (Brewin, Andrews, & Valentine, 2000; Kessler et al., 1995; McFarlane, 1988).

These findings are consonant with a recently developed idea about PTSD as a disorder of recovery (Shalev, 2007). In this view, complex emotional appraisals of the self and the social environment, play critical roles in regulating normal, acute stress symptoms, their failure to extinguish over time, and resulting pathogenesis (Brewin & Holmes, 2003). For example, shame, guilt, anger, sadness, and mistrust, are clinically speaking the most widely reported emotions in PTSD (Glover, 1988; Resick & Schnicke, 1992; Reynolds & Brewin, 1999). In studies surveying a range of traumatic stressors, a small but significant percentage of people diagnosed with PTSD report feelings of shame and anger at the most intense moments of the traumatic events rather than fear and terror (Grey, Holmes, & Brewin, 2001; Reynolds & Brewin, 1999). Shame-proneness positively correlates with PTSD symptom severity, whereas other personality attributes such as guilt-proneness do not (Leskela, Dieperink, & Thuras, 2002). Also, in studies of violent crime and child abuse, shame was the only emotion that predicted PTSD symptoms past the one-month diagnostic threshold and beyond six months (Andrews, Brewin, Rose, & Kirk, 2000). Such evidence contributes to an emerging view of PTSD as a disorder resulting from a "disturbance of affect systems" in which shame plays a critical role (Stone, 1992, p. 132).

What is shame anyway?

In affect theory (e.g., Fessler, 2007; Gilbert, 2003; Lewis, 1987; Nathanson, 1987; Scheff, 1988; Sedgwick & Frank, 1995; Tangney & Fischer, 1995; Tomkins, 1962; Wilson, Drozdek, & Turkovic, 2006; Wurmser, 1987) shame is the quintessential social emotion underlying social threat, comprising a family of negative feelings ranging from mild embarrassment to severe humiliation. It is the painful self-consciousness of or anxiety about negative judgment, unwanted exposure, inferiority, failure, and defeat. As a dimension of the self, shame has both external and internal orientations (Gilbert, 2003). It registers the rejection of a perceived external critical audience and it also manifests in reflexive self-criticism based on internalized ideals. Both orientations are concomitant with defensive postural responses including body slumping, gaze aversion, turning away of the face, and dissociative stupor. Externally, these "safety behaviors" signal submissiveness or defeat, while internally they signal the need to withdraw from social interaction. In these respects, shame affect and appraisal, shame-proneness, and shame avoidance are powerful motivators of private and interpersonal behavior.

Shame is part of both individual experience and collective ethos. Although for many societies shame is to be avoided, it has more ambiguous cultural meanings for some groups. It is both an aversive feeling of exposure and censure and also a publicly sanctioned goal and virtuous state-of-being. For example, "having shame" can signify the preservation of dignity, modesty, and moral integrity, whereas "shame-*lessness*" and "shame-*fulness*" can both suggest moral failure and the loss of prestige and honor. These dual meanings are apparent, for example, in the shame/honor codes of *haji* in Japan (Ikegami, 2003), *takarakit* among the Tuareg of Mali (Rasmussen, 2007), *lajya* in South Asia (Parish, 1991; Shweder, 2003) and in concepts of *shame* in the United States (Hollander, 2003).

Normatively, shame serves regulatory and protective functions that consolidate the psychic structure of the social self and prevent anticipated exposure and loss of personal boundaries (Lewis, 1987; Schore, 1994). However, in the course of peri-traumatic events, including torture, sexual abuse, accidents and unexpected loss, the

social self comes under attack and those boundaries can be destroyed. The acute experience of shame acts as the primary register of these threats to the social self. As Wilson et al. (2006) state, unlike other emotions, "shame damages the soul of the person, his or her most cherished and inner sense of identity and humanity" (p. 139). Below, the discussion will review a model of normative shame developed by psychological anthropologist Daniel Fessler and then examine its relevance to traumatic shame and PTSD.

Fessler's dual logics model

Based on ethnographic research and an exhaustive review of shame-like emotions in different societies and cultural domains, Fessler (1999, 2007) posits that shame is a panhuman defensive emotion elicited by two different classes of relational events, or logics. The first logic involves the *recognition of one's own inferior social status* and associated aversive feelings. The second involves the painful recognition of the self's *failure to conform to social norms and expectations* (see Fig. 1). Drawing on evolutionary theory, Fessler argues that both logics co-evolved in the human ancestral environment as adaptive action tendencies in social contexts organized by dominance hierarchy as well as cooperation and conformity (cf., Gilbert, 2003). Both logics are dimensions of the same emotion because they each elicit the same set of evolved, shame-typical behaviors that include turning away of the face and body, stooping, gaze aversion, physical withdrawal and avoidance of social contact. In his review, Fessler (1999) found that some cultural descriptions of this emotion use both logics, while others tend to emphasize only one of the two logics.

For example, *malu*, the Malay term for shame in parts of Indonesia (where Fessler conducted ethnographic research), reflects both recognition of status inferiority and personal norm violations. *Lajya*, the shame term in India, tends to refer to status inferiority and timidity, while *shame* in North America tends to emphasize the personal norm violations and resulting deficiencies in self-esteem (see Fig. 1). This evidence strongly suggests that cross-cultural variations in meanings and social orientations to shame are not incommensurate, as some scholars have argued (e.g., Shweder, 2003). Rather, they reflect local elaborations on this panhuman biogenetic structure based in the dual logics. This point is significant because it provides researchers, clinicians, and aid workers a common reference for identifying and managing shame cross-culturally rather than the specter of unbounded cultural variability. The framework for normative shame described above serves as a foundation for the mechanisms of traumatic shame.

Peri-traumatic shame

The term "peri-traumatic emotions" refers to direct responses to intensely stressful circumstances. These responses do not to involve substantial cognitive elaboration in secondary appraisal systems like full-blown secondary emotions. Rather they are primary affects, or "hot spots," that are also associated with the intense re-experiencing of events (Grey et al., 2001). Fear, horror, and helplessness (stressor criterion A) are considered to be the definitive peri-traumatic bases of psychological trauma leading to PTSD. However, there is cause to argue that shame should also be part of this picture.

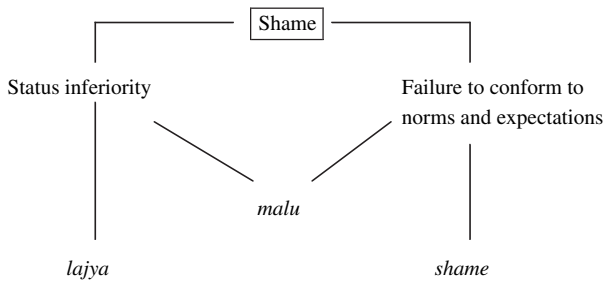

Fig. 1. The dual relational logics of the panhuman human emotion shame and their cultural elaborations: lajya (India), malu (Indonesia), and shame (North America).

Emotion theorists since Darwin have noted that shame/humiliation and fear/horror share a family resemblance as defensive emotions anchored in the mammalian "fight or flight response" (e.g., Gilbert, 2003; Sedgwick & Frank, 1995; Tomkins, 1962). In a recent meta-analysis of non-clinical populations, Dickerson, Gruenewald, and Kemeny (2004) found that specific patterns of elevated cortisol and pro-inflammatory cytokines are associated with perceptions of uncontrollable events, helplessness, social exposure, and failure that are specific to shame. Pro-inflammatory cytokines, in particular, orchestrate "sickness behaviors" that underlie social withdrawal in the face of threatening or negative evaluations and can also impair immune functioning. The authors argue that these biomarkers function as coordinated adaptive (or maladaptive) responses to threats to *social* self-preservation, which are distinct from psychobiological correlates of fear and *physical* self-preservation. Notably, DSM-IV stressor criteria do not reflect the explicit link between helplessness and shame found here. Acute social threats can also precipitate peri-traumatic dissociations (involving disruptions of normally integrated perception, memory, and identity). Peri-traumatic dissociation is a strong predictor of PTSD (Ozer, Best, Lipsey, & Weiss, 2003) and has a distinctive relationship with shame, a relationship that does not exist with other emotions such as guilt (Irwin, 1998).

Although there has been relatively little empirical focus on peri-traumatic emotions in PTSD, studies and narrative analyses confirm that peri-traumatic shame dynamics are key features of interpersonal trauma. These include female-directed violent crime and sexual abuse (Kaysen, Morris, Rizvi, & Resick, 2005; Trumbull, 2003), gender-neutral physical assault (Grey et al., 2001), child abuse (Schore, 1994), combat exposure in war veterans (Wong & Cook, 1992), and politically motivated violence (Levi, 1988; Rice & Benson, 2005; Shapiro, 2003).

Levi's (1988) writings on the Holocaust offer a lens for understanding the underlying structure of interpersonal traumas. They describe that the chronic circumstances in concentration camps (e.g., torture, rape, participating in or witnessing other forms of brutality, erasure of previous identity, and the specter of death) became particularly potent sources of shame for Jewish survivors. These were encounters with the vicious contempt, rejection, and subjugation by their Nazi captors. They inflicted extreme violations of moral values and expectations about a predictable world and the incapacity to defend against "the Other" or to mount a retreat. Traumatic experiences of this nature strip individuals of their status, dignity, and all sense of person control and render them unable to act congruently with moral values (see Wilson et al., 2006). Indeed, scholars of political violence and human rights contend that the principle goal of breaking someone with acts like torture is to strip away dignity and to render the victim completely humiliated, defenseless, and compliant (Chilton, 2006; Shapiro, 2003).

These characteristics can be elaborated in a model of traumatic shame. Although physical assaults, sexual abuse, combat, and severe accidents can pose physical threats to life and limb, they also threaten the integrity of the social self. Social threats manifest in two principle ways: 1) the experience of acute domination and subjugation; and 2) acute violation or erasure of norms, values, and expectations about the world. This double structure is fluid with Fessler's dual logics of shame. Hence, in the peri-traumatic response

to overwhelming social threat, the experience of status inferiority becomes magnified through hyperbolic domination/subjugation into acute helplessness in which the victim's sense of personal agency and control is lost. The second logic, corresponding to failures to conform to norms and expectations, also distorts in the context of acutely stressful events. Such experiences register as violations of normative assumptions about the world, which incite a profound sense of exposure and the loss of moral integrity and identity. In short, peri-traumatic shame represents expressions of the dual logics of shame, pushed to the extreme (see Fig. 2). This model, unlike the DSM-IV stressor criterion (A1), accounts for threats to the social self within interpersonal dynamics regulated by hierarchy and power asymmetries as well as collective meanings and goals. Thus, it resonates with anthropological perspectives on emotions and selfhood and has significant utility for addressing the social embedding of trauma.

Overwhelming events associated with PTSD are not always characterized by experiences of domination/subjugation by discrete external agents. Accidents and injury, disruptions in intimate relations, personal loss, financial troubles, large-scale disasters, and social upheaval can also precipitate peri-traumatic reactions of helplessness, exposure, and defeat (see Kirmayer et al., 2007; see Rosen & Lilienfeld, 2008). Perpetrators of brutality and abuse may initially take on the role of dominator, but once beset by intense feelings of shame, they too can feel traumatized self-criticism often heard in bearers of PTSD that "I am not what I thought I was" (Stone, 1992, p. 134). In affect theory, shame is partly the experience of self-evaluation that registers dissonance between and the ideal and "real" self. The shock of unexpected stressful events exposes the social self and magnifies this dissonance. As a consequence, the self comes to feel dominated and subjugated under the weight of internalized ideals, which may develop into prolonged self-contempt (Wilson et al., 2006).

Posttraumatic shame and PTSD symptoms

Dimensions

Peri-traumatic shame can get elaborated over time into posttraumatic shame depending on experiences in the social environment. Clinical literature indicates that shame is a pervasive emotional response in protracted posttraumatic coping and a key mediator of PTSD symptoms. This includes evidence of posttraumatic shame in female-directed sexual assault (Vidal & Petrak, 2007), child abuse (Andrews et al., 2000; Deblinger & Runyon, 2005; Schore, 1994), and combat exposure in war veterans (Mason et al., 2001; Singer, 2004; Wong & Cook, 1992). Posttraumatic shame also emerges in personal and collective narratives related to political violence and dislocation (Elsass, 2001; Kinzie, Fredrickson, Ben, Fleck, & Karls, 1984). For example, in work by Kinzie et al. (1984), Cambodian concentration camp survivors diagnosed with PTSD expressed overwhelming shame about their personal ordeals under Pol Pot's regime and also about their sense of a failed national history and their very identity as Cambodians.

Wilson et al. (2006) define posttraumatic shame as both acute and prolonged feelings and secondary appraisals of the damaged social self, and they identify its core maladaptive dimensions. One subset constellates around diminished personal value including the loss of face, esteem, and self-worth; diminished wholeness, virtue, and moral integrity; and feelings of powerlessness, inadequacy, failure, and smallness. These refer to ego-defensive processes that conflict with ideal self-images. Another subset encompasses compromised social relations and integrity of the self in the eyes of others. These include loss of self-respect and self-continuity within culturally defined roles, status, and expectations; self-consciousness over letting down intimate relations; and social condemnation and failure. The last dimension involves alienation and the rupturing of social ties including self-annihilation and suicidality in fantasy or action, desire for escape and isolation, and actual social withdrawal. These processes refer to acute social exposure and censure as well as a fall from grace due to the inability to act in consonance with cultural norms and values. Taken together, these features of posttraumatic shame embody the dual logics of shame and the subjective features of peri-traumatic shame. Wilson et al. (2006) suggest that they also reflect discrepancies between internal and external orientations of shame that dysregulate self-experience in social context and orchestrate clinical symptoms.

PTSD symptoms

In light of the argument that PTSD develops from the temporal course of affective disturbances, it is untenable to think that shame operates separately from other emotions. As indicated earlier, *fear, guilt, anger, mistrust, disgust,* and *grief* are widely observed in PTSD. Psychologist Allan Schore (1994) contends that, "Shame has the capacity to linger, spread, and regulate all other emotion expressions" (pp. 361–362). Bearers of PTSD intrinsically seek meaning about eliciting events and posttraumatic experience. Thus, a *dimensional* view of shame is necessary in order to get a better read on the temporal flux of consciousness and the vicissitudes of the social environments that influence pathogenesis and symptom course.

Shame has an active role in PTSD symptoms that goes largely unrecognized in DSM-IV-TR core symptom criteria (APA, 2000). Criterion B is defined as re-experiencing events involving recurrent, intrusive recall or dreams of distressing events, feelings that the stressful events are happening, and intense psychological distress and physiological reactivity to cues that symbolize or resemble the traumatic moments. Henning and Frueh (1997) found that the degree of severity in shame experience was positively associated with this symptoms cluster in combat veterans. In clinical observations, posttraumatic shame states are frequently associated with events that symbolize the profound horror of traumatic experiences (see Wilson et al., 2006).

Criterion D is defined as states of hyper-arousal that involve hyper-vigilance and startle responses, disturbances in sleep and concentration, and irritability and outbursts of anger. In addition to re-experiencing symptoms, these states may have some basis in

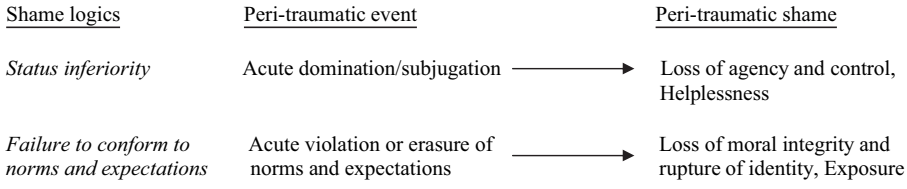

Fig. 2. A model for peri-traumatic shame based on the dual logics of shame as social threat.

dissociative processes, although evidence for this is equivocal (see Rosen & Lilienfeld, 2008). Literature on the psychology of shame addresses the basis of anger/rage in shame, wherein the exposed, entrapped, and humiliated self turns outward with hostile attempts to save face (e.g., Giligan, 2003; Lewis, 1987; Scheff & Retzinger, 1991; Rice & Benson, 2005, Tangney & Fischer, 1995). More clinical and empirical attention must be given to this dynamic in the context of PTSD.

The link of shame to generalized hyper-arousal and vigilance is less clear. By considering that re-experiencing (B) and hyper-arousal symptoms (D) can co-regulate each other, shame's involvement may be conceptually substantiated. When situational cues prompt hyper-arousal states, they can lead to a flood of intrusive memories. Initial recurrent and distressing memories can also prompt startle responses and hyper-vigilance. Shame, surfaces as defensive psychological and behavioral reactions to acute threats, which can initially resemble fear. Hence, shame and fear may also co-emerge, co-assemble, and dysregulate one another in posttraumatic responses to both physical and social threats. For instance, hyper-vigilance and startling, usually assumed to be fear-anxiety reactions, may correspond to latent shame and an intense preoccupation with socially threatening triggers or the suppression of overwhelming shameful memories. Additionally, situational cues that elicit shameful memories may also prompt the reliving of terrifying scenarios and hyper-vigilant or dissociative reactions that attempt to escape them. Terrorizing memories, hyper-arousal, and fearful affect may also provoke shame in response to the inability to control oneself and to the specter of public ridicule. Once shame manifests, it can further instigate a cycle of *shame-shame*; that is, shameful feelings *about feeling ashamed* (Lewis, 1990). Thus, *fear-shame, shame-fear* and *shame-shame* cycles may very well underlie the development and course of core clinical symptoms of PTSD, as well as co-morbid affect syndromes of generalized anxiety, social anxiety, panic, and dissociative disorders (Rosen & Lilienfeld, 2008). Empirical questions remain about the phenomenal and psychobiological relation of shame and fear that deserve greater attention.

Emotional numbing and stimulus avoidance comprise the final core symptom cluster in PTSD (Criteron C). This includes efforts to avoid activities and thoughts associated with traumas, amnesias for aspects of traumatic events, diminished interest in significant activities, detachment and estrangement from others, and a restricted range of affect. There is strong evidence to suggest that shame forms its pathological nucleus. Henning and Frueh (1997) found PTSD-related avoidance symptoms in combat veterans were strongly associated with severity of shame experiences. Tendencies toward avoidance may overlap with some of the process described above in which shame represents efforts to flee triggering stimuli or to bury intrusive memories. The psychic tension of this self-estrangement can compel symptomatic dissociative amnesias, derealizations, and emotional numbing (Wilson et al., 2006; Wurmser, 1987). In another study with combat veterans diagnosed with PTSD, Mason et al. (2001) found low urinary cortisol levels to be a persistent neuroendocrine trait of PTSD underlying maladaptive coping strategies of disengagement and emotional numbing in the study population. The researchers found these behaviors to be closely linked to "intractable shame-laden depressive affect" (p. 387) and suggest that much greater attention must be given to the role of shame in all aspects of the disorder.

Withdrawal, the desire for escape and isolation, and suicidality are salient dimensions of posttraumatic shame identified by Wilson et al. (2006). These inclinations can have their roots in feelings of "social death" or "death of self," sentiments widely noted in clinical and ethnographic observations of both overwhelming shame (Giligan, 2003; Kilborne, 1999; Parish, 1991) and PTSD (Brewin & Holmes, 2003). Chronic negative appraisals of the self and the social environment that go unresolved can subsequently get channeled into major depression, alcohol abuse, and suicidality. These are all outcomes that have significant co-morbity with PTSD (APA, 2000).

In sum, posttraumatic shame functions in a number of ways: It activates defensive reflexes to social threats; it transforms acute subjugation and violations of norms into helplessness, loss of moral integrity, painful self-consciousness; and it severs continuity with cultural meaning, identity, and social roles. These social self experiences can then orchestrate posttraumatic symptoms. Although clinical research indicates substantial variability in symptom patterns (Rosen & Lilienfeld, 2008), the evidence reviewed here substantiates traumatologist Andrew Stone's (1992) claim that "shame can and does play a significant role in every phase of the acquisition, manifestation, and treatment of PTSD" (p. 133).

Identification of shame in socio-cultural context

The focus until now has been on mechanisms of traumatic shame in PTSD and will now turn to the issue of context. Conceptions of how shame operates cannot be divorced from questions about how people experience, communicate, and manage shame through their collective meanings, norms, and status roles. Because of the unfortunate dearth of cross-cultural studies of traumatic shame, this section will draw on findings from anthropological studies of normative shame that may help us think about the implications for traumatic shame and PTSD. Four domains that are critical for identifying shame are considered: 1) *emotion discourse*; 2) *ethnopsychology*; 3) *changing status roles and social relations*; and 4) *stigma*.

Emotion discourse

Emotion discourse is a key domain for detecting cultural variability in emotional orientations and meanings. *Talk* about emotional life hinges largely on language socialization through which different social groups cognitively elaborate (*hypercognize*) some feeling states and suppress or underemphasize (*hypocognize*) others (see Levy, 1984). For example, Fessler (2004) showed that Malay-speakers in Indonesia hypercognized the shame term *malu* with rich lexical elaborations. In contrast, Southern Californians hypocognized shame. Also, Southern Californians tended to hypercognize guilt in place of shame, whereas Fessler's Malay informants did not posses an emotion concept for guilt. In another case, anthropologist Gananath Obeyesekere (1984) showed that Sri Lankans typically conjoin the Sinhala term for shame, *lajja*, with the fear term, *baya,* as *lajja-baya*, or *shame-fear*, which connotes "fear of ridicule or social disapproval." However, in American English, fear, frequently stands in for shame, such as in notions of *stage fright*, *fear of public speaking*, *fear of failure*, and *social phobia.* These constructs, like *lajja-baya*, gloss painful anticipation or feelings of social exposure and ridicule, but unlike the Sri Lankan term, they mask the referent shame.

The recourse that actors have to emotional language has important implications for how trauma-related distress is expressed and managed in clinical care. Some scholars contend that the concept of shame is largely disappearing in contemporary American discourse (e.g., Cohen, 2003; Scheff, 1988). Paradoxically, recent scholarship maintains that shame is gaining prominence in the clinical language of trauma in the West and has eclipsed terms like guilt (Leys, 2009). Yet, clinical theorists acknowledge that, in practice, shame is often difficult to detect in patients because it gets buried in tendencies to withdraw, in language styles, and in distortions of memory, only to resurface in clinical symptoms, maladaptive behaviors, and somatic distress (see Lewis, 1990). When emphasis is placed on guilt reactions in PTSD, such as

perpetrator guilt or survivor guilt, psychotherapeutic interventions may focus on seeking external means of reparation while overlooking the shame-damaged self. When emphasis is placed on fear, intervention may favor desensitization psychotherapies or anxiolytic treatment to blunt hyper-reactivity. Here too, shame lurks unaddressed. Arguably, linguistic norms in English that favor fear-talk over shame-talk also help explain why the concept of fear is privileged in state-of-the-art neurological and diagnostic models of PSTD. In short, detecting shame cross-culturally and in clinical settings requires attention to discursive practices that pattern its expression and its relations with other emotions. The salience of shame has potential implications for developing new strategies for therapeutic management of PTSD (see Grey et al., 2001).

Ethnopsychology

The meanings and uses of emotion terms are also embedded within ethnopsychologies of personhood. Cultural values regarding autonomy and community have been particularly important for contextualizing orientations to shame. Clinical psychologist Peter Elsass (2001) worked with village communities in Peru and Columbia that have suffered from intense political conflict that inflicted murder, rape, torture, and disappearances on inhabitants of the region. He found that in collectivist communities of Peru, people diagnosed with PTSD tended to downplay symptoms and the need for psychological crisis intervention. They instead favored efforts to strengthen the reconstruction and solidarity of the community and emphasized the need to forget past events as the path to true healing. Colombians who live in communities with individualistic values and social organization tended to favor psychological interventions directed at individual symptoms and, indeed, emphasized problems of shame and guilt in their trauma narratives. Elsass' findings are compelling, though somewhat paradoxical in that shame is reputed to be more hypercognized in groups with collectivist orientation.

This ambiguity calls to mind problems with cultural typologies like individualism and collectivism. Although they have been long been staples of anthropological and social psychological research, such abstract constructs tend to speciously reduce human groups and social emotions into bounded and homogenous 'cultures' in which individuals putatively conform to either independent or interdependent personality types. In contrast, recent studies in cognitive anthropology indicate that individuals have more multi-faceted and flexible ethnopsychologies that draw on diverse value orientations and situated social contingencies (D'Andrade, 2008; Strauss, 2000).

Changing status roles and social relations

Actors also inhabit dynamic social environments in which the meanings of shame and of moral personhood for a 'cultural group' can also change. For example, in a study with Muslim Turkish immigrants in Denmark, Gretty Mirdal (2006) describes how, over a twenty-year span of time, women's understandings of shame, or *ayip*, changed as a function of newly adopted gender roles. Mirdal's informants initially spoke of *ayip* in association with female sexual honor, inappropriate exposure, and protection of gendered space as a religious duty. Over time, these same women gained greater socio-economic mobility in Denmark's labor force, more educational opportunities, and new personal and sexual freedoms. Their shame meanings correspondingly took on different significance, reflecting newfound concerns with socio-economic inferiority and family provisioning. Women's orientation to shame became more like those of Turkish men, resembling typical male sentiments of social disgrace over failed productivity and social prestige.

Mirdal's study shows that shame ideologies and the conditions that elicit shame for a given ethnocultural group are not static, but rather flexible and porous. Through enculturation to new environments and institutional practices, actors reconfigure their social identities and the meanings they assign to experiences of shame. Notably, the changing signification of shame for these Turkish-Danish women hinges on Fessler's dual shame logics with a shifting preoccupation from upholding gendered norms to concern over status inferiority.

The focus on changing social roles and relations does not invalidate traditional constructs like individualism and collectivism or ethnocultural identity, but rather provides a way to embed them within the shifting relational contingencies of everyday life. Research on trauma and posttraumatic experience must account for such realties and how they are linked to widespread social transformations involving trans-national migrations and dislocation, cultural pluralism, ethnic hybridization, as well as shifting gender politics and power relations. These are all important relational domains for examining the social causes, experiences, and consequences of traumatic shame and PTSD, especially considering shame's intersubjective orientation to power asymmetries. Notably, all types of interpersonal traumas observed in clinical studies and interventions occur directly as a function of an interpersonal power dynamic. When social institutions breakdown or become themselves the grounds for atrocities and injustices, they can become the grounds for acute injuries to the social self and the unfolding of PTSD.

Stigma

Shame is not exclusively about individual experience but also exists in ideologies that motivate conformity to norms. The public ethos of shame that normally promotes solidarity also has a dark side. Stigma is rooted in collective processes of shaming, social control, and maintenance of in-group boundaries. With respect to psychiatric disorder, stigma evokes humiliation and embarrassment over one's broken state and can hinder attempts to find assistance or to maintain important bonds of social support. Stigma also silences actors in their attempts to voice distress and identify sources of trauma.

In their study of child sexual abuse in British-Asian communities, Gilligan and Akhtar (2006) show that stigma is a significant factor in the underreporting of abuse and related psychological disturbance, particularly because mothers' of abused children felt intense anxiety about the criticism that would be levied in the community and by local social services. Thus, they concealed the identities of the perpetrators in the community rather than put the emotional needs of their children first. Several themes emerged in mothers' narratives: *sharam* (shame/embarrassment), *izzrat* (honor/respect), and *haya* (modesty). Together, they underpin a collective ethos of shame, which provided a basis for self-protection and for maintaining a false sense of community. This account demonstrates that stigma deserves particular attention in traumatology because of how it strips people of agency and obstructs the processes of narration, care seeking, and restitution.

Conclusion

The focus will now turn to recommendations for the DSM-V revision. Psychological traumas are, in a very profound way, about threats to the social self. Overwhelming social threats tear away the fibers of one's very being, inasmuch as they destroy relational bonds with the social world. This paper has conveyed that traumas are not merely private experiences. They are part of a relational order that upends interpersonal and intersubjective coherence in ways that

hinge on overwhelming power dynamics embedded in our common social institutions. The focus on threats of physical injury and death in DSM-IV-TR falls short of capturing these pervasive psychosocial dimensions of traumatic experience. Thus, the stressor criterion (A1) should be amended to give more emphasis to perceived threats to the social self, which are mediated by shame's dual relational logics.

Secondly, peri-traumatic and posttraumatic shame regulate the broad range of core symptoms of PTSD. Whereas the stressor criterion (A2) focuses on feelings of fear, horror, and helplessness as the core of traumatization, a primary focus should also be on shame as a response to most, if not all, types of elicitors. Helplessness should be more explicitly linked to shame, in line with the model proposed in this paper.

PTSD emerges and stabilizes through dysregulation of affects that co-assemble in temporal patterns of consciousness and behavior, with shame as the anchor. The symptom criteria (B, C, and D) should be revised to emphasize the dimensions of posttraumatic shame that influence pathogenesis and pathology of PTSD.

Finally, clinical understanding must account for spheres of social and cultural life in which traumatic shame unfolds. The four identified here can be thought of as integral processes that regulate the experiences and expressions of traumatization and psychopathology and could be added to the DSM Axis IV criteria that describe psychosocial and environmental characteristics relevant to the clinical dimensions. By widening our lenses beyond individual symptom profiles, clinicians and researchers can gain a better picture of socio-cultural factors that shape shame meanings and expressions while also remaining cognizant of its basis in our common heritage.

This paper offers a starting point for re-thinking models of trauma and PTSD. As a conceptual framework, it requires additional validation through continued clinical and ethnographic description and empirical testing. Such an effort can stimulate interdisciplinary collaborations to refine our diagnostic tools and our understanding of the social and emotional life of PTSD. In taking up this challenge, we may also better serve those who suffer under its weight.

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