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EARLY NEGATIVE MEMORIES, HUMILIATION AND DEFECTIVENESS/SHAME SCHEMA: AN EMOTION-FOCUSED THERAPEUTIC APPROACH TO SOCIAL ANXIETY

Yousef Asmari[1], Behrouz Dolatshahi[2], Hamid Poursharifi[2] and Usha Barahmand[3]*

[1] University of Social Welfare and Rehabilitation Sciences, Tehran, Iran.
https://orcid.org/0000-0002-9334-6697

[2] Department of Clinical Psychology, University of Social Welfare and Rehabilitation Sciences, Tehran, Iran.
https://orcid.org/0000-0002-1999-7774
https://orcid.org/0000-0003-3864-9924

[3] City University of New York, Queens College, New York, USA.
https://orcid.org/0000-0003-3049-2854

Abstract

Introduction: Recently emotion-focused therapy has developed as an additional approach and considers the role of primary emotions such as shame in the formation and persistence of SAD.

Objectives: The purpose of this study was to investigate the theoretical model of emotion-focused therapy for SAD by considering the role of early negative memories, humiliation and the mediating role of self-defectiveness/shame schema in the etiology of SAD.

Method: This cross-sectional descriptive study recruited a sample of 105 students, 44 males (41.9%) 61 females (58.1%), diagnosed with SAD by psychologists from Shahid Beheshti University Counseling Center. Participants ranging in age from 18 to 34 with a mean age of 23.1 years (*SD*=3.5) completed the Social Phobia Inventory, Humiliation Inventory, Early Life Experiences Scale, Defectiveness /Shame Schema subscale of the Young Schema Questionnaire-Short Form.

Results: Data were analyzed using SmartPLS-SEM. The results showed that early childhood experiences and humiliation significantly predict SAD. Also, the indirect effects of the independent variables through defectiveness/shame schema on SAD were significant.

Conclusions: Consistent with the assumptions of the emotion-focused approach to SAD, these results confirm that early life experiences and

[*] Correspondence concerning this article should be addressed to Usha Barahmand, Department of Psychology, Division of Mathematics and Natural Sciences, Queens College, City University of New York, 65-30 Kissena Blvd., Flushing, NY11367, USA.
Email: usha.barahmand@qc.cuny.edu

humiliation with the development of shame schemes play an important role in the etiology of SAD and must be considered for therapy to be effective. The results of this study suggest that the components of the emotion-focused model can have therapeutic value as targets of intervention in randomized clinical trials.

Keywords*:* social anxiety disorder, emotion-focused therapy, defectiveness/ shame schema, humiliation

Early Negative Memories, Humiliation and Defectiveness/Shame Schema: An Emotion-Focused Psychopathological Approach to Social Anxiety

Also known as Social Phobia, Social Anxiety Disorder (SAD) is the condition in which an individual experiences persistent and debilitating anxiety, fear, or panic in social interactions typically because he or she anticipates being embarrassed or negatively judged by others (American Psychiatric Association, 2013). The 12-month prevalence of social anxiety disorder is estimated to be around 2.3% (Spence et al., 2018) to 7.4% (Kessler et al., 2012). while its lifetime prevalence is reported to be about 10.7% (Kessler et al., 2012), making it the third most common mental disorder after depression and substance use (Kessler et al., 2012). In a recent study (Jefferies & Ungar, 2020), the prevalence of social anxiety in seven countries with diverse cultures and economic conditions from different parts of the world was estimated to be 36%, with an additional 18% not perceiving themselves as having social anxiety yet meeting the criteria for a social anxiety disorder. The negative consequences and impairment associated with social anxiety disorder are wide-ranging including academic performance (Archbell & Coplan, 2021), emotion regulation strategy use (Daros et al., 2019), interpersonal relations both offline (Acquah et al., 2016) and online (Weidman & Levinson, 2015), occupational functioning (Nordahl & Wells, 2020), quality of life (Alsamghan, 2021) and cannabis use (Walukevich-Dienst et al., 2020).

There are two main cognitive models and treatments of Social anxiety disorder (SAD), one suggested by Clark and Wells (1995) and the other by (Rapee & Heimberg, 1997). The Clark and Wells' model holds that self-regulatory cognitive processes (e.g. self-focused attention) maintain social anxiety. According to this model, when an individual with SAD enters a social situation, negative cognitive beliefs about the self are triggered, which leads to negative interpretations of performance. Attention is then shifted to the self in a biased manner. The individual also uses safety behaviors to deal with negative beliefs about how one appears to others. Furthermore, anticipatory worry before social encounters and post-event rumination after social interactions serve to maintain SAD. A systematic review of treatments for adults with SAD (Mayo-Wilson et al., 2014), found individual cognitive-behavioral therapy (CBT) to be the best intervention for the initial

treatment of SAD as it was associated with large effect sizes and lower risk of side-effects.

The Rapee and Heimberg model suggests that individuals with SAD hold assumptions that others are critical and judgmental (Heimberg et al., 2014). According to this cognitive model, individuals with SAD form a mental representation of the self as viewed from an observer perspective. This mental representation is influenced by internal cues, such as symptoms of anxiety and memories of previous social interactions, and external cues such as observable signs of feedback from others in the social situation. Individuals with SAD then compare this mental image of the self to beliefs about the standards of performance expected by the audience, and perceive a discrepancy, with their performance viewed as not meeting those expectations. This leads to negative thoughts, emotions, and avoidance behaviors, which only serve to reinforce and maintain the negative self-image and the perceived social threat. In this model, a distorted negative self-image is considered to be the key maintenance factor of SAD (Heimberg et al., 2014). Imagery-enhanced CBT targets the individual's negative self-image, but robust empirical support for it has yet to accumulate.

Another model that is gaining recognition is the metacognitive model proposed by Wells and Matthews (1996). In this model, any psychological disorder including SAD is conceptualized as resulting from a thinking style called the cognitive attentional syndrome (CAS). The CAS consists of excessive thinking including worry/rumination, self-focused attention and maladaptive coping strategies which are the cause of SAD. Metacognitive therapy has been reported to be very effective for anxiety and depression (Normann et al., 2014).

Emotion-Focused Approach to Social Anxiety

Given the widespread research on maladaptive cognitive processing in the development of SAD (Craske et al., 2008; Heimberg et al., 2010) some theoretical models suggest the presence of underlying shame-based cognitive-affective structures that shape the negative self-referent cognitions and symptoms of SAD (Moscovitch, 2009).

SAD is conceptualized as traumatic shame-based memories that result in the internalizing of shame-based cognitive-affective schemes(Lazarus & Shahar, 2018; Matos et al., 2013). Shahar explains that in the emotion-focused therapy case formulation of SAD, the primary source of SAD is the experience of social degradation in early childhood or adolescence (Shahar, 2014). Social degradation is rooted in early attachment injuries such as bullying, criticism, rejection, neglect or any form of interpersonal trauma such as physical, emotional or sexual abuse by primary caregivers, siblings or peers. Social degradation experiences characterized by invalidation and lack of emotional support result in traumatic emotional pain (shame, humiliation, fear and/or sadness) and are stored as traumatic shame-based memories that are then incorporated into a maladaptive emotional scheme marked

by shame and inadequacy. This emotional scheme then results in the individual becoming hypervigilant and anxious about the potential exposure of his or her deficiencies in social situations, the symptomatology of SAD. More specifically, the early injuries of rejection, abuse, or neglect are internalized as an aspect of the self that serves as a harsh internal critic/coach which primes the individual to look out for dangers so as to protect him or her from harm (Elliott, 2013).

Literature review

A large body of research has demonstrated that parenting characteristics such as overprotection (Yaffe, 2021), harsh punitive control (Chubar et al., 2020), intrusive and manipulative control (Gómez-Ortiz et al., 2019), lower autonomy support (Nelemans et al., 2020), rejection (Smout et al., 2019) are also associated with social anxiety. Longitudinal studies have demonstrated that parenting behavior has an impact on the emotion regulation strategies that children with behavioral inhibition use, which in turn contributes to social anxiety outcomes (Suarez et al., 2021). That is, parental overprotection, psychological control and lack of support for autonomy can be postulated to lead to a decrease in opportunities for exploration and acquisition of new skills which in turn results in a reduction of social competence and an increase in anxiety about and avoidance of exposure to social situations.

Shahar et al. (Shahar et al., 2015) endorsed that shame and self-criticism mediate the relationship between childhood maltreatment and symptoms of social anxiety. More recently, shame and hostile criticism from parents were found to make individuals prone to paranoid ideation regarding others' behaviors (Carvalho et al., 2019). Self-criticism is posited to serve as a regulatory coping strategy when experiencing shame, thereby leading to SAD (Lazarus & Shahar, 2018).

Like shame, humiliation is also associated with SAD (Association, 2013). The internal experience of humiliation is a deep emotional pain associated with the perception of the self that has been unjustly ridiculed, degraded or disparaged (Lazare & Levy, 2011), so that the individual's identity has been undermined and deemed worthless (Hartling & Luchetta, 1999). Similar to shame, humiliation is another self-conscious emotion that involves the distortion of the whole self and carries long-term consequences (Hartling & Luchetta, 1999). Historically, it has been difficult to differentiate humiliation from shame, as both involve feeling inferior, a decrease in self-esteem, and withdrawal/avoidance behaviors (Elshout et al., 2017). However, unlike shame, humiliation focuses on the actual Humiliating event rather than just blaming the self, and the victim's appraisal of the humiliating act as unjust and thus partial blame is placed on the perpetrator (Elshout et al., 2017; Fernández et al., 2015).

One experience of humiliation in childhood is being a victim of bullying in which the individual is humiliated, ridiculed and physically abused by a peer. This kind of humiliation is known to be associated with SAD (Copeland et al., 2013; Gómez-Ortiz et al., 2018; Pörhölä et al., 2019). Although several studies have

implied the role of traumatic family experiences in SAD (Binelli et al., 2012; Bruijnen et al., 2019), the association of humiliation as an independent factor that occurs mostly in relationships with peers and early life experience that are not necessarily traumatic have not been explored. So also studies have suggested the role of traumatic experiences in the formation of social anxiety (Fitzgerald, 2021; Fitzgerald & Gallus, 2020; Shahar et al., 2015), but early life experiences that are not necessarily traumatic, such as discrediting emotions in childhood and the mechanism of action based on the emotion-focused treatment model, have not been studied.

These factors have been derived from the theoretical model of Shahar and Elliott in which they are hypothesized to impact social anxiety through the development of shame-ridden/defective-self schemes. Two hypotheses were examined in this study: i) levels of early life experience will significantly predict the levels of SAD through the mediation of shame-ridden/defective-self schemes; ii) levels of the experience of humiliation mediated by shame-ridden/defective-self schemes will significantly predict levels of SAD.

Method

Participants

This was a descriptive-cross sectional study. Data from the sample was obtained only at one point in time. The primary goal was to collect data on exposure (early life experiences) and outcomes (humiliation, shame and social anxiety) which would reveal patterns and possible associations among them. Participants with social anxiety were selected as they were relevant to the study question. There was no prospective follow-up.

The sample was selected from among all clients seeking therapeutic services at the Shahid Beheshti University Counseling Center between April 3rd 2019 and March 4th 2020 and had received a diagnosis of Social Anxiety Disorder based on a semi-structured clinical interview conducted by clinical psychologists. The Persian version of the Structured Clinical Interview for DSM-5® Disorders—Clinician Version (SCID-5-CV) was used. Each interview lasted 45 minutes. For each client, two interview sessions were conducted to receive the final diagnosis of social anxiety and to review the inclusion and exclusion criteria. In this study, four clinical psychologists were trained on the symptoms and accurate diagnosis of social anxiety based on diagnostic and statistical manual of mental disorders (DSM–5).

Following the interview, only those individuals who also scored above the cut-off score of 19 on the Social Phobia Inventory (SPIN) (Connor et al., 2000) and met the inclusion and exclusion criteria were retained in the study. The SPIN was administered for the purpose of having a quantitative measure of social phobia which was necessary for the examination of the study hypotheses. The inclusion criteria

were 1) being at least 18 years old, 2) being a college student, and 3) having a principal diagnosis of social anxiety disorder. The exclusion criteria were 1) having a medical condition, 2) having a history of mental illness other than social anxiety disorder, and 3) existence of current substance use.

To determine sample size, we used the *a priori* power analysis using G*Power (Faul et al., 2007). With the selection of the F test family for linear multiple regression and the recommended medium effect size (f^2 = 0.15) for multiple regression analyses (Cohen, 1992), three predictor variables, a target power of .80 and an alpha of .05, a minimum sample size of 77, and with a power of .95, a minimum sample size of 119 was recommended. Based on the results of the power analysis, we settled on having a minimum number of 100 participants for the present study. We began the study when we had 105 participants that met the inclusion criteria.

The study sample included 105 students, 44 males (41.9%), 61 females (58.1%) ranging in age from 18 to 34 with a mean age of 23.1 *(SD* = 3.5). There was no gender difference in social anxiety ($t_{(101)} = 0.037, p > .05$). In terms of educational status, 46 individuals (43.8%) were undergraduates, 48 (45.7%) were master's students and 11 (10.5%) were doctoral students. No significant differences in social anxiety were observed across these three groups ($F_{(2, 100)} = 0.425; p > .05$). The majority of the participants (94.3%) were single, never married, and 6 (5.7%) were married. The two groups did not differ in social anxiety ($t_{(101)} = 1.81; p > .05$). All participants provided written informed consent to participate in research. The demographic characteristics of the sample are presented in Table 1.

Measures

Social Phobia Inventory (SPIN)

The Social Phobia Inventory (SPIN) was developed by Connor et al. (2000) and was based on the Brief Social Phobia Scale. This 17-item scale measures social phobia using three subscales: fear, avoidance and physiological symptoms. Items are scored on a five-point Likert scale, ranging from zero ("not at all") to four ("extremely"). The fear subscale refers to fears of social events, of authority, of receiving criticism and includes items such as "being criticized scares me a lot" and "Being embarrassed or looking stupid are among my worst fears" (Connor et al., 2000). The avoidance subscale refers to one's avoidance of interpersonal interactions and conditions under which they may be forced to interact with others or be criticized by others ("I avoid talking to people I don't know"). The physiological subscale describes the different symptoms of physiological discomfort, such as sweating and blushing ("Trembling or shaking in front of others is distressing to me"). The SPIN has demonstrated adequate test-retest reliability, which varied from 0.78 to 0.89 (Connor et al., 2000). Cronbach's alpha was found to vary from 0.68 to 0.94, suggesting acceptable internal consistency (Connor et al., 2000). In this study, internal consistency with Cronbach's alpha was 0.82

Humiliation Inventory (HI)

The Humiliation Inventory (HI) measures humiliation along two subscales: fear of humiliation and cumulative (Hartling & Luchetta, 1999). This 32-item scale is divided into four sections, the first of which assesses how much participants believe themselves to have been affected by particular experiences ("Throughout your life how seriously have you felt harmed by being ridiculed?"). The second section measures how fearful participants are of being humiliated ("At this point in your life, how much do you fear being harassed?"). The next section attempts to measure participants' concerns over experiencing humiliation ("At this point in life, how concerned are you about being discounted as a person?"). The last section consists of only two items, which assesses participants worries ("How worried are you about being viewed by others as incompetent?"). All 32 items are measured on a five-point Likert scale, ranging from one ("Not at all") to five ("Extremely"). Cronbach's alpha for the fear of humiliation subscale and the cumulative humiliation subscale was found to be 0.96 and 0.94 respectively, suggesting high internal consistency (Hartling and Luchetta, 1999). The instrument was found to have good reliability as reflected by the coefficients of internal consistency: Cronbach's alpha for HI, CHS, and FHS were .96, .87, and .94, respectively.

Early Life Experiences Scale (ELES)

The Early Life Experiences Scale (ELES) is used to measure participants' emotional memories and personal feelings regarding early life experiences with significant, familial figures (Gilbert et al., 2003). Each item on this 15-item scale is scored along a five-point Likert scale, where one indicates that the item is "completely untrue" and five indicates that the item is "very true". The ELES consists of three subscales: threat, submissiveness, and unvalued. The first factor, threat, refers to how threatened participants felt as young children ("I felt on edge because I was unsure if my parents might get angry with me"). The second factor, submissiveness, assesses participants' inclinations towards feeling dominated by the significant figures in their childhood ("I often had to give in to others at home"). The items belonging to the last factor, unvalued, are reverse coded and measure participants' personal beliefs and feelings of being an equal member of their family ("I felt able to assert myself in my family"). The fear, submissiveness, and unvalued subscales demonstrate acceptable internal consistency with Cronbach's alpha values of 0.89, 0.85, and 0.71 respectively. In the current sample, Cronbach's alpha for each of the subscales was good (ELES: α=0.92, Unvalued: α=0.83, Submissiveness: α=0.80, Threatened: α=0.82).

Young Schema Questionnaire-Short Form (YSQ-SF)

The Young Schema Questionnaire-Short Form (YSQ-SF) provides a measure of early maladaptive schemas (Young & Brown, 1998). The 75 items on the YSQ-SF are scored using a six-point Likert scale, ranging from one ("Completely

untrue for me") to six ("Describes me perfectly"). Higher scores indicate the presence of more maladaptive schemas/core beliefs. There are 15 maladaptive schemas considered in this scale, which may be grouped under five broader domains: disconnection and rejection, impaired autonomy, impaired limits, other-directedness, and over vigilance and inhibition (Young, 1998). Internal consistency is acceptable and is typically greater than 0.80 for the 15 early maladaptive schemas/factors considered (Waller et al., 2001). In this study, only the subscale assessing defectiveness/shame schema (Questions 21, 22, 23, 24, 25) was used. The Persian version of this scale has been translated by Sadooghi and acceptable reliability and validity have been reported (Sadooghi et al., 2008). The internal consistency of the subscale in this study was found to be excellent (Cronbach's α= .93)

Results

Descriptive statistics and Pearson product-moment correlation coefficients of study variables are presented in Table 2. Specifically, early life experiences (r = .49, p < .001) and humiliation (r = .52, p < .001) were both positively associated with social anxiety. Early life experiences (r = .40, p < .001) and humiliation (r = .62, p < .001) were also found to correlate positively with shame schema. Thus, both early life experiences and humiliation appear to be risk factors for both shame schema and SAD. The positive association between shame schema and SAD (r = .68, p < .001) also suggests that shame schema may be a risk factor for SAD.

Table 1. Demographic Characteristics of the Sample and Relevant Descriptive Statistics of Study Variables

Variable	Frequency (% of Total)	SA		H		ELE		SS	
		M(SD)	*p*	*M(SD)*	*p*	*M(SD)*	*p*	*M(SD)*	*p*
Gender			.80		.59		.17		.78
Male	44 (41.9%)	44.5 (5.9)		65.3 (21.8)		43.8 (11.4)		13.8 (6.3)	
Female	61 (58.1%)	44.1 (7.09)		62.7 (23.9)		40.4 (11.7)		13.5 (6.6)	
Marital Status			.06		.31		.19		.13
Single	99 (94.3%)	44.8 (5.5)		63.2 (12.3)		41.5 (11.7)		13.7 (6.3)	
Married	6 (5.7%)	49.3 (6.5)		73.1 (10.6)		48.3 (12.4)		17.7 (6.4)	
Education			.74		.21		.97		.24
Bachelor's	46 (43.8%)	43.8 (6.4)		39.0 (13.2)		63.9 (22.8)		12.3 (5.2)	
Master's	48 (45.7%)	44.5 (6.9)		43.1 (12.1)		62.7 (25.2)		14.1 (6.8)	
Doctorate	11 (10.5%)	44.3 (5.4)		44.1 (10.3)		64.7 (16.2)		14.1 (6.1)	
Residence Status			.91		.89		.91		.43
Native to Tehran	41 (39%)	44.9 (6.3)		63.1 (21.2)		41.5 (12.2)		13.5 (7.6)	
Non-native	64 (61%)	44.5 (6.6)		64.2 (21.3)		41.7 (12.7)		14.7 (6.4)	

Note. SA = Social Anxiety; H = Humiliation; ELE = Early Life Experiences; SS = Shame Schema

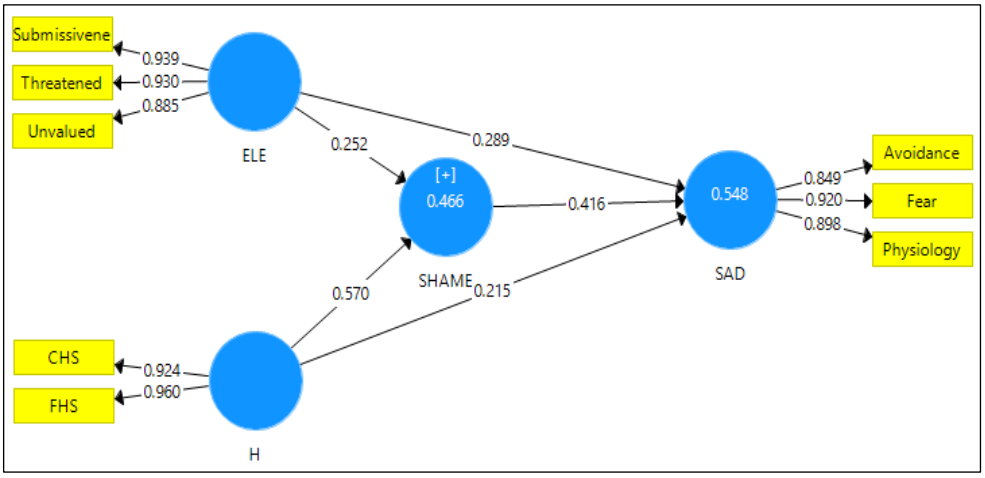
To examine the potential mediating role of shame schema in the association of both early life experience and humiliation with SAD in college students, SmartPLS-SEM v3.3.7 was used. With SmartPLS, direct and indirect effects in mediation models are estimated using the partial least squares path modeling method. The procedure utilizes bootstrapping and bias correction of the bootstrapping distribution. A benefit of SmartPLS is that it makes no distribution assumption, and can, therefore, account for possible non-normality and/or asymmetry of the indirect effect. The bootstrap method based on 5000 resamples of the data can produce 95% bias-corrected confidence intervals to test the significance of indirect effects. Compared with other methods, this method can provide a more accurate balance between power and Type 1 error and generate the most accurate confidence intervals for indirect effects (Hair et al., 2021).

The structural model reflects the paths hypothesized in the research framework. A structured model is assessed based on R^2, Q^2, and significance of paths. The goodness of the model is determined by the strength of each structural path determined by the R^2 value for the dependent variable (Briones Peñalver et al., 2018), the value for R^2 should be equal to or greater than 0.1 (Falk & Miller, 1992). The results in Table 3 show that all values are over 0.1. Therefore, the predictive capability is established. Furthermore, Q^2 establishes the predictive relevance of the endogenous constructs. If the value of Q^2 is greater than 0, it shows that the model has predictive relevance. The results show that there is significant prediction of the constructs (see Table 3). The model fit was assessed by SRMR which was found to be .08 Indicating acceptable model fit as an SRMR $\leq$ .09 indicates an acceptable level of model fit (Cho et al., 2020).

Table 2. Means, Standard Deviations and Correlations for the Study Variables along with Scale Reliabilities

Variables	Cronbach's α	M	SD	2	3	4
1. Social anxiety	.82	44.3	6.61	.68***	.52***	.49***
2. Shame Schema	.93	13.4	6.29		.62***	.40***
3. Humiliation	.96	63.1	21.3			.19
4. Early Events	.92	42.0	12.7			

As outlined in Fig. 1, in the current study, two indirect pathways arise, one reflecting the influence of early life experience and the other reflecting the effect of humiliation on social anxiety. Both these pathways include effects through shame schema. Bootstrapping (n = 5,000) was used to construct 95% bias-corrected, accelerated (BCa) confidence intervals (CIs) for each effect; significant mediation ($p < 0.05$) was established if CIs did not contain zero.



H1 = Early life experiences → Social Anxiety
H2 = Early life experiences → Shame → Social Anxiety
H3 = Humiliation → Shame → Social Anxiety

Figure 1. Three-Path Mediation Model

Mediation analysis was conducted to examine the possible mediating role of shame schema in the relationship between early life experience and social anxiety (see Fig. 1). According to results obtained, early life experiences were found to have significant positive associations with shame schema (β=.25, t =3.14, p < .001, 95% CI [.1, .4]). In addition, shame schema (β=.41, t = 4.57, p < .01, 95% CI [.25, .61]) was positively associated with social anxiety. The findings show significant indirect effects through shame schema (β=.10, t = 2.34, p < .001, 95% CI [.03, .20]) as well as significant direct effect of early life experience on social anxiety (β=.29, t = 3.1, p < .001, 95% CI [.10, .46]). Accordingly, it was seen that the entire model was statistically significant and explained about 55% of the variance (R^2 = 0.548, p < .001). The mediation effect is decided only by looking at the significance of the indirect effect, and Bootstrap bias correction is an effective way to reveal the mediating effect (Hair et al., 2021). Based on this method, the mediating role of shame schema in the relationship between early life experience and social anxiety was found to be significant.

Shame schema also mediated the association of humiliation with social anxiety. Specifically, humiliation positively predicted shame schema (β=.57, t =7.23, p < .001, 95% CI [.41, .71]). which in turn positively predicted social anxiety (β=.21, t =2.9, p < .001, 95% CI [.05, .34]). The findings show significant indirect effects through shame schema (β=.23, t =3.36, p < .001, 95% CI [.12, .39]). Therefore, the hypotheses of this study were supported.

Estimates of the effect and 95% BCa CIs from all pathways are reported in Table 3.

Table 3. Path Coefficients and Indirect Effects for Mediation Model

	Path Coefficients		Indirect Effects Bias Corrected	
	To SA $R^2 = .548$ $Q^2 = .418$	**To SS $R^2 = .455$ $Q^2 = .377$**	**Estimate**	**Bootstrap 95% Confidence Interval**
Effects from EE to SA				
EE	.29 (.002)	.25 (.001)		
SS	.41 (.001)			
Total	.39 (.001)			
Effects from H to SA				
H	.21 (.004)	.57 (.001)		
SS	.41 (.001)			
Total	.45 (.001)			
EE → SS → SA			.10 (.01)	.03, .21
H → SS → SA			.23 (.001)	.12, .39

Note. EE = Early Events; H = Humiliation; SS = Shame Schema; SA= Social Anxiety

Discussion

In this study, based on the psychopathological model of emotion-focused approach to SAD, the effect of early life experiences and humiliation mediated by the shame-based cognitive-affective schema on social anxiety was investigated. The first hypothesis was to investigate the role of the defectiveness/shame schema in the relationship between early life experiences and social anxiety in students with SAD. The results showed that early life experiences had a positive and significant correlation with social anxiety. This finding is consistent with the results of Cunha et al**.** (Cunha et al., 2015), and Binelli et al (Binelli et al., 2012) who showed that early negative life experiences significantly predict social anxiety**.** These findings were also consistent with previous research that early life experiences lead to the formation of the defectiveness/shame schema (Sedighimornani et al., 2020) and the defectiveness/shame schema significantly predicts social anxiety (Lee et al., 2014).

These findings imply that early life experiences mediated by shame/defect significantly predict social anxiety are in line with those of Lazarus and Shazar (Lazarus & Shahar, 2018), Shahar et al. (Shahar et al., 2015), Elliott and Ben Shahar (2017), who suggested, consistent with the emotion-focused model, that childhood abuse and maltreatment experiences contribute to the development of social anxiety by creating shame-based cognitive-affective schema (Elliott & Shahar, 2017). The emotion of shame causes people with social anxiety to have a feeling of inferiority

and imperfection and constantly worry that their flaws will be seen and ridiculed by others (Moscovitch, 2009).

The emotion-focused approach in the psychopathology of social anxiety emphasizes two types of childhood experiences in the family: actual maltreatment in the form of physical, sexual, and emotional abuse or neglect that occurred during the childhood of a person with social anxiety and other experiences not necessarily abusive but involving social degradation experiences characterized by invalidation and lack of emotional support (Elliott & Shahar, 2017). This study, unlike previous research hereof, focused on the second category of early childhood experiences in people with social anxiety. As Gilbert's psycho-evolutionary perspective (Gilbert, 2000; Gilbert & Trower, 2001) explains, feelings of shame, inferiority and deficiency experienced in childhood come to be internalized as autobiographical schemas that lead the individual with social anxiety to perceive the social world in terms of hierarchies, and the self as ranking low and being inferior to others with the likelihood of losing social status and being socially excluded. That is, in social situations, individuals who have experienced shame and invalidation in childhood recall autobiographical shame memories which then activate a shame-based cognitive-affective schema. This schema is composed of components such as experiencing the self as inferior and deficient and others as superior, dominant, critical and rejecting. The evolutionary function of these components is to induce the individual to engage in submissive, appeasing behaviors which signal to others that the individual is not a threat and elicit empathy rather than rejection. Shame is thus a self-conscious emotion that regulates social rank and the preoccupation with social rank is associated with social anxiety (Shahar et al., 2015).

In examining the second hypothesis of the study, the results showed that the experiences of humiliation mediated by the defectiveness/shame schema are significant predictors of social anxiety. The experience of humiliation examined in this study were mostly related to interactions with peers, including experiences such as being a victim of bullying. Based on the emotion-focused psychopathology model, it is one of the sources of SAD (Elliott & Shahar, 2017). These results support prior research that reported a greater likelihood of peer victimization among students with SAD compared to those without (Pontillo et al., 2019). Adolescents experience changes and increases in social anxiety levels as they struggle to understand puberal development while transitioning to larger schools, and encountering difficulties managing changes in peer groups (Gómez-Ortiz et al., 2018). Those experiencing high levels of social anxiety are likely to engage in dysfunctional emotion regulation strategies and, attempting to control their emotional responses to situations before the emotion is fully developed, and, therefore, failing to mitigate the actual physiological reactions or the subjective, emotional affect (Gómez-Ortiz et al., 2018).

The interpersonal humiliating event in which the victim is placed in an inferior, degraded position by someone who is in a superior, powerful position compared to the victim (Hartling & Luchetta, 1999) is similar to the aforementioned definition of bullying provided by Olweus (1993; cited in Gredler, 2003). Also, like

bullying, humiliating situations include three roles; the victim, the perpetrator, and the witness, although the witness may be imagined and internally constructed by the victim, or the perpetrator alone may serve as the witness to the victim's exposed, violated self (Dorahy, 2019). Although victims Internalize the devaluation of the self and perceive that they were unfairly devalued during the humiliating incident and may seek revenge, oftentimes they do not carry out such intentions, initiating a "quiet rage" or an inertia effect (Fernández et al., 2015). It also may appear paradoxical that humiliation is associated with both withdrawal behaviors (e.g. wanting to leave, avoiding eye contact) and seeking revenge, however avoidance behaviors are more prototypical of humiliation (Elshout et al., 2017).

Humiliating experiences such as childhood/adolescent peer victimization can arouse shame when the humiliating or bullying events are perceived as attacks on the victim's social self, resulting in a decrease in social status, social attractiveness, and possible exclusion from social groups (Strom et al., 2018). Childhood/adolescent bullying typically occurs within view of other peers, and the resulting loss of social status incurred during an age in which peer acceptance or rejection greatly contributes to the victim's social identity may stimulate feelings of shame (Strøm et al., 2018).

From the emotion-focused formulation of social anxiety, early childhood experiences of being bullied, criticized, rejected, or neglected elicit strong feelings of shame and humiliation which are encoded as memories and internalized into an overall maladaptive shame-based emotion scheme, characterized by a sense of inferiority, rendering the individual hypervigilant that core deficiencies might be exposed to others (Moscovitch, 2009). Therefore, in this model, social anxiety is a secondary emotion just symptomatic of the basic sense of worthlessness (Elliott & Shahar, 2017).

Research Limitations

One of the limitations of this study is that was since a descriptive cross-sectional design with self-report questionnaires were used, the development and causal trend cannot be inferred from its results. Another important limitation of this study is the difference in the meaning of constructs in emotion-focused therapy theory with what is quantitatively measured on a scale. This means that each construct in the emotion-focused psychopathology model is based on an individual's phenomenal world and is part of each individual's lived experiences (including memories and symptoms of the disorder). Despite these limitations the study has certain strengths. Firstly, this study looked into childhood experiences which were not necessarily traumatic, such as disparaging experiences and secondly, data were collected from patients with a diagnosis of social anxiety, not from a non-clinical community.

Conclusions

The results of the study confirm that early childhood experiences and shame play an important role in the psychopathology of social anxiety. Previous research has examined the relationship between childhood abuse and social anxiety, but this study revealed the role played by individual memories of disparaging experiences in childhood in social anxiety. Attention to the traumatic history and addressing the unresolved childhood emotions and underlying shame can lead to better treatment outcomes for social anxiety. Future studies may investigate the emotion-focused model in larger samples and in different subtypes of social anxiety. Furthermore, the components mentioned in this model may be studied as a target variable or a change process in randomized clinical trial studies for social anxiety,

Conflict of interest

The authors have no conflict of interest to disclose.

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