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The Impact of Shame on Post Traumatic Stress Disorder Symptoms in Victims of Interpersonal Violence

Sarah Bamford[1]

[1] The University of Sheffield

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Despite advancements in therapies to treat Post Traumatic Stress Disorder (PTSD), many individuals continue to experience symptoms after completion of these therapeutic interventions. Recognising shame as a critical barrier to healing is an essential part of resolving this gap between therapeutic intervention and mitigation of PTSD symptoms. This review analyses empirical evidence linking shame to psychopathology. Specifically, it focuses on the heightened symptoms of shame and PTSD following trauma, in cases involving interpersonal violence. A substantial body of research illustrates the significant influence that interpersonal violence has on PTSD and shame responses (Andrews et al., 2000; Beck et al., 2011; Lopez-Castro et al., 2019; Badour et al., 2017). Numerous approaches to shame reduction have been explored, but a comprehensive and integrated model for shame recovery is yet to be established. This review underscores the necessity for targeted research to develop and implement effective intervention strategies. Ultimately, addressing shame within trauma-informed therapeutic interventions could enhance PTSD recovery outcomes, reduce symptom persistence, and improve overall patient wellbeing.

THE IMPACT OF SHAME ON POST TRAUMATIC STRESS DISORDER SYMPTOMS IN VICTIMS OF INTERPERSONAL VIOLENCE

Shame and its association with Post-Traumatic Stress Disorder (PTSD) and victims of interpersonal violence has been documented at an increasing rate over the past two decades (Lopez-Castro et al., 2019). Gold standard therapies have been developed to treat PTSD, such as Prolonged Exposure Therapy (PE), Cognitive Processing Therapy (CPT), and Eye Movement, Desensitisation, and Restructuring (EMDR) (Schrader & Ross, 2021). However, approximately 30–50% of the individuals who receive these therapies continue to be symptomatic after therapeutic intervention (Bradley et al., 2005; Saraiya & Lopez-Castro, 2016). This has led researchers to examine the possible disturbances that may be interfering with the individual's healing process, such as the experience of shame.

Shame has been psychologically studied for several decades now, with Lewis (1971) being one of the first to present a clear definition of shame. Lewis highlighted the difference between shame and guilt, suggesting that in guilt, the individual judges an action, whereas in shame, the individual judges the self. Arguments for whether shame has a positive or negative impact on individuals' psyche has been debated; however, in more recent years, many researchers have identified it as a barrier to healing from trauma and PTSD, leading to both empirical and theoretical research focusing on the relationship between shame and PTSD (Matloub (Lepak) et al., 2024).

As the area of research has grown, some psychologists have suggested ways to reduce shame in partnership with existing approaches for PTSD recovery (Van Vliet, 2008; Salter & Hall, 2020; Gilbert & Irons, 2005; Gilbert & Procter, 2006; Dolezal & Gibson, 2022); however, very few have developed clear approaches specifically aimed at shame recovery. Some researchers have developed new approaches designed to encourage shame recovery (e.g., Van Vliet, 2008, 2009; Dolezal & Gibson, 2022), but there are still gaps within this research, and at present there is limited to no data to demonstrate these approaches being implemented. To improve recovery from PTSD, it is vital to understand the underlying processes that exacerbate symptoms, such as shame. As well as this, it is important to investigate possible solutions to the negative effects that these underlying mechanisms have.

SHAME

Shame is seen as a prosocial construct that involves a negative view of the self (Tracy & Robins, 2004). It can play an important role within development and psychosocial functioning; however, this does not always lead to positive resolution within the self, but rather can become a debilitating belief that oneself is entirely flawed (Van Vliet, 2009). Research into shame has demonstrated a significant variation in how shame is defined and perceived, as well as how its components can be subcategorised (Lopez-Castro et al., 2019; Lewis, 1992, 2000; Velotti et al., 2016; Gilbert, 2007). To develop a well-rounded understanding of shame, it is important to acknowledge the scope of the emotion.

Shame can be categorised into two primary types. The first is dispositional shame, also referred to as "trait shame" or "shame proneness" (Velotti et al., 2016, p. 172). Dispositional shame occurs through frequent recurring feelings of shame that are not directly associated with any particular event, such as believing one is inherently bad or by

putting oneself down repeatedly, even for minor mistakes (Velotti et al., 2016; Lopez-Castro et al., 2019). The second type is state-dependent shame, which refers to an individual's experience of shame as a discrete, present-moment phenomenon, characterised by the immediate emotional response and associated feelings of shame (Robins et al., 2007). As an example, the State Shame and Guilt Scale (SSGS; Marschall et al., 1994) was created to measure state shame and uses items such as "I feel remorse, regret" and "I feel tension about something I have done".

Several approaches to understanding shame have emerged over time, including functionalist, evolutionary, and attributional. These can have some difference in perspectives but generally follow a common theme that shame is a functional emotion to protect oneself from social outcast and ensures survival (Gilbert, 2007; Tracy & Robins, 2004); however, it can develop into a maladaptive response that can evoke negative mental health responses (Ferreira et al., 2022; Mills, 2005; Van Vliet, 2009; Lopez-Castro et al., 2019). Functionalism views shame as holding a protective pro-social, survival role, and it can be either adaptive or maladaptive, depending on the circumstances (Dempsey, 2017; Mills, 2005). The evolutionary biopsychosocial perspective similarly considers shame to be an involuntary defensive response that has developed to aid an individual's social survival (Gilbert, 2007). Through this perspective, shame can be separated into two distinct dimensions: internal and external shame.

Internal shame relates to the inner dynamics of how one judges oneself, with cognitive processing being inwardly directed towards one's attributes, behaviours and emotions, often focusing on their failures, flaws and shortcomings (Gilbert & Andrews, 1998; Gilbert, 2003; Lewis 2003; Ferreira et al., 2022). External shame is understood as the experience of the self being viewed negatively in the minds of others, with cognitive processing being outwardly directed and behaviours such as appeasing or submission occurring for the purpose of positively influencing others view of you (Gilbert & Andrews, 1998; Gilbert, 2003, 2007; Ferreira et al., 2022). This distinction between internal and external shame is referred to by other psychologists who emphasise the importance of attributions (Lewis, 2003; Van Vliet, 2008, 2009).

Attribution theory suggests individuals decide, consciously or otherwise, whether they should experience shame as a result of their internal narrative (Etherson, 2023). Attributions, specifically, refers to the process of inferring causal explanations for events and behaviours (Van Vliet, 2009) and is considered to have a strong effect on psychological adjustment (Feiring et al., 2002; Wall & Hayes, 2000) and emotions (Petrocelli & Smith, 2005). Lewis (1992, 2000) formed a cognitive-attributional model of self-conscious emotions and within this model, shame is considered to stem from internalised cultural standards and evaluations of internal and external circumstances and events. Cultural standards are shared beliefs and expectations within a specific society (Wilson-James, 2021). An example of a cultural standard that can impact survivors of interpersonal violence comes from Jamaica. In Jamaica, the stigma from being labelled an "informer" (Wilson-James, 2021, p. 57) can influence individuals to be apprehensive about reporting their abuse and this can also lead to shame (Caribbean Policy Research Institute [CPRI], 2018; Yuce et al., 2015).

The idea of shame stemming from evaluations of internal and external circumstances and events and internalised cultural standards has been supported by others, such as Tangney and colleagues (see Tangney et al., 1998; Tangney & Fischer, 1995; Tangney, 1995; Tangney & Dearing, 2002). They have conceptualised shame as involving an individual's evaluation of themselves, considering negative events and outcomes, and using internal and global attributions. Negative internal attributions, such as blaming oneself for negative events, often lead to blame and feelings of being powerless to change who they are (Van Vliet, 2009). Taking an alternate perspective, several psychologists argue that shame can occur without blaming the self (Gilbert, 2004). Regardless of these differences, it is consistently believed and evidenced that shame can produce a variety of negative consequences.

SHAME AND MENTAL HEALTH

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in cortisol and proinflammatory cytokines, shame can have a negative toll on physical and mental health (Dickerson et al., 2004; Scheer et al., 2020). Shame's impact on mental health is perhaps more complex, and a clear understanding is still in the process of being developed and evidenced. There is significant evidence for shame being associated with psychopathology, (Gilbert & Andrews, 1998; Tangney & Dearing, 2002; Lopez-Castro et al., 2019) including increased suicide risk (DeCou et al., 2018), depression (Van Vliet, 2009; Andrews et al., 2002; Thompson & Berenbaum, 2006), addiction (Dearing et al., 2005) and of particular relevance to this review, PTSD (Lee et al., 2001; Leskela et al., 2002; Wilson et al., 2006).

Shame's relationship with PTSD has been further researched in recent years (Saraiya & Lopez-Castro, 2016), with more emphasis placed on addressing shame in trauma treatment and recovery. It has become evident that shame can be considered an important emotion, that is both greatly influenced by traumatic experiences, as well as being significantly negatively influential to PTSD symptom recovery (Øktedalen et al., 2014). This dynamic between shame, trauma, and PTSD requires substantial focus because it is hindering the recovery of individuals with PTSD, so it must be addressed to improve their health, wellbeing, and therapeutic outcomes.

PTSD

PTSD can occur in individuals who experience trauma, with symptoms involving elements of re-experiencing the event, negative thoughts/feelings produced or worsened by the trauma, trauma-related arousal and avoidance, and distress or functional impairment lasting longer than one month (American Psychiatric Association, 2022). The DSM-5 diagnostic criteria for PTSD was edited in 2013, adding shame to the list of persistent negative states (American Psychiatric Association, 2013). PTSD can occur following a variety of traumatic experiences and the differences between these experiences can alter the association of symptoms with shame (la Bash & Papa, 2014; Ginzburg et al., 2009; Velotti et al., 2014; Seah & Berle, 2023). Therefore, for the purpose of specificity, this review will focus on the relationship between PTSD and shame within victims of interpersonal violence.

Interpersonal violence can be defined as intentional use of power or force directly inflicted by an individual or small group of individuals against another person. This violence may be sexual, physical, emotional/psychological or neglectful (Mercy et al., 2017). The reason for this specific focus on interpersonal violence is, in part, due to the higher intensity and impact of shame found in victims of interpersonal violence in contrast to non-interpersonal violence, such as natural disasters, non-interpersonal injury, and war (Ford et al., 2006). Moreover, excluding other types of trauma, such as from being involved in war, limits some of the complexities within the understanding of shame that can arise, such as moral injury. Moral injury is often related to experiences of guilt and shame that arise when an individual feels that their actions have violated their moral values, which is a different experience to shame that arises from experiencing interpersonal violence (Lopez-Castro et al., 2019).

Survivors of interpersonal violence may experience autonomic hyperarousal, an active stress response that is a common symptom of PTSD and can be characterised by difficulty concentrating, hypervigilance, irritability, exaggerated startle response and irregular sleep patterns (American Psychiatric Association, 2013). Traditionally, the autonomic hyperarousal in survivors of interpersonal violence has been attributed to fear, but recent research has led to the revelation that shame also contributes to the development of autonomic hyperarousal (Lopez-Castro et al., 2019). Some research has found that shame was a stronger predictor of increased autonomic arousal than fear (Lopez-Castro et al., 2019; Freed & D'Andrea, 2015; Badour et al., 2017).

SHAME AND PTSD

Significant empirical evidence has been found to implicate the varying

negative impacts of shame on PTSD (Lopez-Castro et al., 2019). Multiple studies provide evidence that shame is a significant mediator for PTSD symptoms from interpersonal violence, such as childhood abuse and domestic violence (Andrews et al., 2000; Beck et al., 2011). Individuals exposed to childhood sexual abuse, amongst other high impact types of trauma and abuse, often relate negative attributions to the trauma, which can influence PTSD symptoms, such as blaming the self or believing everyone is the same as their abuser (Feiring et al, 2002). In relation to this, where there is social stigma surrounding the trauma/abuse, such as sexual abuse, greater shame is experienced (Aakvaag et al., 2016). Victims of childhood abuse/maltreatment are often prone to high levels of self-criticism (Sajjadi et al., 2022) which can significantly relate to shame, as it reinforces the sense of continuing threat (Ehlers & Clark, 2000).

There is also evidence for individuals with higher trauma-related shame to experience more severe and persistent PTSD symptoms (Matloub (Lepak) et al., 2024). It is also important to note that PTSD symptoms may occur immediately after the traumatic experience, with the majority arising within 6 months of the event though for some, symptoms can start weeks, months, or years later (Royal College of Psychiatrists, 2021). Shame has been found to predict both immediate post-traumatic stress reactions to trauma (one to six months after the trauma) as well as future reactions (one to six years after the trauma; Feiring & Taska, 2005). A longitudinal study has demonstrated that children who experience consistently high levels of abuse-related shame during a one-year period showed the highest levels of PTSD symptoms (Feiring et al., 2002). These PTSD symptoms were measured using The Children's Impact of Traumatic Events Scale—Revised (CITES–R; Wolfe et al., 1991), rather than being directly based on clinical diagnosis (Feiring et al., 2002). Since shame has been implicated in the maintenance of PTSD symptoms, it is possible that shame may also decrease effectiveness of therapies designed to reduce these symptoms and heal PTSD (Oktedalen et al., 2014; Saraiya & Lopez-Castro, 2016). This leaves the important task of reaching an understanding of how to remedy this. Whilst some researchers have attempted this, there remains limited literature at present.

THERAPEUTIC INTERVENTIONS THAT IMPACT SHAME

There have been multiple therapies developed that indirectly have a positive impact on shame reduction and recovery (Van Vliet, 2010). These include social fitness training (Henderson & Zimbardo, 2001), Emotion-Focused therapy (EFT; Greenberg, 2002), and Acceptance and Commitment Therapy (ACT; Hayes et al., 1999). The Social Fitness Model conceptualises social anxiety and shyness as deficits in social fitness and social skills. Whilst PTSD was removed from the anxiety disorder category in the DSM-5 due to considerable evidence demonstrating the broader range of emotions associated with PTSD (e.g., anger, shame, guilt; American Psychiatric Association, 2013; Resick & Miller, 2009; Pai et al., 2017), it is still evident that PTSD involves elements of anxiety, and there are similarities between PTSD and anxiety-related disorders (Williamson et al., 2021). Experiences of shame also relate to symptoms of anxiety; for instance, they have similar resulting behavioural manifestations such as avoidance, withdrawal, and submissive behaviours (Swee et al., 2021; Gilbert, 2000; Piccirillo et al., 2016). Social fitness training focuses on building confidence, social skills, and developing social fitness through the three core areas: cognitive restructuring, simulated exposures, and social skills training. Collectively, these involve challenging negative beliefs and thoughts, developing self-compassion whilst reducing self-blame, practising social interactions in a safe and controlled environment, and learning specific skills that aid the effective navigation of social situations (Henderson & Zimbardo, 2001). The reduction of shame and self-blame are directly emphasised within this model (Henderson & Zimbardo, 2001). Additionally, challenging negative thoughts and beliefs, developing feelings of self-compassion, reducing self-blame, and the encouragement of developing safe social connections could also be effective on shame reduction (ShamsAlam et al., 2025; Van Vliet, 2008).

Relatedly, EFT is the practice of informing therapeutic intervention with an understanding of the role emotions play in psychotherapeutic change (Greenberg, 2017). This approach uses strategies that promote regulation, expression, acceptance and awareness of emotions with the goal of "strengthening the self, regulating affect, and creating new meaning" (Greenberg, 2017, p. 3). EFT has been shown to significantly improve symptoms of depression, PTSD, low self-esteem and interpersonal problems (Paivio & Nieuwenhuis, 2001; Paivio & Pascual-Leone, 2010). EFT changes emotions by understanding and transforming maladaptive emotion schemas, such as shame and fear, that underlie the presenting symptoms. It encourages clients to process their emotions and painful experiences whilst evoking more adaptive mechanisms, such as self-compassion, assertive anger, and self-soothing (Greenberg, 2017). Evidence demonstrates that EFT can effectively improve self-compassion and self-reassurance while reducing self-criticism (López-Cavada et al., 2025). This evidence, and the underlying processes of EFT, suggest it could be an effective treatment for shame recovery.

ACT is a form of third-wave cognitive behavioural therapy (CBT) that involves six interconnected processes: acceptance, cognitive defusion, being present, values, self as context (the observing self), and committed action (Hayes et al., 1999; Harris, 2019). Gloster et al. (2020) conducted a meta-analysis of ACT involving 133 studies and 12,477 participants. Their findings demonstrated that ACT is consistently effective across an extensive range of intervention targets, involving varied mental health conditions and other health conditions, such as chronic pain. Whilst there is limited research of ACT being used specifically for shame, it has been proposed as an effective approach for reducing the negative symptoms of shame (Linde et al., 2023). ACT can effectively increase psychological flexibility and decrease experiential avoidance and has been shown to weaken the effect of self-critical thoughts (Luoma & Platt, 2015). Psychological flexibility is the ability to accept, cope with and adjust to a diverse range of situations, positive and negative (Burton & Bonanno, 2016; Harris, 2019; Kashdan et al., 2006; Kashdan & Rottenberg, 2010). Experiential avoidance is the tendency to avoid difficult internal experiences and is associated with higher levels of shame (Luoma et al., 2006; Mitmansgruber et al., 2009).

Another therapeutic intervention that was created to reduce shame and self-criticism is compassionate mind training (CMT), which works by cultivating a self-soothing system (Gilbert & Irons, 2005; Gilbert & Procter, 2006); however, research revealed that CMT did not significantly impact components of shame such as self-criticism and self-correction in an initial pilot study (Gilbert & Procter, 2006). More recent research into the effectiveness of CMT has yielded mixed results. There is evidence that CMT can significantly decrease depression and anxiety, with some evidence for decreased self-criticism and shame and increased self-compassion (Matos et al., 2017), but many of these results were not statistically significant (Noorbala et al., 2013; Gilbert & Proctor, 2006; Halamová et al., 2020). Consequently, compassionate mind training is not referred to often in the literature around shame and PTSD, which may be due to its limited effectiveness on shame specifically.

As well as exploring the impact of specific therapeutic interventions on shame reduction and recovery, several researchers have argued for a focus on recovering from shame as part of a trauma and/or shame informed approach (e.g., Dolezal & Gibson, 2022; Van Vliet, 2008; Salter & Hall, 2020). This includes approaches that can be used within existing therapies that reduce shame, including developing quality therapeutic relationships. This is vital, because without a positive therapeutic relationship with their practitioner, they could feel at risk of further shame. Therefore, having a trustworthy, quality therapeutic relationship is essential in PTSD and shame recovery (Cordess et al, 2005).

It has been noted that shame can cause individuals to feel powerless, withdraw from others and isolate themselves (Van Vliet, 2008). Therefore, receiving empathetic responses can increase an individual's sense of power and connection (Brown, 2006) and reverse some of the effects of shame. Shame-sensitivity as part of therapeutic practice has also been suggested as essential for recovery. This involves practitioners being competent in their understanding of shame at an individual and organisational level, being able to recognise shame and shaming, and

appreciating individual differences in shame (Dolezal & Gibson, 2022). Salter and Hall (2020) argue for the promotion of dignity as the resolution to shame in complex trauma, basing this on the idea that dignity can be seen as the opposite of shame and humiliation (Statman, 2000; Salter & Hall, 2020). Promoting dignity in therapeutic practice would also aid the therapeutic relationship between client and practitioner, further assisting the process of shame recovery.

Self-compassion and mindfulness also have uses, reducing negative experiences through interrupting rumination and removing negative judgements of the self and their experience (Ehret et al., 2015). Along a similar line, acceptance and resilience have been identified as helpful processes, as acceptance plays a key role in mental wellbeing in general (Hayes et al., 2011) but also in the healing of shame (Clark, 2012). Emotional resilience can also be shown to protect from shame or can be developed to heal shame (Van Vliet, 2008).

All of the approaches discussed above have individual merits and evidence for their positive effects, but there is a noticeable disconnect between these approaches within the literature. This disconnection can be seen in the range of suggestions made for shame recovery, whereby no coherent or cohesive approach is recommended consistently across the literature. The majority of these therapies and approaches are designed for other purposes, yet have elements applicable to shame and PTSD recovery. Therefore, assessing the aspects of these and individual approaches that are effective at reducing shame and improving symptoms would be helpful for the development of a complete and specific approach to shame recovery.

There are plenty of connections and similarities between these individual approaches. These similar themes include promotion of mindful and self-compassionate processes, such as acceptance, reduction in rumination, and a curtailment of negative judgements of experience and the self (Ehret et al., 2015; Hayes et al., 2011; Clark, 2012). Furthermore, there is a repeated importance placed on therapeutic relationships. Demonstrating empathy, trust, a strong understanding of shame and promoting dignity within therapeutic practice can help improve effectiveness of therapeutic intervention (Brown, 2006; Cordess et al, 2005; Dolezal & Gibson, 2022; Statman, 2000; Salter & Hall, 2020). These ideas prompt the question of whether an integrated approach could be developed specifically to work with improvement in shame and PTSD symptoms. There is one notable paper that somewhat fulfils this task. Van Vliet (2008) outlines a dedicated process for shame recovery that involves several steps that relate to many of the suggestions that other psychologists have made.

A GROUNDED THEORY STUDY OF SHAME: STUDY INFORMATION

Van Vliet (2008) conducted a grounded theory study, aiming to contribute to the understanding of shame and emotional resilience and develop a theory of shame recovery. This study consisted of qualitative analysis of interviews with 13 adults (9 female and 4 male, aged 24 to 70 years old) recalling experiences of intense shame. Whilst small, the sample was reasonably culturally diverse, with 8 participants identifying as Caucasian, 2 as South Asian, 2 as Aboriginal Australian, and 1 as Middle Eastern. Amongst this selection, 5 considered themselves Christian, 3 as other, 3 as agnostic/atheist, 1 as Muslim and 1 as Buddhist. All participants had a significant shame experience in adulthood (ranging from 10 months to 26 years prior to the interview) and perceived they had made significant progress in overcoming and recovering from the situation or event involved in the shame experience (with varying experiences in accessing therapy at the time of or after the shame experience).

Shame experiences were dependent on the perspective of the participants, with some being classed as trauma or abuse, but all shame experiences referred to a specific event or situation that induced significantly distressing shame (Van Vliet, 2008). Whilst the participants did not need a PTSD diagnosis to participate in the study, the focus on shame experiences, including those induced by trauma and interpersonal abuse such as sexual assault, could be applicable to the broader field of shame and PTSD.

All participants were interviewed at least twice, mostly in person but sometimes over the phone, with the focus of the interviews being to understand the characteristics of shame and the impact it has, as well as how shame was overcome by the individuals. Keeping in tone with grounded theory methodology, certain questions and directions of the discussions were unique to the participant, with the researcher naturally exploring the topics using information and ideas that arose from the flow of conversation. A selection of questions that were asked to all participants in some capacity included variations of the following:

Please describe the specific situation or event in as much detail as you can. What was the experience like for you at the time? What about the situation made you feel shame? What helped you overcome or heal from the shame? What didn't help? What tells you that the shame has healed or lessened?" (Van Vliet, 2008, p. 235).

Themes that occurred in participant's discussions of the impact of their shame experience included: shame as an assault on the self, attack on self-concept, attack on the self in relation to others, and avoidance and withdrawal behaviours. Individuals experiencing intense shame described themselves as "bad," "worthless," "disgusting" (Van Vliet, 2008, p. 237). Many of these negative self-judgments were accompanied by self-blame, involving participants describing the belief that the event occurred because "It's my fault" (Van Vliet, 2008, p. 237). This sometimes resulted in disruption or destruction of the self-concept, with participants describing the experience "a shattering of who I am" (Van Vliet, 2008, p. 237).

Shame experiences also impacted the self in relation to others, with participants feeling exposed and, in response, being desperate to escape from view. They described wanting to "run", "disappear" or "feeling completely lost, like there was no one to turn to" (Van Vliet, 2008, p. 237). There were also themes of individuals withdrawing from other people in an attempt to cope, but this only worsened their feelings of isolation. Behaviours aimed at avoiding the pain of the shame experience were common, with participants describing their attempts at this avoidance as "going into denial," and "suppressing," (Van Vliet, 2008, p. 237) as well as engaging in destructive behaviours such as drinking alcohol to numb the pain (Van Vliet, 2008).

Drawing upon these prevalent themes within participant responses, the study identified three specific types of impairments developed from shame: undermining positive self-concept, damage to individuals' ability to connect with others, and a feeling of diminished power and control. These impairments can also be seen in survivors of interpersonal violence who experience PTSD (Hyland et al., 2017; Gilbert, 2015; Li & Liang, 2023). These similarities between shame experiences and traumatic experiences resulting in PTSD demonstrate how the theory of Van Vliet (2008) can be applicable to PTSD symptoms as well as shame. These similarities could also reinforce why evidence suggests shame worsens and maintains PTSD symptoms (Andrews et al., 2000; Beck et al., 2011; Matloub (Lepak) et al., 2024; Feiring et al., 2002).

THE PROCESS OF SELF-RECONSTRUCTION

Van Vliet (2008) conceptualised shame recovery as a process of "self-reconstruction" (p. 233) made up of five underlying processes: (1) connecting with others, which includes talking to others, socialising with others, finding allies, repairing relationships, participating in counselling, and connecting to a higher power, (2) refocusing on positive actions, which includes clearing away negativity, working on self-improvement, focusing on the positive, shifting priorities, and focusing on action, (3) accepting vulnerable feelings, which includes accepting the situation, facing one's feelings, and expressing one's feelings, (4) understanding shame triggers, which involves separating from the shame, understanding external factors, developing insight into oneself, and creating meaning, and (5) resisting rejection of negative judgements, instead asserting oneself and challenging others where appropriate (Van Vliet, 2008; Plante et al., 2022).

This study is an important contribution to this subject area as it is one of the only papers to conceptualise a clear theory for shame recovery. By using a grounded theory design, Van Vliet (2008) was able to develop an understanding of how people interpret shame events, construct meaning from them, and how individuals then behave based on these constructed

beliefs and interpretations. This approach enables a wide scope and deep understanding of the subject area. Other strengths of this study include the cultural diversity within the sample and the extensive number of shame events studied, demonstrating strong external validity and generalisability. Although, it should be acknowledged that whilst there was a diverse sample used, most of the minority cultural groups were acclimated to Western society, therefore non-Western cultures may show differences if studied. Additionally, due to the data collected being from retrospective reflection of participants, it is possible that certain events and experiences may have been recalled differently to how they perceived the event or experience as it occurred. This theory could be the basis for a future shame intervention being developed.

To gauge the accuracy and implications of this theory, it would be wise to apply the steps of the "self-reconstruction" (Van Vliet, 2008; p. 233) process to a sample of participants and study the impact these steps have on shame recovery and mental wellbeing. Utilising Van Vliet's (2008) theory of self-reconstruction, in combination with aspects of other interventions that affect shame and PTSD, could be key to addressing the negative effect of shame on the maintenance and severity of PTSD symptoms, particularly in survivors of interpersonal violence. Aspects of therapies such as Social Fitness Training, ACT, EFT, and CMT hold similarities to certain steps of the self-reconstruction process, and already have evidence supporting them. It could be possible to collate these applicable aspects into one therapy that follows the steps of self-reconstruction, and then implement this as an intervention and study its effectiveness.

CONCLUSION

The research discussed in this review has been particularly varied, including both quantitative and qualitative analyses, meta-analyses, systematic reviews and more. Despite this, there has been a consistent understanding throughout that demonstrates the importance of shame's influence on PTSD symptoms, particularly in victims of interpersonal violence. The research into this subject is still in relatively early stages with the majority being undertaken within the past 20 years (Lopez-Castro et al., 2019). Within most of the literature reviewed, the authors make some suggestions for reducing shame and improving PTSD treatment outcomes; however, these recommendations are predominantly basic processes that are only briefly touched upon. There are very few approaches specifically dedicated to outlining a shame recovery approach (Dolezal and Gibson, 2022; Van Vliet, 2008), and even where there are specific approaches, there are issues with limitations and a lack of empirical evidence to support them. Van Vliet (2008) makes the most persuasive proposal for a complete approach to shame recovery; however, this approach would benefit from being implemented and tested to gain a full understanding of its relevance and effectiveness.

Future research should focus on understanding shame recovery to better support PTSD treatment, as this area remains underexplored. Developing a coherent approach to integrating shame recovery into existing therapies or creating a dedicated shame-focused program would be highly beneficial. This approach can be studied to show effectiveness and altered as needed so that it could be administered in therapeutic practice. In theory, this would aid PTSD recovery and effectiveness of PTSD specific therapies, reducing the rates of long-term continuance of symptoms and improving overall quality of life. Based on the wider literature, shame recovery would also benefit many other psychopathologies as well. It would also likely have a secondary benefit of relieving some of the strain on therapeutic services, as patients would be more likely to make full recovery in a shorter space of time. Overall, it would be highly beneficial to develop, assess and implement a shame specific therapeutic intervention particularly aimed at those recovering from PTSD.

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