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Shame Regulation in Personality Pathology

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Drawing on extant work on shame and emotion regulation, this article proposes that three broad forms of maladaptive shame regulation strategies are fundamental in much of personality pathology: *Prevention* (e.g., dependence, fantasy), used preemptively, lessens potential for shame; *Escape* (e.g., social withdrawal, misdirection) reduces current or imminent shame; *Aggression*, used after shame begins, refocuses shame into anger directed at the self (e.g., physical self-harm) or others (e.g., verbal aggression). This article focuses on the contributions of shame regulation to the development and maintenance of personality pathology, highlighting how various maladaptive shame regulation strategies may lead to personality pathology symptoms, associated features, and dimensions. Consideration is also given to the possible shame-related constructs necessitating emotion regulation (e.g., shame aversion and proneness) and the points in the emotion process when regulation can occur.

Keywords: shame, emotion regulation, personality disorders, personality pathology

Nearly one-tenth of individuals in the general population and nearly one third of clinical samples have at least one personality disorder (PD; Trull, Jahng, Tomko, Wood, & Sher, 2010; Zimmerman, Rothschild, & Chelminski, 2005). PDs are thought to be particularly difficult to treat and can complicate the treatment of other disorders (e.g., Piper & Joyce, 2001; Dolan-Sewell, Krueger, & Shea, 2001), making personality pathology all the more important to address in clinical settings. To address personality pathology appropriately, it is important to have a sufficient understanding of why it develops. In this article, we propose that maladaptive shame regulation is at the core of many pathological personality features.

Both emotion regulation and shame have previously been implicated as important factors in personality pathology. For example, borderline personality disorder (BPD) involves affective instability (American Psychiatric Association [APA], 2000), which some suggest is indicative of emotion dysregulation (e.g., Gratz, Rosenthal, Tull, Lejeuz, & Gunderson, 2006). With regards to shame, for example, the *Diagnostic and Statistical Manual of Mental Disorders-IV* (*DSM–IV*; APA, 2000) indicates that those with avoidant personality disorder (APD) have pervasive fears of rejection and view themselves as inferior, both suggestive of shame. Surprisingly, the relationship between personality pathology and shame regulation has not been thoroughly discussed. The goal herein is to generate testable hypotheses regarding the role of shame regulation in personality pathology. We propose that the

diminished ability to effectively use emotion regulation strategies to avoid and/or alleviate shame plays an important role in the development and maintenance of some personality pathology, which would therefore make maladaptive shame regulation strategy use an important treatment target.

Emotion Regulation

Emotion regulation includes any conscious or unconscious attempt to influence when emotions arise, which ones they are, their duration, and/or the elements of those emotions—their subjective experience, behavioral expression, and/or physiological impact (see Gross & Thompson, 2007). Like the popular Process Model of emotion regulation (Gross & Thompson, 2007), our organization of the shame regulation strategies takes the timing of strategy use into consideration, distinguishing between forms that occur well in advance of shame elicitation and those that occur later in the emotion process, when shame is imminent or ongoing.

Shame and Shame-Related Constructs

Shame involves the subjective experience of the *self* as defective (Lewis, 1971). It can be elicited in a variety of public or private situations, whenever flaws become apparent to the self (e.g., Tangney, Miller, Flicker, & Barlow, 1996). Behaviorally, shame is often expressed by downcast eye-gaze, head tilting down or to the side, covering the face with the hand, and/or postural changes to make the body appear smaller (e.g., Keltner & Buswell, 1996). Although several emotions (e.g., fear) are undoubtedly relevant to personality pathology, we believe that shame is particularly important. Negative self-beliefs that might trigger shame onset are likely to be highly distressing, as evidenced by their prominent role in depression theories (e.g., Beck, 1963). Moreover, as previously suggested by others (e.g., Whelton & Greenberg, 2005), we believe that the shame sometimes engendered by awareness of negative self-beliefs is possibly even more important than the beliefs themselves in the generation of psychological ill-health. We be-

lieve that little else could be more upsetting than the shame created when perceiving oneself to be a "bad" person. Whereas other emotions are elicited primarily based on situation-specific factors (e.g., guilt elicited by attributing blame to oneself for a specific behavior in a specific situation, regardless of how one perceives oneself typically behaving), shame results from attributing information about a specific situation to characterological defects. Therefore, shame triggers are unique in that they are carried around by individuals, constantly threatening to cause distress. Thus, like personality pathology itself, shame and/or the threat of shame may be pervasive across time and situation.

The shame literature provides some preliminary support for our assertion that, compared with other emotions, shame is especially detrimental. In existing correlational and quasi-experimental studies, shame has repeatedly been associated with a variety of psychological problems (e.g., Tangney & Dearing, 2002; Thompson & Berenbaum, 2006), and there is little evidence that shame serves an adaptive function (see de Hooge, Breugelmans, & Zeelenberg, 2008). By contrast, other emotions—even unpleasant emotions—can be adaptive. For instance, guilt that arises from a bad decision/behavior leads to apologizing or reparations, which are adaptive responses resulting in good interpersonal functioning (de Hooge, Zeelenberg, & Breugelmans, 2007).

Because of its distressing and maladaptive nature, we expect most individuals to try to down-regulate shame. We propose that individual differences in shame forecasting, shame-proneness, and shame aversion are associated with preferences for using certain forms of shame regulation, with the inappropriate use of shame regulation then leading to the development and/or maintenance of personality pathology.

Shame forecasting.   In order to use shame regulation strategies before shame is elicited, people must first anticipate shame. Predicting how situations will make one feel if encountered in the future is termed affective forecasting (Wilson & Gilbert, 2003). Regardless of their accuracy, it is reasonable to expect that people will behave in accordance with the emotions they anticipate, fostering anticipated pleasant emotions and avoiding anticipated unpleasant emotions.[1] Thus, we hypothesize that greater shame forecasting will result in more frequent use of shame regulation strategies before emotion elicitation.

Shame-proneness.   Most research on shame focuses on individual differences in the propensity to experience shame across situations, referred to as shame-proneness (e.g., Tangney, Wagner, & Gramzow, 1992). Shame-proneness is associated with a wide variety of negative psychological outcomes (see Tangney & Dearing, 2002), including some personality pathology (e.g., Schoenleber & Berenbaum, 2010; Gramzow & Tangney, 1992). Being shame-prone implies that the emotion is experienced with some frequency. Therefore, we expect that the use of shame regulation strategies used after emotion elicitation will be more common among individuals with elevated shame-proneness.

Shame aversion.   Recently, we hypothesized that shame aversion—the tendency to perceive of shame as an especially painful and undesirable emotion—is relevant to psychopathology (Schoenleber & Berenbaum, 2010). In our study, shame aversion was related to Cluster C PDs even after taking shame-proneness into account. Moreover, both shame aversion and shame-proneness were significant predictors of these disorders over and above general negative affect. We expect that shame aversion

contributes to maladaptive shame regulation at any point in the emotion process. When shame is elicited or forecasted, individuals for whom shame is particularly aversive may feel more motivated to use strategies to reduce shame or its likelihood. Therefore, we hypothesize that many individuals with personality pathology have elevated shame aversion, contributing to pervasive maladaptive shame regulation.

Forms of Shame Regulation

The literature on shame suggests three broad forms of shame regulation. A depiction of these forms and their respective strategies is shown in Figure 1. Behavioral shame responses include preemptive avoidance of and escape from perceived shame triggers (Lindsay-Hartz, De Rivera, & Mascolo, 1995). Thus, we distinguish between strategies that are used to completely circumvent situations that might elicit shame (Prevention) and those that allow for disengagement from situations in which shame is impending or already elicited (Escape).

Our final form of shame regulation-Aggression—is based on long-standing theory that shame is associated with anger/aggression, referred to as "shame-rage" (Lewis, 1971). Angry self-loathing in response to perceived defects can be expressed in self-directed aggression (e.g., self-injury; Brown, Linehan, Comtois, Murray, & Chapman, 2009). Moreover, hostile acts against others are thought to occur when shame becomes so overwhelming that the person refocuses self-hate onto others and reacts accordingly (e.g., Lewis, 1971). Similar to Escape, Aggression shame regulation occurs after shame elicitation. Unlike Escape, however, Aggression shame regulation reflects attempts to actively deal with shame-eliciting situations, rather than disengaging.

Shame Regulation in Personality Pathology

We propose that problems regulating shame are central to the understanding of many forms of personality pathology and are directly related to the development of (a) several of the PD symptoms currently outlined in the *DSM–IV*; and (b) some pathological personality dimensions being considered for inclusion in the *DSM-5* (see www.dsm5.org). In fact, we propose that frequent maladaptive shame regulation attempts are essentially used as indicators of many forms of personality pathology.

We believe that some individuals have dispositional characteristics (e.g., a tendency to forecast shame) that increase their propensity to engage in behaviors designed to down-regulate shame. Furthermore, the expression of these dispositions via particular shame regulation strategies will vary to some extent depending on the situation. Thus, our proposal can be broadly situated within the cognitive-affective processing system approach (Mischel & Shoda, 1995) that has previously been used in models of personality pathology (see Morf, 2006). Unlike other models, however, our conceptualization focuses on the strong motivation to decrease shame. Therefore, this article focuses on strategies that individuals

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[1] Research indicates that, under some circumstances, individuals are willing to promote unpleasant emotions if they believe doing so will serve some other purpose (Tamir, Chiu, & Gross, 2007). However, we expect that in most cases people will be motivated to lessen shame, as we do not believe that shame is likely to assist in obtaining other goals.
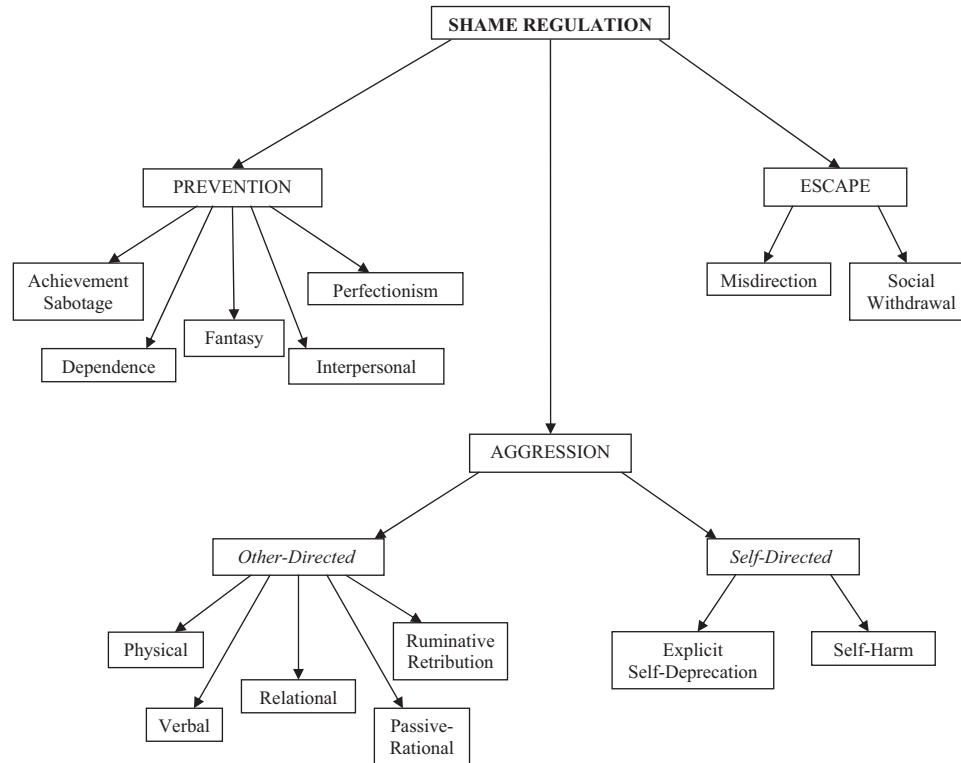
Figure 1. Forms of shame regulation and the strategies that constitute them.

may use in attempts to reduce shame, and we highlight some dispositions and situational factors that may be relevant to understanding how the (likely common) motivation to reduce shame may ultimately lead to maladaptive shame regulation and thereby contribute to personality pathology development.

We do not intend to imply that *anyone* who seeks to regulate shame has personality pathology—in fact, for most people, in most situations, finding an appropriate means of down-regulating shame is adaptive. Although we highlight how some strategies could have positive consequences, we focus on how personality pathology may develop out of shame regulation that has become maladaptive. First, personality pathology may arise from the use of relatively dysfunctional shame regulation strategies. For example, self-injury is likely never a constructive means of down-regulating shame, given its physical dangers. Second, personality pathology may arise when individuals use strategies that are inappropriate to the given situation. For example, although seeking some reassurance can sometimes be adaptive, it may be problematic to wait and wait for abundant reassurance about one's planned approach before initiating time-sensitive tasks. Finally, personality pathology may arise when individuals take an otherwise reasonable strategy to an extreme. For example, although having elevated standards might sometimes be beneficial, needing to be absolutely perfect is likely to be maladaptive, given that achieving perfection is highly improbable. Thus, our goal is to describe a variety of shame regulation strategies and explicate the ways in which maladaptive shame regulation contributes to the development and/or maintenance of many symptoms/features of personality pathology (understood categorically or dimensionally).

Expected associations between shame regulation strategies and *DSM–IV* categories are shown in Table 1, and those for proposed *DSM-5* dimensions are shown in Table 2. It is beyond the capacity of this article to fully explicate how each strategy may be evident in each of the categories/dimensions in Tables 1 and 2. Instead, we provide descriptions of each strategy and then provide theoretical and/or research evidence in support of the presence of that strategy for exemplars of personality pathology. Finally, some future research possibilities related to each respective strategy are briefly mentioned.

Prevention Shame Regulation

Some shame regulation strategies may be used to preemptively reduce shame's likelihood and prevent elicitation altogether; thus, we refer to this form as Prevention. Figure 1 presents the strategies constituting Prevention shame regulation. We expect Prevention shame regulation to be highly associated with shame forecasting, as the anticipation of shame enables individuals to use preemptive strategies. Moreover, we expect increases in shame aversion to be strongly associated with more Prevention strategy use, especially among those high on shame forecasting, because individuals who do not find shame aversive may not be motivated to preemptively reduce the likelihood of shame. Finally, some individuals who use Prevention strategies may also exhibit heightened shame-proneness, as experiencing shame frequently may sometimes contribute to a perception of shame as particularly intolerable. However, we expect that Prevention strategies will be more strongly related to shame forecasting and aversion than to shame-proneness.

Table 1
Associations Between Shame Regulation and DSM–IV Personality Disorders

Forms of shame regulation	DSM–IV personality disorders									
	Paranoid	Schizoid	Schizotypal	Antisocial	Borderline	Histrionic	Narcissistic	Avoidant	Dependent	Obsessive-compulsive
Prevention										
Achievement sabotage								X		X
Dependence					X				X	
Fantasy			X			X	X	X		
Interpersonal avoidance	X							X		X
Perfectionism					X		X	X	X	X
Escape										
Misdirection			X			X	X	X	X	
Social withdrawal								X		
Aggression										
Other-directed										
Verbal				X	X					X
Passive-rational				X	X		X			X
Physical				X	X					
Relational				X	X		X			X
Ruminative retribution	X				X		X			X
Self-directed										
Explicit self-deprecation					X		X	X	X	
Physical self-harm					X					

Note. No hypotheses are depicted for schizoid personality disorder, as we do not expect shame regulation strategies to relate to this disorder as it is currently conceptualized in the *DSM–IV*.

Achievement Sabotage[2]

Achievement Sabotage is the tendency to undermine one's performance, work, or progress. Achievement Sabotage may commonly occur in academic and occupational settings, but it is probably not limited to such settings. For example, some individuals may sabotage their performance in recreational activities. Moreover, sabotage may be active (i.e., intentionally performing poorly) or passive (i.e., avoiding performance situations or "aiming low" to ensure success). Existing theory and research supports the idea that some individuals will create barriers that reduce their ability to perform well, sometimes termed self-handicapping (e.g., Jones & Berglas, 1978). Some forms of self-handicapping are Prevention strategies that allow for later externalization of blame, should the individual's work be seen as a failure (Ferrari, 1991).

One example is procrastination, which may be used as a means of avoiding the possibility of shame, and we suggest is a means of Achievement Sabotage. For example, what appears behaviorally as a preoccupation with details, lists, order, and so forth in obsessive–compulsive personality disorder (OCPD; APA, 2000) may actually be an attempt to put off finishing tasks even more than it is an attempt to achieve high standards. It has been argued elsewhere that delaying the completion of work is simply a means of delaying the evaluation of that work (e.g., Fee & Tangney, 2000). For individuals with elevated OCPD or *DSM-5*'s proposed Perfectionism—who likely experience shame when they fail to perform perfectly—a perceived inability to achieve perfection in a given situation may instead lead to procrastination (i.e., focusing on the planning/details of tasks). This procrastination may ultimately sabotage the individual's ability to produce acceptable work, according to the standards of others.

Existing research indicates that OCPD is related to shame-proneness and aversion (Schoenleber & Berenbaum, 2010). Pro-

crastination is also associated with shame-proneness (Fee & Tangney, 2000). Moreover, procrastination is related to other-oriented and socially prescribed perfectionistic standards, with these relationships moderated by shame-proneness (Fee & Tangney, 2000). Thus, support exists for the hypothesis that shame is relevant to both personality pathology and behaviors consistent with Achievement Sabotage. However, future research is still necessary to determine whether the use of these behaviors serves the goal of down-regulating shame, especially among individuals with personality pathology.

Dependence

To reduce the likelihood that their incompetence will be exposed, some individuals may avoid taking responsibility for tasks, choosing instead to depend on others to take the lead. Prevention strategies that allow for overreliance on others to avoid being responsible for decisions, actions, and outcomes are referred to as Dependence. By placing responsibility in others' hands, individuals can avoid shame that would be elicited if their decisions/actions resulted in less-than-acceptable consequences and exposed their perceived characterological flaws in judgment and/or behavior.

To use Dependence, individuals must first foster supportive/ nurturing relationships with others on whom they can then (over-)rely. The existing literature suggests that individuals high on trait de-

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[2] In using the term "sabotage," we do not wish to imply that all of the actions described are intentional or deliberate attempts to undermine one's abilities and/or opportunities. Rather, our goal is to convey the potential harmfulness of the actions, as sabotage occurs when barriers are put up that prevent individuals from accomplishing tasks and taking advantage of opportunities.

Table 2

Associations Between Shame Regulation and Proposed DSM-5 Dimensions

Forms of shame regulation	Possible DSM-V personality dimensions																																				
	Negative emotionality										Introversion					Antagonism								Disinhibition				Compulsivity					Schizotypy				
	Anxiousness	Depressivity	Emotional lability	Guilt/shame	Low self-esteem	Pessimism	Self-harm	Separation anxiety	Submissiveness	Suspiciousness	Anhedonia	Intimacy avoidance	Restricted affectivity	Social detachment	Social withdrawal	Aggression	Callousness	Deceitfulness	Histrionic style	Hostility	Manipulativeness	Grandiose narcissism	Oppositionality	Distractibility	Impulsivity	Irresponsibility	Recklessness	Orderliness	Perfectionism	Perseveration	Rigidity	Risk aversion	Cognitive dysregulation	Dissociation proneness	Eccentricity	Unusual beliefs	Unusual perceptions
Prevention																																					
Achievement sabotage	X				X	X																		**X**				X	X	X		X					
Dependence					X	X		X	X					X	X											**X**		X		X		X					
Fantasy					X				X			X		X	X				X			X		X					X							X	
Interpersonal avoidance	X	X		X	X	X			X	X		X	X	X	X																						
Perfectionism	X	X		X	X								X	X								X		**X**		**X**	**X**	X	X	X	X	**X**					
Escape																																					
Misdirection								X		X									X		X	X															
Social withdrawal	X	X		X	X	X		X	X			X	X	X	X																	X					
Aggression																																					
Other-directed																																					
Verbal			X								X					X				X	X	X	X		X												
Passive-rational																X		X		X	X	X	X														
Physical			X													X	X	X		X	X	X	X		X		X										
Relational			X													X	X	X		X	X	X															
Ruminative										X																											
Retribution																				X		X	X													X	
Self-directed																																					
Explicit self-deprecation				X	X		X		X												X	X															
Physical self-harm		X	X	X	X		X																		X												

Note. Personality dimensions drawn from www.dsm5.org on 4/24/2011. Boldface Xs indicate that an inverse relationship is expected.

pendency engage in various behaviors to elicit approval and nurturance from others (e.g., Bornstein, Riggs, Hill, & Calabrese, 1996). However, the particular behaviors used may differ depending on the current circumstances. For example, if individuals with elevated trait dependency believe highlighting their strengths will foster a future supportive relationship, they will engage in self-promotion (Bornstein et al., 1996). At other times, these individuals will put themselves down if they believe that self-denigration will lead to longer-term support. Both behaviors are consistent with a desire to avoid exposing personal flaws in judgment/ability by creating relationships in which Dependence shame regulation is possible. Such relationships may be engendered using other behaviors as well (e.g., being self-sacrificing so that relationship partners have more incentive to maintain the relationship).

We expect that frequently using Dependence as a shame regulation strategy will result in a diagnosis of dependent personality disorder (DPD) and/or elevations on the *DSM-5* proposed Dependency dimension. Research indicates that shame is associated with pathological dependency. For example, DPD elevations are associated with higher shame-proneness and aversion (Schoenleber & Berenbaum, 2010). Moreover, trait dependency is related to fears of evaluation and a view of oneself as powerless and ineffectual (e.g., Bornstein, 1997), a view that may engender shame, especially if such defects are exposed. However, research has yet to examine whether particular actions encompassed by the Dependence strategy are also associated with shame.

Fantasy

Another Prevention shame regulation strategy is Fantasy, or engaging in wishful thinking about attaining positive outcomes and/or attributes.[3] In their fantasies individuals can envision themselves possessing desirable characteristics or achieving desirable outcomes, allowing them to divert their focus away from flaws they are concerned they have in reality. Successfully refocusing may help individuals reduce shame's likelihood by helping them ignore the presence of flaws. Thus, fantasy is potentially adaptive, if it is not overused or used at inappropriate times. However, overuse of fantasy could be maladaptive, contributing to personality pathology development.

Similar to our proposal, previous theorists have suggested that fantasy is a defensive strategy, providing defense against depression among narcissists (e.g., Kohut, 1971). We contend that fantasies are a defense against shame in particular. Research supports a relationship between shame and depression (e.g., Tangney, Wagner, & Gramzow, 1992), and we expect the reason fantasy may defend against depression is that it leads to a reduction of shame.

Although its relation to shame has yet to be examined, schizotypal personality disorder (SZPD) has been found to be associated with depression (Lentz, Robinson, & Bolton, 2010). Additionally, schizotypal personality, particularly magical ideation, has been found to be associated with fantasy proneness (Sánchez-Bernardos & Avia, 2006). We hypothesize that some individuals' use of fantasy to prevent shame will predispose them to develop the sorts of odd ideas that are characteristic of SZPD and potentially the proposed *DSM-5* Unusual Beliefs.

A preoccupation "with fantasies of unlimited success, power, brilliance, beauty, or ideal love" (APA, 2000, p. 717) is a criterion for narcissistic personality disorder (NPD), which is likely to be highly overlapping with the proposed Grandiose Narcissism *DSM-5* dimension. One study has examined narcissism and fantasy—Raskin and Novacek (1991) found that individuals high on trait narcissism tend to fantasize about achievement, heroism, and so forth. Supporting our proposal that Fantasy is a shame regulation strategy, Raskin and Novacek (1991) found that in the face of stress, fantasizing was especially likely to be seen among individuals with high narcissism if they also had low levels of self-sufficiency. In other words, fantasy is most likely to be used in the face of threat by individuals high on narcissism who believe they are not competent at handling things on their own, a belief that may otherwise engender shame.

Importantly, there is already support for shame's relationship to trait narcissism (e.g., Gramzow & Tangney, 1992). Unfortunately, there does not yet appear to be research on shame and fantasy. Future studies should examine whether wishful thinking about desirable characteristics/outcomes is associated with shame forecasting, proneness, and aversion. Such relationships would provide initial support for the hypothesis that Fantasy is a Prevention strategy for reducing the likelihood of shame.

Interpersonal Avoidance

Engaging in Interpersonal Avoidance, behaviors designed to circumvent potentially shameful interactions with others, may also contribute to the development of some personality pathology. An obvious example is staying away from situations where other people are likely to be present. Interpersonal Avoidance also encompasses more subtle behaviors; for example, some individuals may evade eye contact and/or talking about themselves. These behaviors have elsewhere been referred to as "safety behaviors" (see Cuming et al., 2009), though that term is broader and includes other behaviors that we would not consider Interpersonal Avoidance. For our purposes, Interpersonal Avoidance includes any behavior that restricts the degree to which individuals actually engage with others in interpersonal situations, with the goal of reducing shame's likelihood. For instance, avoiding eye contact is nonassertive and may prevent genuine engagement with others. These behaviors may contribute to personality pathology if they are used too frequently or in inappropriate situations.

Current symptoms of APD, such as avoidance of occupational and recreational/social activities because of fears of criticism/rejection, can be understood as attempts to down-regulate shame that have become maladaptive. More subtle Interpersonal Avoidance use is also seen in other pathological personality features. For example, individuals with OCPD tend not to disclose personal information, being particularly uncomfortable expressing their emotions (APA, 2000). We hypothesize that this self-protective communication style (e.g., DePaulo, Epstein, & Steele-LeMay,

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[3] We recognize that Fantasy may sometimes be used when shame is imminent and/or ongoing, consistent with Escape shame regulation (described later); however, we classify Fantasy as a Prevention shame regulation strategy as we expect that the use of this strategy is relatively chronic. In other words, although Fantasy may be used just before or sometime after shame is elicited, we posit that this is coincidental to an individual's tendency to use Fantasy frequently across time. However, whether Fantasy is better classified as a Prevention or an Escape shame regulation strategy remains an open empirical question.

1990) serves to decrease the interpersonal engagement between individuals with personality pathology and those around them. Thus, Interpersonal Avoidance is expected to be positively associated with the proposed *DSM-5* Social Detachment dimension, which includes "having only impersonal relations and being taciturn with others" (www.dsm5.org), to the extent that this dimension reflects detachment that is not based on disinterest in others.

As mentioned above, both APD and OCPD are associated with shame-proneness and aversion (Schoenleber & Berenbaum, 2010). Moreover, safety behaviors and a self-protective communication style have both previously been linked to social anxiety, which is furthermore related to experiences of shame and fears of rejection and criticism (e.g., Cuming et al., 2009; Cuming & Rapee, 2010). However, research has yet to examine whether behaviors encompassed by Interpersonal Avoidance operate to regulate shame, especially among individuals with personality pathology.

Perfectionistic Behaviors

As a Prevention strategy, we define Perfectionistic Behaviors as actions designed to either attain excessively high standards or, at least, avoid exposure of imperfections. Recently, the trait perfectionism literature has distinguished between three perfectionistic self-presentational styles (see Sherry, Hewitt, Flett, Lee-Baggley, & Hall, 2007). First, individuals may engage in perfectionistic self-promotion, wherein they draw attention to their achievements at times when they meet high standards. Second, individuals may engage in nondisclosure of imperfections, or the omission of information regarding failure to achieve high standards. Third, individuals may engage in nondisplay of imperfections, in which they conceal from others those features of themselves they believe are flawed. We suggest that these presentational styles are examples of Perfectionistic Behaviors as a shame regulation strategy. Individuals who engage in self-promotion, nondisclosure, and/or nondisplay may be seeking to avoid painful shame that would occur were they to confront their imperfections. Beyond these presentational styles, Perfectionistic Behaviors include any behavior designed to increase the likelihood of achieving exceptionally high standards. For example, individuals may focus heavily on task details or may do excessive preparatory work before initiating tasks, all in the hopes of successfully accomplishing perfectionistic goals and thereby foregoing shame.

When moderately used, we expect Perfectionistic Behaviors to be adaptive, motivating individuals to work hard at achieving their goals. However, inappropriate or excessive use of Perfectionistic Behaviors is likely maladaptive. Trait perfectionism is a hallmark feature of OCPD (APA, 2000) and has also been linked to other PDs, such as narcissistic, avoidant, and dependent PDs (e.g., Hewitt, Flett, & Turnbull, 1992). Initial research on perfectionistic self-presentational styles indicates that Cluster B PDs are especially related to self-promotion, whereas Cluster C PDs are especially related to nondisplay of imperfections (Sherry et al., 2007). Unfortunately, this research did not distinguish among the disorders in each PD cluster. Perfectionism is also among the *DSM-5* proposed dimensions (see www.dsm5.org). Shame-related constructs are also associated with trait perfectionism and the many *DSM–IV* PD categories associated with trait perfectionism. For example, extant research indicates that shame-proneness, fears of negative evaluation, and self-criticism are all related to trait per-

fectionism (e.g., Tangney, 2002). Cluster C PDs are associated with shame aversion and shame-proneness (Schoenleber & Berenbaum, 2010). Shame is also related to trait narcissism (e.g., Gramzow & Tangney, 1992) and BPD (e.g., Brown et al., 2009). Therefore, future research should consider whether perfectionistic actions and self-presentational styles are used as a means for reducing the likelihood of shame.

Escape Shame Regulation

Whereas Prevention strategies occur well before the elicitation of shame, Escape strategies are used to reduce shame that is either imminent or already occurring. As depicted in Figure 1, the Escape shame regulation strategies include Misdirection and Social Withdrawal. Tables 1 and 2 depict the expected associations between Escape strategies and personality pathology. We hypothesize that shame forecasting will be less strongly associated with Escape shame regulation than with Prevention shame regulation. Although some shame forecasting is likely to occur when Escape strategies are used just before the elicitation of shame, more considerable shame forecasting is necessary to engage in the preemptive down-regulation of shame seen in Prevention. We also expect post-elicitation Escape strategies to be highly positively associated with shame-proneness, as being shame-prone implies that the emotion is elicited often. Moreover, we expect shame aversion to be positively associated with Escape strategies used just before or sometime after shame onset, given that elevated shame aversion should motivate individuals to down-regulate shame.

Misdirection

Misdirection, behaviors designed to divert attention away from oneself and one's defects, may be used to down-regulate shame. Individuals who use Misdirection strategies may do so not only to refocus the attention of others onto other people/things but also to try to distract themselves away from personal flaws. Two behaviors we believe exemplify Misdirection are ingratiation and self-promotion. Ingratiation diverts attention onto other people in the situation, and self-promotion ensures that attention is focused on positive attributes rather than flaws. Existing theory and research on the objectives of self-presentation (Jones & Pittman, 1982) suggest that individuals who ingratiate themselves with others are judged as more likable, whereas individuals who self-promote are judged as more competent (Godfrey, Jones, & Lord, 1986). Therefore, both seem to reduce the likelihood of shame, given that being judged as unlikeable or incompetent may elicit shame.

We hypothesize that maladaptive use of Misdirection can lead to pathological personality features. For instance, ingratiation as a form of Misdirection is expected to be used by individuals with elevated DPD and NPD, as both disorders involve attempts to affiliate oneself with others who can supply nurturance or status, respectively (APA, 2000). Furthermore, making ingratiating comments to divert attention onto the positives of others is expected to be associated with the *DSM-5* proposal's Submissiveness, Grandiose Narcissism, and Manipulativeness dimensions. NPD and trait narcissism may also involve the use of self-promotion as a Misdirection strategy. Whereas ingratiation may engender likability when interacting with an authority figure, self-promotion may engender a sense of superior competence when interacting with

equals or individuals over whom one has authority. Consistent with this expectation, research indicates that self-promotion is often used by individuals who are highly competitive (Thornton, Audesse, Ryckman, & Burckle, 2006), a trait which is also associated with narcissism (Exline, Single, Lobel, & Geyer, 2004).

Behaviors indicative of histrionic personality disorder (HPD) may also be examples of Misdirection. Using an overly dramatic self-presentational style may distract others away from the flaws that those with HPD are most concerned about having noticed, distracting others into focusing on more superficial characteristics of the individual. Even if those superficial characteristics are judged poorly by others, such judgment is likely less painful than the negative judgment of core features of the self.

As noted above, shame is related to dependency, DPD, and narcissism (e.g., Gramzow & Tangney, 1992; Schoenleber & Berenbaum, 2010). To our knowledge, research has yet to examine shame and histrionic behaviors or to directly examine the relationship of shame to Misdirection strategies. However, ingratiation and self-promotion have been associated with low self-esteem, fear of negative evaluation, public self-consciousness, and social anxiety (e.g., Thornton et al., 2006), the last of which is also related to shame (e.g., Fergus, Valentiner, McGrath, & Jencius, 2010).

Social Withdrawal

As an Escape strategy, some individuals may engage in Social Withdrawal, attempts to remove oneself physically (e.g., leaving a social gathering) and/or mentally (e.g., disengaging from conversations) from current interpersonal situations. Although they are similar to Interpersonal Avoidance (described above), means of Social Withdrawal are used in the face of impending or ongoing shame. Whereas Interpersonal Avoidance is used to avoid engaging in a social situation in order to prevent shame altogether, Social withdrawal is used to reduce and/or stop engaging in an ongoing social situation when shame is imminent or has already been elicited.

Social Withdrawal is expected to be related to some—but not all—of the same personality pathology that are related to Interpersonal Avoidance. For example, both Interpersonal Avoidance and Social Withdrawal are posited to contribute to APD and *DSM-5*'s proposed Social Detachment. Also likely to be related to Social Withdrawal shame regulation is *DSM-5* Social Withdrawal, which involves "preference for being alone to being with others, reticence in social situations, avoidance of social contacts and activity, and lack of initiation of social contact" (www.dsm5.org). The proposed *DSM-5* Social Withdrawal dimension seemingly combines behaviors that we separate into Social Withdrawal and Interpersonal Avoidance. We believe this separation is important because individuals who use Interpersonal Avoidance when shame is anticipated in advance of a situation will not necessarily use Social Withdrawal shame regulation when faced with imminent/ongoing shame. For example, even though we expect them to use Interpersonal Avoidance when they anticipate shame in advance of a situation, we expect individuals with elevated OCPD to engage in some means of Aggression shame regulation rather than Social Withdrawal when faced with imminent/ongoing shame.

Existing theory and research suggests a strong relationship between shame and features of social anxiety (e.g., Fergus et al., 2010), which is a core feature of APD. Moreover, as mentioned

previously, APD is associated with shame-proneness and aversion. However, research on the use of Social Withdrawal specifically to down-regulate shame has yet to be conducted. Furthermore, future studies should consider whether individual differences in shame forecasting can predict differences in the use of Interpersonal Avoidance and Social Withdrawal strategies.

Psychodynamic theories also implicate Social Withdrawal as a shame regulation strategy in schizoid personality[4] dynamics (e.g., McWilliams, 2006; PDM Task Force, 2006), though this alternative perspective does not map clearly onto any of the *DSM–IV* PDs.[5] These theories describe individuals with schizoid personality as limiting interpersonal contact to protect their sense of a core self because they are easily emotionally overstimulated, especially in interpersonal situations where they may feel that the boundary between themselves and others is fuzzy. From this perspective, shame would be extremely painful—and therefore important to down-regulate—when elicited.

Aggression Shame Regulation

We propose that hostile and aggressive acts are sometimes used after shame has begun as a maladaptive means of regulating shame, specifically to change shame's subjective experience, behavioral manifestations, and/or physiological impact into those generally associated with anger. We hypothesize that the use of Aggression strategies is positively associated with both shame-proneness and aversion. Shame-prone individuals will have more opportunity to redirect shame into anger and consequent aggression. Also, the redirection of shame into an alternative unpleasant emotion suggests that shame is likely to be particularly distressing and unwanted.

The relationship between Aggression shame regulation and shame forecasting may be more complicated. One hypothesis is that shame is experienced/expressed as anger because individuals are frustrated by the unexpected exposure of defects; thus, shame forecasting would be expected to be low among individuals who use Aggression strategies. Alternatively, individuals may become angry about their shame because they had tried to, but were unsuccessful at, avoiding shame. In this case, shame forecasting would be expected to be high. Research on the relationship between shame forecasting and aggressive acts has yet to be conducted.

Other-Directed Aggression

Currently, the relationship between shame and other-directed aggression is not well-delineated, as most studies use measures that confound aggression and anger (see Stuewig, Tangney, Heigel, & McCloskey, 2010). Some studies that specifically assess

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[4] We hypothesize that schizoid personality disorder (SPD), as conceptualized by the *DSM–IV*, is related to pervasive developmental disorders (see relevant work by Wolff; e.g., Wolff, Narayan, & Moyes, 1988) and is the only personality disorder whose symptoms are not related to shame regulation.

[5] It is beyond the scope of this article to discuss relationships between other shame regulation strategies and personality pathology from the perspective of psychodynamic theories; however, the *Psychodynamic Diagnostic Manual* may be useful in generating further hypotheses.

aggression have found a positive relationship between shame and other-directed aggression (e.g., Stuewig et al., 2010), whereas others have found no relationship (e.g., Tangney, Wagner, Fletcher, & Gramzow, 1992). However, it may be that the relationship between shame and other-directed aggression depends on the presence of other factors. Stuewig et al. (2010) found that shame was associated with other-directed aggression only when individuals also had elevated externalization of blame. We posit that various forms of other-directed aggression may be used to retaliate against others who are blamed for exposing personal flaws.[6]

Physical aggression. Physical fighting is among the criteria for antisocial personality disorder (ASPD; APA, 2000). However, we argue that ASPD does not simply involve trait aggressiveness. Rather, we predict that individuals with elevated ASPD will sometimes cause others pain in response to feelings of shame. Indeed, persons with ASPD have been found to be hypersensitive to criticism and defeat (Gunderson & Ronningstam, 2001).[7] Whether this tendency to react intensely to shame-eliciting circumstances influences the relationship between ASPD and physical aggression, however, remains an open question.

The *DSM-5* proposal includes several dimensions we expect will be associated with physical aggression used in the hopes that such acts will reduce shame. For example, we predict that *DSM-5* Grandiose Narcissism will be associated with the use of physical aggression as a shame regulation strategy. Self-report studies indicate that trait narcissism is associated with reactive physical aggression (e.g., Schoenleber, Sadeh, & Verona, 2011). Moreover, in laboratory task studies, individuals with elevated narcissism are more likely to cause others physical pain in the form of administering an intense noise blast (e.g., Bushman & Baumeister, 1998). However, this is only the case in the presence of ego threat or insults to the individuals' self-worth/competence. Individuals high on narcissism did not aggress in response to physical provocation (Jones & Paulhus, 2010) or against individuals who were not responsible for their shame (Bushman & Baumeister, 1998). Thus, those with elevated narcissism are expected to regulate shame via physical aggression, especially when they believe that others are somehow responsible for eliciting that emotion.

Verbal aggression. We further hypothesize that verbal aggression (i.e., intense arguments and/or berating others) can be used as a means of down-regulating shame. In a recent study, this form of aggression was associated with trait narcissism, but the relationship between verbal aggression and narcissism was limited to the vulnerable dimension of narcissism (Schoenleber et al., 2011). These findings are unsurprising, given that vulnerable narcissism entails fragile self-esteem and fears of criticism (Wink, 1991). Importantly, vulnerable narcissism is also associated with shame (e.g., Gramzow & Tangney, 1992). Grandiose narcissism, involving inflated self-esteem, entitlement, and exhibitionism, was unrelated to reactive verbal aggression (Schoenleber et al., 2011).

Unfortunately, *DSM–IV* NPD currently conflates vulnerable and grandiose narcissism (see Miller, Widiger, & Campbell, 2010); therefore, verbal aggression may not show a significant relationship to NPD, as this category is thought to reflect somewhat more grandiose than vulnerable narcissism. More-

over, although it is currently termed "Grandiose Narcissism," it is not clear that the *DSM-5*'s proposed dimension truly represents one or the other narcissism dimension. To the extent that this dimension reflects vulnerable narcissism, we predict that it will be positively associated with verbal aggression. We further hypothesize that the use of verbal aggression by those with elevated Grandiose Narcissism will be the result of a desire to down-regulate shame.

Relational aggression. Attacking others via malicious social exclusion and/or the spreading of negative information about others with the goal of harming their status/social relationships has been referred to as relational aggression (e.g., Crick & Grotpeter, 1995). Werner and Crick (1999) found that relational aggression was associated with BPD-related characteristics such as affective instability. Given that affective instability is similar to the *DSM-5*'s proposed Emotional Lability (see www.dsm5.org), we therefore predict that this dimension will also be associated with relational aggression. The limited existing research (e.g., Tangney, Wagner, et al., 1996) is consistent with our expectation that elevated shame contributes to acts of reactive relational aggression. We further suggest that these acts may sometimes be viewed as symptoms of personality pathology.

Passive-rational aggression. We also predict that some symptoms of personality pathology result from using passive-rational aggression as a means of shame regulation. Passive-rational aggression impedes others as they attempt to achieve their goals, using tactics such as withholding assistance, using rational-

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[6] The existing literature on other-directed aggression often divides these acts into those that are proactive and those that are reactive in nature (e.g., Dodge, 1991; but see Bushman & Anderson, 2001, for an alternative perspective). Proactive aggression is typically unprovoked and serves to help individuals obtain desired instrumental and/or relational outcomes. By contrast, reactive aggression is driven by negative affect (most often assumed to be anger), occurring when individuals feel threatened and subsequently respond in hostile and/or violent ways. Only reactive aggression is expected to be relevant to shame regulation. Specifically, threats to self-worth that elicit shame may engender reactive aggression as a means of retaliating against those who are viewed as the reason for experiencing shame at that time.

[7] Although we expect that ASPD will be associated with the use of physical aggression as a means of down-regulating shame, we would not expect the same relationship to exist between physical aggression and psychopathy, a related but not isomorphic construct. Psychopathy is composed of two broad factors, themselves often found to be divisible into different facets, and the latter of which most strongly correlates with ASPD. Existing research on psychopathy and aggression suggests that, like ASPD, the Antisocial Lifestyle dimension of psychopathy (Factor 2) is marked by emotional and behavioral dysregulation, including impulsive physical aggression (e.g., Lorber, 2004; Schoenleber et al., 2011). In contrast, the Interpersonal/Affective dimension of psychopathy (Factor 1) is marked by characterological interpersonal and emotional deficits. Thus, individuals high only on the Antisocial Lifestyle dimension of psychopathy may use reactive physical aggression as a shame regulation strategy; however, we do not expect that those high only on the Interpersonal/Affective dimension of psychopathy will be as likely to use reactive aggression in response to shame because they are particularly unlikely to experience that emotion.

appearing arguments, and undermining another person's abilities (Verona, Sadeh, Case, Reed, & Bhattacharjee, 2008).[8] No research currently exists on the connection between shame and passive-rational aggression. Future research is warranted to examine whether acts of passive-rational aggression serve a shame regulatory function.

Only one study has considered the relationship between passive-rational aggressive acts and personality pathology, providing evidence for an association between passive-rational aggression and trait narcissism (Schoenleber et al., 2011). We further hypothesize that passive-rational aggression contributes to features of OCPD; for instance those with OCPD tend to become angry when "they are not able to maintain control of their physical or interpersonal environment, although the anger is typically not expressed directly" (APA, 2000, p. 727). We expect that individuals with OCPD may engage in passive-rational aggression to retaliate against others whom they feel have inappropriately usurped control and/or to regain some control over the situation for themselves.

Ruminative retribution.   Shame is positively related to hostility (e.g., Tangney, Wagner, Hill-Barlow, Marschall, & Gramzow, 1996), and we expect that internal, aggressive thoughts can also be used in an attempt to down-regulate shame. We define Ruminative Retribution as a tendency to dwell on hostile thoughts of harm and ill-will against others as a means of reducing shame. As opposed to engaging in behaviors that will cause tangible harm to the perceived perpetrator of their distress, some individuals may take out their aggression on the other person in their minds, putting others down or imagining them getting their comeuppance. Whether this mental aggression is at all successful in reducing shame is an open question. Regardless, taking this strategy to an extreme may generate negative beliefs about others, which may lead to suspiciousness/paranoia that has the potential to damage interpersonal relationships. Thus, we predict that Ruminative Retribution will be associated with features of paranoid personality disorder (PPD) and the *DSM-5*'s proposed Suspiciousness and Hostility dimensions.

There is some evidence to suggest that shame is related to paranoia. Smith et al. (2006) found that persecutory delusional beliefs were related to negative self-views, which is consistent with shame. Moreover, this relationship remained even after taking both depression and low self-esteem into account, but this was not true of negative views of others. Therefore, destructive *self*-views may be particularly relevant to persecutory delusional beliefs similar to those held by individuals with elevated PPD and Suspiciousness. These findings are consistent with some existing theories of delusional beliefs, such as Bentall, Kinderman, and Kaney's (1994) attribution self-representation model, which suggest that persecutory delusional beliefs reflect latent negative perceptions of the self.

Initial evidence suggests that shame is positively associated with paranoid ideation and hostility (e.g., Tangney, Wagner, Fletcher, & Gramzow, 1992). However, research directly examining the relationship of shame to PPD has yet to be conducted. Thus, it remains an open question whether a tendency to engage in mental aggressive acts is used as a means of shame regulation in PPD. Future research should consider the role of shame-related constructs in the development of personality pathology associated with paranoia.

Self-Directed Aggression

Not all aggression is targeted at others, and aggression targeted at the self may be more directly related to shame. Unlike other-directed aggression (see Stuewig et al., 2010), we would not expect the relationship of shame to self-directed aggression to be contingent on elevations in externalization of blame. In fact, existing research indicates that shame is associated with self-directed aggression, in the form of both tendencies to berate oneself (e.g., Tangney, Wagner, et al., 1996) and physical self-harm (e.g., Brown et al., 2009). Importantly, self-directed aggression involves a trade-off; individuals using self-directed aggression to regulate shame appear willing to cause some harm to the self to reduce the harm inflicted by shame.

Explicit Self-Deprecation

We define Explicit Self-Deprecation as a self-directed, verbal form of Aggression shame regulation in which individuals openly belittle themselves in front of others. We do not assume that all instances of self-deprecation are used to regulate shame. For example, self-critical comments made by those suffering from major depressive disorder may be a genuine expression of disliking oneself. However, we hypothesize that self-deprecating statements are sometimes made because it is hoped that doing so will have short- or long-term shame-reducing benefits. Evidence already exists to suggest that self-deprecation is associated with shame (e.g., Lutwak, Razzino, & Ferrari, 1998). However, the existing studies do not speak to the question of whether shame results in the use of self-deprecation as an emotion regulation strategy.

Making self-deprecating comments may ultimately result in shame reduction by eliciting reassurance from others. For one thing, individuals who put themselves down may forestall the criticisms of others, who may come off as particularly heartless if they put down individuals who are already berating themselves. Moreover, when individuals put themselves down, listeners may respond by refuting the self-deprecating statements or by offering evidence of positive attributes to make them feel better. Although we are not the first to suggest that self-deprecation might be met with reassurance (e.g., Tice, Butler, Muraven, & Stillwell, 1995), we were not able to locate any studies testing this hypothesis, even among nonclinical samples. We expect Explicit Self-Deprecation to be associated with elevations in NPD and/or the proposed *DSM-5* Grandiose Narcissism dimension. Consistent with this expectation, the *DSM–IV* states that in requiring excessive admiration, individuals with NPD "may constantly fish for compliments" (APA, 2000, p. 715).

Self-deprecation may also help down-regulate shame by allowing individuals to exert control over when, how, and/or which defects are exposed. Consider some stand-up comedians who make jokes at their own expense. They are making humorous yet self-deprecating statements, and they may be doing so to modify the way in which others are paying attention to their characterological

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[8] Passive-rational aggression involves acts elsewhere referred to separately as *passive-aggression* (i.e. failures to act designed to impede the goal attainment of others; e.g., Buss, 1961) and *rational-appearing aggression* (i.e. engaging in acts designed to impede the goal attainment of others; e.g., Björkqvist, Österman, & Lagerspetz, 1994). However, the findings of Verona et al. (2008) suggest that these two forms of aggression may be highly overlapping. They note that future research is still needed to better determine whether passive-aggression and rational-appearing aggression should indeed be treated as separable forms of aggression.

flaws. Basically, the idea is to alter the circumstances so that it seems others are laughing *with* you, rather than *at* you. Used under the right circumstances, self-deprecation may therefore be adaptive, as it may suggest a healthy level of self-awareness and an ability to not take oneself too seriously. In fact, use of self-deprecating humor among high-status individuals increases attractiveness in the long-term (Greengross & Miller, 2008). However, further research on the use of self-deprecating humor remains necessary, as we expect that misuse of self-deprecation may result in personality pathology.

Physical Self-Harm

Some individuals may engage in physical self-harm, which we define as any deliberate act of injury to one's body, with or without suicidal intent (sometimes referred to as parasuicidal behavior; e.g., Brown, Comtois, & Linehan, 2002), as a means of regulating shame. The relevance of physical self-harm to personality pathology is most evident in BPD, a salient feature of which is recurrent suicidal or self-mutilating behaviors (APA, 2000). This shame regulation strategy also clearly overlaps with the proposed *DSM-5* dimension of Self-Harm. We are not the first to suggest that self-injury serves to regulate emotion. Existing research on motivations for nonsuicidal self-injury indicates that the majority of individuals who self-harm do so as a means of emotion regulation (see Klonsky, 2007). This rationale is also prominent among individuals engaging in self-injury with the intent to die (Brown et al., 2002). However, studies of the emotion regulation model of self-injury in samples with BPD generally assess a broad range of negative affect, rather than shame in particular (e.g., Kemperman, Russ, & Shearin, 1997).

The second most commonly endorsed motivation is self-punishment (see Klonsky, 2007). It has been suggested, for example, that individuals with BPD have learned that they deserve punishment and thus seek to express anger toward themselves by self-harming (e.g., Linehan, 1993). Although they are typically investigated as separate motivations, the emotion regulation and self-punishment models of self-injury are not thought to be mutually exclusive. Understood in the context of each other, these two motivations suggest that individuals engage in self-harm to decrease or compensate for a perception of one's self as defective, inferior, or otherwise problematic. In other words, physical self-harm is used as an emotion regulation strategy if/when individuals feel they deserve punishment for being flawed. We therefore hypothesize that physical self-harm is a means of emotion regulation with a specific focus on down-regulating shame. Consistent with this hypothesis, shame is associated with BPD (e.g., Gratz, Rosenthal, Tull, Lejeuz, & Gunderson, 2010), and shame can prospectively predict acts of self-injury (Brown et al., 2009). Research simultaneously considering the emotion regulation and self-punishment models will be important in the future.

Discussion

We have proposed that the use of maladaptive shame regulation is central to the development and maintenance of many pathological personality features. The variety of shame regulation strategies presented herein include behaviors that are currently used as indicators of *DSM–IV* PD categories and are proposed for use as indicators of pathological personality dimensions in the forthcoming *DSM-5*. Overall, we believe that much of what is considered personality pathology is, in fact, the result of behaviors indicative of an inability to avoid or alleviate shame adaptively. The conjectures we have made regarding the role of shame regulation in personality pathology are supported by existing correlational and quasi-experimental evidence, though typically indirectly. However, our proposal also has great heuristic value, generating a wide variety of testable hypotheses.

Although we expect that shame regulation is important in a broad range of pathological personality features, we do not believe that the maladaptive use of the strategies outlined above accounts for all possible features. Rather, we believe it would be useful to consider emotion regulation as a broad lens through which to understand much of personality pathology. Other pathological features may be the consequence of maladaptive regulation of other emotions. For instance, the regulation of anger in the case of BPD (e.g., Koenigsberg et al., 2002) and fear in the case of PPD (Key, Craske, & Reno, 2003) are undoubtedly important. Therefore, further theorizing and research on the association between personality pathology and the regulation of numerous emotions is necessary. Importantly, research should also more consistently consider the incremental predictive validity of particular emotions, over and above the influence of general negative and/or positive affect.

One could also argue that other person-specific factors would be equally good central constructs in models of personality pathology dynamics; for instance, impulsivity is undoubtedly important in BPD- and ASPD-related behaviors. We can imagine arguments for its importance in other PDs as well (e.g., HPD). We recognize that maladaptive emotion regulation is not the sole factor in the development of personality pathology. The generation of personality pathology undoubtedly depends on a number of person-specific factors (e.g., core beliefs, personality traits, current environment, learning history, genetics, etc.), some of which have already been considered in previous research and theory. However, we believe that maladaptive shame regulation provides the most parsimonious explanation for much (though not all) of personality pathology. In fact, we posit that the motivation to down-regulate shame contributes substantially to behaviors indicative of nine of the 10 current PDs.

Some other person-specific factors may, in fact, moderate the relationship between shame regulation and personality pathology, such as by influencing the choice of shame regulation strategy. For instance, impulsivity among individuals who engage in antisocial behavior is related to variations of 5-HTTLPR and serotonin (e.g., Dolan & Anderson, 2004), which may contribute to the use of reactive, other-directed aggression to regulate shame when it is elicited. As another example, gender differences in personality pathology may be partially attributable to gender differences in shame-related constructs that promote the use of particular forms of shame regulation. Although it is beyond the scope of this paper to discuss more completely, we expect that these other factors are likely to contribute to and/or interact with maladaptive shame regulation in the emergence of personality pathology.

We believe that the ideas presented herein have potentially important implications for the treatment of personality pathology. Our proposal suggests a novel target for intervention with individuals with a wide range of personality pathology. Specifically,

addressing shame and its regulation should be a primary treatment focus. Although the exact strategies may differ across individuals, we believe that developing treatment techniques/modules that address maladaptive shame regulation broadly would benefit a substantial portion of those with PD diagnoses.

Although we hope clinicians (including those working with individuals suffering from personality pathology) are already attempting to address shame in therapy, most existing treatments generally do not focus explicitly on shame. A few promising, but underresearched, shame-focused approaches have recently appeared in the literature (see Tangney & Dearing, 2011). We believe clinicians could consider targeting shame and its regulation by modifying supported therapeutic techniques/approaches. For instance, dialectical behavior therapy (DBT; Linehan, 1993) includes a focus on Distress Tolerance, which aims to increase adaptive coping and alleviate painful emotions in general. Although DBT was designed to treat BPD, some DBT elements may be useful for those with many other personality pathologies, especially if these elements are adapted to include a more substantial focus on shame and its regulation. We expect individuals with many personality pathologies would benefit from Distress Tolerance training that included (1) increased time in session focused on the role of shame regulation in the generation of maladaptive behaviors and their unpleasant consequences, and (2) an emphasis on the practice of those techniques already included in DBT which may best address shame (e.g., use of cheerleading statements). We also hope that, as research accumulates, novel treatment techniques for addressing shame and its regulation in therapy will be developed and tested.

Understanding the mechanisms by which personality pathology develops should also enable us to create more useful classification systems. Previous theorists (e.g., Cooper, Frone, Russell, & Mudar, 1995) have proposed that classification should take etiological mechanisms into consideration. However, the *DSM* classification systems have relied primarily on observable behaviors without consideration for why these behaviors are used, which is problematic in the case of some pathological personality features. Two individuals may appear quite similar behaviorally but have very different motivations. For example, the description of the proposed *DSM-5* Social Withdrawal dimension does not clarify whether individuals prefer to be alone/avoid contact because they are disinterested in others or because they are fearful of negative social consequences. *DSM-5* Social Withdrawal would therefore be associated with elevations in what is currently encompassed in SPD and in APD (APA, 2000). We believe our hypotheses regarding the etiology of much of personality pathology are relevant to classification because, in our view, the diagnosis of personality pathology should focus more than it currently does on *why* individuals behave in the ways that they do, rather than simply describing *what* they do.

Finally, although we believe it is fundamental to the development of personality pathology currently classified on Axis II, maladaptive shame regulation may also contribute to some Axis I psychopathology. For example, popular theories suggest that worry is used as a means of avoiding feelings of internal distress (e.g., Borkovec, Alcaine, & Behar, 1994). It is conceivable that some individuals may attempt to down-regulate shame by worrying about potential future threats to distract themselves from thinking about perceived flaws. Binge eating has also been posited

to be a response to and a means of temporarily alleviating negative affect (e.g., Heatherton & Baumeister, 1991) and is associated with shame over and above general negative affect (e.g., Gupta, Rosenthal, Mancini, Cheavens, & Lynch, 2008). Moreover, Gupta et al. (2008) found that the relationship between shame and binge eating is mediated by difficulties regulating emotion. Overall, if individuals who use the maladaptive shame regulation strategies described in this article—whom we propose are likely to develop personality pathology—also use strategies such as worry or binge eating to reduce shame, they may simultaneously develop features of personality pathology and Axis I disorders. Thus, a tendency to use maladaptive shame regulation strategies may account for some of the comorbidity between Axis I and Axis II disorders.

In summary, our goal was to explicate ways in which shame and its regulation may be important in personality pathology, in the hope that doing so will assist in understanding the current behaviors seen among individuals with personality pathology. We hope our proposal will foster further investigations into the role of emotion regulation more broadly, and shame regulation more specifically, in the development/maintenance of personality pathology. If future investigations reveal ways in which shame regulation is relevant to personality pathology, we hope the findings of such investigations will eventually be reflected in both treatment and classification.

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