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

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

Shame: Concept Analysis

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

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

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

Purpose

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

Review of Literature

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

Definitions of the Concept

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

Related concepts. Terms and concepts similar to shame include guilt, embarrassment, and humiliation. Shame and guilt although often used interchangeably to describe a person's feelings have important conceptual differences (Cleary, 1992; Stuewig & McCloskey, 2005). According to Stuewig and McCloskey (2005), the major difference between shame and guilt concerns the distinction between the self and behavior. Experienced guilt motivates a person to make amends for the behavior while experienced shame makes a person feel awful about one's self and can be debilitating. According to Feiring and Taska (2005), guilt con-
cerns one's action while shame concerns one's entire being. Guilt, an emotion that motivates productive behavior, differs from shame because shame is a nonproductive and often incapacitating emotion (Deblinger & Runyon, 2005).

Humiliation is a person's perception of being degraded, ridiculed, belittled, or criticized at the hands of another while concurrently holding a negative attribution of blame to that person (Stuewig & McCloskey, 2005). Keltner and Buswell (1997) state that embarrassment shares some attributes with shame but differs from shame because the latter reflects violations of a deeper state that embarrassment shares some attributes with.


delinquency. Feiring and Taska (2005) investigated abuse-related anger, and anger mediates the possible relation between shame and behavior problems.

Stuewig and McCloskey (2005) studied how maltreatment might influence the development of shame-proneness and guilt-proneness and how these predispositions relate to depression and delinquency. Feiring and Taska (2005) investigated abuse-related shame, particularly Childhood Sexual Abuse (CSA) during a 6-year period, and their findings suggest that shame as a consequence of childhood sexual abuse should be a focus of treatment.

Negao, Bonanno, Putnam, and Trickett (2005) explored the contributions of shame, anger, embarrassment, and humiliation by examining the relationship between emotional coherence, disclosure of childhood sexual abuse, and trauma. The journal Child Maltreatment (Berliner, 2005) devoted a special section to research on the concept of shame in an effort to explain the contribution of shame to child abuse consequences. Berliner concludes that research increases knowledge of abuse consequences but leaves unanswered questions about clinical implications.

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

Uses of the Concept

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

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

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

Defining Attributes

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

Physical expressions of shame consist of several behaviors occurring when a person experiences shame. Kaufman (1996) states that the facial signs of shame include lowering or averting eye contact, blushing, and hanging the head. Wigginton (1999) describes the physical expressions of shame as blushing, diverted eyes, or lowered head. Rahm et al. (2005) state that shame is physically expressed by blushing, breaking eye contact, putting one's hands in front of one's face, and other hiding behaviors.

Bennett et al. (2005) indicate body collapse, eyes lowered, and corners of the mouth turned downward are physical expressions of shame. Feiring and Taska (2005) describe shame posture as head down, shoulders hunched, and nonverbal behaviors as avoiding eye contact, covering the face, head down, body collapsed, and body hidden by coat or object. Harper and Arias (2004) indicate external responses to shame include avoiding eye contact and wanting to hide or escape. Bonanno, Noll, Trickett et al. (2002) conclude that survivors of CSA who did not voluntarily disclose prior CSA showed the greatest facial shame and non-Duchenne smiles. Non-Duchenne smile is defined by Kaufman as a smile that excludes cheek and eye movement. Bonanno et al. indicate non-Duchenne smiles tend to occur when hiding negative emotions, expressions of shame.

Worthlessness or feelings of being inadequate, unworthy, and powerless is a defining attribute of shame. Deblinger and Runyon (2005) state that individuals suffering feelings of shame may see themselves as damaged or unworthy. Kroll, Eagan, Erickson, Carey, and Johnson (2004) indicate that shame leaves a person powerless to change in response to diminishing the person.

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Persist, and she frequently experiences the effects of internalized shame. AB seeks psychological counseling for alcohol abuse and depression and exhibits low self-esteem and physical behaviors of worthlessness and powerlessness over her desires. She feels that she can no longer tolerate or contain these feelings and begins weekly sessions of cognitive behavioral and exposure therapy with a psychologist.

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

**Borderline Case**

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

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

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

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

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

**Related Case**

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

CS is a 17-year-old, white female who lives with her parents and is active in her high school. She is a bright, above average student who has many friends. Recently her parents noticed a change in her attitude about school and her friends. She presents to a psychologist after admitting to her parents episodes of purging after eating meals for approximately two months. CS expresses feelings of dissatisfaction with her body (poor body image) and feeling...
hurt by comments made by her classmates. CS makes appropriate eye contact and maintains an upright posture except when she talks about the purging episodes and the comments made by her peers. CS states that she is ashamed of her behavior and wants to stop. She believes peer pressure and hurtful comments about her size prompted her to lose weight by purging.

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

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

**Contrary Case**

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

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

**Antecedents and Consequences**

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

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

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

**Empirical References**

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

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

Ekman and Friesen’s Facial Action Coding Systems (FACS) (cited in Negaro et al., 2005) codes facial muscle movements into facial expressions of anger, embarrassment, and shame. Two coders
rate facial muscle movement using a 5-point scale and a calculated ratio of agreement ensures inter-coder reliability.

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

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

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

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

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

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

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

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

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

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**Box 1. Findings of concepts analysis: Shame**

<table>
<thead>
<tr>
<th>Attributes</th>
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<tbody>
<tr>
<td>Physical behaviors</td>
</tr>
<tr>
<td>- Blushing</td>
</tr>
<tr>
<td>- Breaking eye contact, diverting eyes</td>
</tr>
<tr>
<td>- Head lowered, down</td>
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<tr>
<td>- Covering eyes, head, or face</td>
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<tr>
<td>Worthlessness</td>
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<tr>
<td>- Unworthiness</td>
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<tr>
<td>- Inadequacy</td>
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<td>Powerlessness</td>
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<td>Low self-esteem</td>
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<td>- Poor body image</td>
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<tr>
<td>- Self-doubt</td>
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<tr>
<td>- Diminished self</td>
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<tr>
<td>Alienation</td>
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<tr>
<td>- Feeling alone</td>
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<tr>
<td>- Feeling betrayed</td>
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<td>- Feeling like an outsider</td>
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<table>
<thead>
<tr>
<th>Antecedents</th>
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<tbody>
<tr>
<td>Child maltreatment</td>
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<tr>
<td>Eating disorders</td>
</tr>
<tr>
<td>Physical and mental disabilities</td>
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<tr>
<td>Torture/extreme trauma</td>
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<table>
<thead>
<tr>
<th>Consequences</th>
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</thead>
<tbody>
<tr>
<td>- Depression (women)</td>
</tr>
<tr>
<td>- Anger (men)</td>
</tr>
<tr>
<td>- Fear of feeling negative emotion</td>
</tr>
<tr>
<td>- Posttraumatic Stress Disorder</td>
</tr>
<tr>
<td>- Eating disorders</td>
</tr>
<tr>
<td>- Behavior Problems</td>
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<table>
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<tr>
<th>Empirical Referents</th>
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<tr>
<td>Adolescent Shame Measure (ASM)</td>
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<tr>
<td>Test of Self-Conscious Affect for Adolescents (TOSCA-A)</td>
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<tr>
<td>Test of Self-Conscious Affect (TOSCA) - Adults</td>
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</table>
Shame is a complex concept. The most recent research focuses on the relationships among abuse experiences, shame, and outcomes or consequences. The defining attributes of shame are still evolving and warrant further research to clarify the concept. Because the defining attributes are evolving, empirical referents are subject to change as research reveals new findings or refines previous findings.

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

REFERENCES


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Disclaimer: The model and related cases are based on actual events but client initials have been changed to maintain confidentiality.