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The Influence of Shame and Guilt on Sexuality in Men and Women

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ABSTRACT

This review explores contemporary perspectives on the role of shame and guilt in the development of sexual dysfunctions and disharmonies in men and women. Particular attention is given to the relationship between excessive sexual shame and guilt and disturbances of psychosexual development, highlighting the factors contributing to their emergence. The review provides a detailed discussion of the differences between sexual shame and guilt, their associated behavioral patterns, and their impact on sexual function. Based on these distinctions, differentiated therapeutic approaches to sexual shame and guilt are presented, as well as specific psychotherapeutic techniques. The review is grounded in the analysis of original Russian and English-language articles as well as extensive clinical experience of the authors. References are primarily made to statistically reliable, randomized, and placebo-controlled studies conducted over the past 20 years, with some consideration of smaller-scale and unblinded studies. The analysis demonstrated a significant lack of knowledge on this topic. It is concluded that further development of specific psychotherapeutic programs is necessary to address sexual shame and guilt in patients with sexual dysfunction, marital and sexual disharmonies, and other relational issues. Additionally, there is a need for preventive programs to address excessive sexual shame and guilt during childhood and adolescence, emphasizing parental education on their role in sexual upbringing.

Keywords: shame; sexual shame; guilt; psychosexual development; sexual dysfunction.

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Влияние стыда и вины на сексуальность мужчин и женщин

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АННОТАЦИЯ

В обзоре рассматриваются современные представления о роли стыда и вины в развитии сексуальных дисфункций и дисгармоний у мужчин и женщин. Уделяется внимание связи чрезмерного сексуального стыда и вины с нарушениями психосексуального развития, выделяются факторы, влияющие на их возникновение. Подробно обсуждаются различия эмоций сексуального стыда и вины, характерных для них поведенческих паттернов и последствий для сексуальной функции. Представлены созданные на основе выявленных различий дифференцированные подходы к терапии сексуального стыда и вины, а также конкретные психотерапевтические методики. Обзор базируется на изучении оригинальных российских и англоязычных статей и собственном обширном клиническом опыте. Ссылки сделаны преимущественно на статистически достоверные, рандомизированные и плацебоконтролируемые исследования последних 20 лет, в ряде случаев — на малочисленные и открытые исследования. Проведённый анализ продемонстрировал значительный недостаток знаний по данной теме. Сделано заключение о необходимости дальнейшей разработки конкретных психотерапевтических программ для работы с сексуальным стыдом и виной при сексуальных дисфункциях, семейно-сексуальных дисгармониях и других партнёрских проблемах. Также необходимой является разработка программ профилактики избыточного сексуального стыда и вины в детском и подростковом возрасте, основанных на повышении знаний родителей об их роли в половом воспитании.

Ключевые слова: стыд; сексуальный стыд; вина; психосексуальное развитие; сексуальные дисфункции.

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Оялу һәм гаеплелек хисенең ир-ат һәм хатын-кыз сексуальлегенә йогынтысы

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АННОТАЦИЯ

Күзәтүдә ир-ат һәм хатын-кызларда очрый торган сексуаль дисфункцияләр һәм дисгармонияләр үсешендә оялу һәм гаеплелек хисенең роле турындагы заманча күзаллаулар карала. Кирәгеннән артык сексуаль оялу һәм гаеплелек хисенең психосексуаль үсеш тайпылышлары белән үзара бәйләнешенә игътибар бирелә, аларның барлыкка килүенә йогынты ясый торган факторлар аерып күрсәтелә. Сексуаль оялу һәм гаеплелек хисләренең үзенчәлекләре, аларга хас тәртип паттерннары һәм нәтиҗәләре җентекләп өйрәнелә. Сексуаль оялу һәм гаеплелек хисләрен дәвалауда әлеге аерымлыкларга нигезләнеп булдырылган дифференциацияле дәвалау алымнары, шулай ук конкрет психотерапия методикалары тәкъдим ителә. Күзәтү илебездә басылып чыккан һәм инглиз телле оригиналь фәнни мәкаләләрне өйрәнүгә, шулай ук шәхси клиник тәҗрибәләргә нигезләнеп уздырыла. Сылтамалар күбесенчә соңгы 20 елда басылып чыккан, статистика ягыннан чынбарлыкка туры килә торган, рандомизацияләнгән һәм плацебоконтрольле тикшеренүләргә, кайбер очракларда — аз сандагы ачык тикшеренүләргә бирелгән. Үткәрелгән анализ әлеге тема буенча белемнәрнең җитәрлек булмавын күрсәтә. Сексуаль дисфункцияләр, гаиләдәге сексуаль дисгармонияләр һәм башка партнерлык проблемалары вакытында килеп чыккан сексуаль оялу һәм гаеплелек хисе белән эшләү өчен конкрет психотерапеия программалары төзү кирәклеге турында нәтиҗә ясала. Шулай ук ата-аналарның җенси тәрбия бирүдә тоткан ролен арттыруга, балалык һәм яшүсмерлек чорында кирәгеннән артык җенси оялу һәм гаеплелек хисен булдырмауга нигезләнгән программалар булдыру да мөһим.

Төп сүзләр: оялу хисе; сексуаль оялу хисе; гаеп; психосексуаль үсеш; сексуаль дисфункцияләр.

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BACKGROUND

In recent decades, there has been an increased interest in the emotions of shame and guilt, which are the key elements of emotional and moral response, in both research and clinical practice. These emotions include an evaluative component (reflections on how we are perceived by others), cause subjective experience of discomfort or dissatisfaction, and actively influence the perception of both actual and expected behavior, as well as the behavior itself [1, 2]. Analysis and comprehensive understanding of shame and guilt are crucial for effective management of the emotions.

MODERN STUDIES ON SHAME AND GUILT

The emotions of shame and guilt frequently accompany one another, and the distinction between them in everyday speech is ambiguous. However, modern research shows that there is a fundamental difference between the two. The difference warrants a detailed discussion, since the emotions lead to different consequences and require distinct psychotherapeutic approaches.

Most scientists define the difference between shame and guilt as the difference between negative perception of self and a particular behavior [1, 3]. Shame is characterized by evaluation of the whole Self as flawed, bad, unworthy, and not conforming to accepted standards and expectations. In guilt, one is focused on the negative evaluation of a particular behavior and its causes, rather than perception of self. Potter-Efron defined this difference using two questions: "How could I have done that?" (shame) and "How could I have done THAT?" (guilt) [4].

It is universally recognized, that shame is a more severe negative emotion than guilt. Gausel and Leach defined shame as a "dysphoric feeling of contrite self-criticism" [5]. Shame is associated with a persistent global sense of self inferiority and assumption of being judged for some qualities by others. This is why it can be hard to manage [5, 6]. Shame is centered around the fear of negative evaluation of others, while guilt is concentrated on the responsibility for the damage done to others. Shame is often considered a less moral emotion compared with guilt, as it appears not only when violating moral rules, but also when one feels devaluated by others [7].

Shame and guilt are accompanied by different behavioral patterns. The scientists note that shame, as an emotion that is severe and hard to regulate, correlates with significant psychoemotional disturbances, and the defense mechanisms might be destructive. Control mechanisms of painful shame include anger, contempt, envy, depression, withdrawal, and avoidance behavior [8, 9]. Nathanson described 4 ways of coping with shame: attack self, withdrawal, attack others, and avoidance [8–10]. There is also empirical evidence that shame decreases prosocial behavior [1].

The sense of guilt reflects one's preoccupation with social image, leading to attempts to correct the situation and soften the consequences of the act, which is a reparative prosocial behavior [5, 7, 11–12]. Admission of guilt and apology are the main reparative actions. The success of an apology depends on whether or not it is perceived sincere and reflects the intention to correct the mistake and not to behave that way in the future. Consequently, an apology should not only be verbally expressed, but also supported non-verbally, evoking empathy [13]. Thus, guilt has two social functions: it prevents antisocial behavior and encourages prosocial behavior.

Research on the association of shame and guilt with reactive and proactive aggression is interesting. The difference between these types of aggression is determined by the difference in motives. Reactive aggression is a defensive response to a perceived threat. It is impulsive and accompanied by negative affective states, such as frustration and anger. Individuals feeling shame often tend to interpret attitude and intentions of others in ambiguous and even friendly situations as hostile and belittling, and experience prominent social pain and severe agitation. This determines the close connection between shame and a high level of reactive aggression. Studies have shown that decreased shame contributes to a decrease in the level of reactive aggression [14]. Proactive aggression is aimed at reaching the goal and occurs in the absence of a trigger and emotional agitation.

Guilt is divided into rational and irrational [4]. Rational guilt acts as a regulator of human behavior, forming one's "moral behavior", which contributes to the development of self-esteem and corresponds to actual misbehavior warranting correction. Irrational guilt leads to the depression of an individual by vague, ambiguous and not corresponding to the actual behavior accusations. The "aim" of this type of guilt is to prevent any signs of aggressive behavior, including proactive, and punish the victim. Individuals experiencing negative guilt are convinced that they are an absolutely unacceptable person and are focused on their misbehavior, rather than identity. Irrational guilt develops in childhood, as early as 3–5 years of age, when a clear understanding of responsibility is not yet formed. Children may believe that they are the cause of many problems that have nothing to do with them, but are a direct consequence of unworthy and dysfunctional behavior of close and significant adults (parents, relatives). In these cases, they often refuse attempts to assert themselves, do not distinguish between proactive and reactive aggression, and become fearful. Later in life, such individuals try to correct the mistakes completely unrelated to them, punish themselves excessively or decide to distance themselves not to cause trouble for others.

Summarizing numerous studies, Tangney et al. list five differences between shame and guilt that are confirmed by experimental and correlational studies [1].

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1. Shame and guilt determine trends toward opposite actions: shame causes hiding and denial, while guilt leads to reparative actions.

2. Guilt is associated with empathy and concern for others, while people feeling shame tend to focus on their own suffering.

3. Guilt is inversely correlated with aggressiveness, and individuals experiencing shame tend to externalize the blame and anger at others.

4. Shame is linked to several dysadaptive psychoemotional processes and symptoms, and guilt generally does not lead to psychological problems.

5. Shame often causes risky or other unwanted behavior, while guilt motivates individuals toward socially responsible behavior after an unacceptable action. However, according to Elison et al., it is not the shame itself, but the way an individual copes with it that leads to negative consequences [10].

Thus, most studies demonstrate that shame is more of an unhealthy moral emotion and requires appropriate management.

DEVELOPMENT OF SHAME AND GUILT

Shame and guilt, as self-conscious emotions related to moral aspects, arise at the earliest stages of human development and help socialization. Recent empiric studies have shown that the emotions might appear as early as 2 years of age [15]. Their emergence and development depend on the acquisition of several cognitive skills: (1) a sense of self-awareness and the ability to reflect on oneself; (2) knowledge of social rules and the ability to evaluate one's own behavior according to these standards; and (3) the ability to adopt a perspective [2]. Shame and guilt are formed through observation, modeling, and verbal transmission. In this regard, *early parental socialization* of emotions is crucial [15, 16]. Parental behavior, their reactions to children's behavior, and discussing emotions with them also plays an important role. If a child exhibits behavior that violates social rules, parents typically use imperative language, negative affective tone, or explain that the behavior is undesirable. On the other hand, positive behavior is usually reinforced through rewards. Scientists highlight the importance of using the terms describing the mental state (words for emotions, intentions, and cognitions) by parents when talking to their child. Children observe how parents (or other adults) evaluate their behavior and the behavior of others, interiorize the attitude of significant persons to themselves, laying the foundation of emerging self-esteem and the desire to be "good enough", positively evaluated and accepted in the society. The presence of an adult in the process of isolating the child's personal desires protects the child from meaningless and random experiences of excessive shame and fear of doubt, and at the same time supports his or her desire for achievement and recognition [15, 17].

Parental warmth, affection, and support are particularly important for the development of the child's self-esteem and prosocial behavior. Perceiving oneself as worthy or unworthy is the most significant aspect that separates guilt from shame. There is empirical evidence that in parents who show little warmth and affection, children feel unloved, unaccepted, and are more likely to experience shame [2, 15].

All of the above can reasonably be attributed to the process of psychosexual development, which is closely related to the socialization of the child. Starting from early childhood, a sustained idea of one's own sex is formed under parental influence, as well as the ideas of evaluation of the identity by others and its emotional perception, proper primary sexual manifestations in society and one's own gender characteristics, nature of gender-role interaction and its assessment. Clinical practice strongly demonstrates the importance of an early discussion of gender identity and gender characteristics with children, emphasizing the positive aspects of their sex and showing support. At the same time, direct or indirect devaluation, mocking, and harsh punishment can disrupt the formation of sexual identity. They create unsustained perceptions of gender, reinforce the child's sense of sexual inferiority, of not conforming to idealized, unrealistic gender standards, causing excessive shame and guilt. In older children (middle childhood), attention to the emotions and attitudes of others increases, and they begin to attribute negative emotions to others, more often when they do not receive sufficient verbal and nonverbal encouragement [18]. During this period, emotions of shame and guilt associated with sex characteristics are further developed.

In adolescence, sexuality-related shame and guilt reach their peak. According to researchers, the sensitivity to peer evaluation, fear of rejection by them or the desire to belong to a group is the highest during this period [19]. In puberty, the endocrine system is activated, the level of sex hormones increases dramatically, the body undergoes significant changes, new, previously unknown sensations and new needs appear, motivating adolescents to explore their physiology and acquire sexual experience. The rates of somatosexual development vary widely, and the information obtained about the normal physiologic manifestations of sexual development is often incorrect, contradictory, and unreliable. This creates prerequisites for the widespread perceptions of one's own "worthlessness" and "defectiveness" at various stages of puberty, regardless of whether it is accelerated, slowed down or average. It is worth emphasizing that unlike guilt, shame arises not only in situations of violation of moral norms, but also when a person feels devalued by others. This can be a powerful factor contributing to the formation of sexual shame in adolescents.

Integration of awakening sexuality is one of the most important tasks during adolescence (up to the age of 19 years, according to the WHO recommendations), necessary for the full development of personality. Its success requires adult support, empathic discussion of the universal experiences of this

period, timely, adequate information, and "normalization" of the ongoing processes. Longitudinal studies demonstrate that in adolescence and early adulthood, negative emotions about self are most often attributed to the environment [20], which in the face of silenced or distorted information can amplify sexual shame to excessive levels.

Clinical practice shows that the less topics related to gender and sexuality are discussed, the more shame and guilt accumulate in this area. We face a catastrophic lack of adequate knowledge about sexuality among young people. Parents' refusal to talk to their children about sexuality due to the lack of skills and psychological difficulties, communication of exclusively negative sexual information, prohibitions, excessive emphasis on the dangers of sexual activity together with the lack of reliable, scientifically based, age-specific sexual education leads to the perception of some manifestations of sexuality as "wrong", "unnecessary", "shameful" [21]. Later, destructive set-ups that regulate exaggerated, unrealistic "standards" of sexual intercourse that do not correspond to normal physiology join in. It is necessary to note such frequent parental and social messages as "sex is dirty", "a decent woman should not…", "sex is not the main thing in life", "men only need one thing", "a woman should not show her sexual feelings", "sex for a man is a physiological need, and for a woman — an expression of love", "sex only in the dark", "sex is not something that should be discussed" that psychotherapists, sexologists, and psychologists have to deal with in their practice. The contradictory information received from parents, peers, and the media (often not intended for adolescents at all) contributes further to their disorientation. All these factors can disrupt the harmonious process of integration of sexuality, form distorted ideas about it, cause a sense of one's own "worthlessness", imperfection, and shame.

Shame and guilt are inseparable from the subjective experience of body possession, the sense of bodily Self [22]. The somatosexual and psychosexual development of an adolescent includes an aggravated sense of a changing body, the emergence of new self-evaluative characteristics and perceptions of self. They require a harmonious integration in order to develop a positive self-image and acceptance of one's own body, including as a sexual body. This is why adolescents tend to develop various dysmorphic disorders, which are either alleviated by successful communication experiences or exacerbated, leading to detrimental consequences.

In dysmorphic disorders, an individual is largely preoccupied with thoughts about perceived flaws in their own appearance that appear to an outside observer as minor or nothing more than variations in body features. Dysmorphic manifestations in the general population equally affect males and females, although they are more pronounced in females due to the special importance of external attractiveness. For both sexes, there is a correlation of dysmorphic experiences with high rates of other psychoemotional disorders and committed suicides [23].

A deep sense of shame and social isolation is a universal feature of individuals with dysmorphic disorders. Excessive shame is directly related to the opinion of other people, especially significant ones. The feeling of shame originates from traumatic childhood experience, including emotional neglect, humiliation, physical, psychological, and sexual abuse [24]. People with dysmorphic disorders are more likely to have personal experience involving fear of rejection, which perpetuates excessive shame and negative preoccupation with appearance [25]. Such individuals try to avoid publicity and intimacy to protect themselves from the judgment of others (fear of becoming an object of bullying and mocking). Attempts to create the "perfect" body can be considered as a desire for an accepting, loving gaze of others.

The media can also contribute to the development of dysmorphic experiences by advertising the "standards" of genitalia (penis size, structure of the labia minora), that ignore the variations in normal genital anatomy. There are a lot of methods, including surgical interventions such as labiaplasty, "100 ways to increase penis size" and others that are offered to "normalize" the genitals and make them "beautiful". The advertisement for inadequate beauty standards and modern reconstructive genital surgery options can serve as a source of severe shame about one's "ugly" genitalia, with negative consequences for sexual self-esteem and sexual fulfillment.

INFLUENCE OF SHAME AND GUILT ON SEXUALITY IN MEN AND WOMEN

Sexual shame is actively discussed in psychotherapeutic and sexological practice, but is not well studied. Based on the general conceptualization of shame, sexual shame can be considered as shame associated with the perception of sexual Self as "worthless" and based on perceived or actual negative reactions to existing sexual attitudes, behavior, or experience from others. Kyle defines it as a common negative emotion that arises after a critical self-reflection of one's sexual thoughts and experiences, and categorizes it as a distinct and particularly painful subtype of shame [26].

The character of sexual shame experiences is usually related to sexual beliefs formed during psychosexual development. Men are usually ashamed of inexperience, actual or imaginary sexual failures with erection and intercourse duration, masturbation, watching pornography, lack of libido or, in contrast, its excessive expression, small penis size, inadequate reproductive characteristics. Women have a different set of concerns related to sexual shame, including difficulties reaching an orgasm, "wrong" orgasm, the notion of "decency", moral limitations, unacceptability of their own sexual activity and discussion of their sexual needs.

Nobre and Pinto-Gouveia developed conceptual cognitive models of sexual dysfunction, which demonstrated that sexual shame and distress are actively involved in the cycles

of dysfunctional sexual responses [27]. Physiological sexual response is a result of the relationship between the processes of sexual arousal and inhibition. Severe sexual shame and distress disturb the balance between them, triggering an inhibitory response and leading to sexual dysfunction. The analysis of previously published data and our own extensive clinical experience demonstrate the correlation of sexual shame with hypoactive sexual desire disorder in men and women, less sexual arousal and satisfaction, negative perceptions of one's sexual Self, difficulties with sensual intimate touch, and sexual identity anxiety [28, 29]. Sexual pain syndromes in women with a history of sexual abuse are also strongly associated with shame and guilt.

In foreign studies, much attention has been paid to the research into the influence of religiosity on sexual behavior. Religious traditions regulate sexuality through religious messages that create guilt for violating moral standards and shame for one's own qualities that do not conform to religious morality. Female sexual behavior is more rigidly restricted, causing a wide range of sexual shame manifestations and a greater impact on behavior. Studies of the relationship between religiosity and female sexual dysfunction have shown that it is guilt that mediates the link between the two.

Most studies are focused on the relationship between religiosity, guilt about sex, and female sexual pain syndromes such as dyspareunia and vulvodynia [30, 31]. Religiosity, conservative environment (family, friends, religious community) was confirmed to negatively affect the ability to maintain painless sexual intercourse due to severe guilt about sexual relationships. At the same time, neither belonging to more or less conservative Christian denominations nor belonging to them since childhood or recently was associated with an increase in sexual pain syndromes [30]. In women's opinion, the lack of accurate information about sexuality and reproductive anatomy had the highest influence on sexual guilt. It is worth noting that in our practice, the association of sexuality and guilt in women with a non-religious upbringing is also more common in cases with a lack of information.

Regardless of religious upbringing, the society has a set of "rules" for women's sexual behavior, mandating that they perform "sexual duties" and putting the man's needs above the woman's own desires and comfort. These rules strongly affect the emotional aspects of sexual interaction, prevent women from discussing their desires, cause feelings of inferiority, shame, and guilt. Unspoken protest against unwanted sexual activity causes feelings of sexual abuse and can translate into pain during intercourse. Sexual shame and guilt about possible violation of accepted gender sexual scenarios serve as barriers to women seeking medical advice. They interfere with communicating about painful sexual intercourse to the partner, discussing possible strategies to reduce pain, and compel women to endure it. Studies demonstrate that 33%–49% of women with sexual pain syndromes hide their experiences from their partner, and 81.6% of those reporting pain refer to it as "a little painful" (significantly underestimating the pain) [32–34]. Additional motivations for this behavior include the desire to maintain intimacy and avoid conflict, inability to discuss sexuality, normalization of painful sex, and traditional views of vaginal intercourse as the only "right", natural, and acceptable, compared with other forms of sexual activity without vaginal penetration.

Male sexuality is more influenced by sexual shame rather than guilt. Men are highly sensitive to feelings of not conforming their sexual selves to the standards of the traditional masculine role and experience weakness, vulnerability, and anxiety. It is not about restrictions, as with women, but rather about obligations and exaggerated demands on male sexual expressions. Studies demonstrate that men with gender-role conflict experience discomfort, shame, and accompanying anger when discussing sexual health issues even with their physicians [35]. Men may experience shame, up to dysmorphic feelings, about penis size, feeling sexually unattractive [36]. The high prevalence of shame about the actual or more often subjectively estimated small size of the penis is confirmed by the widespread discussion of penis enlargement methods with physicians, on social media and in the scientific publications.

The impact of shame on male sexual health and behavior is most pronounced in male sexual abuse victims. Such cases are not uncommon. According to the US National Intimate Partner and Sexual Violence in the Lifetime Survey (NISVS), nearly one in two bisexual men, two in five homosexual men, and one in five heterosexual men have had an abusive experience [37]. In several studies, male survivors of abuse were shown to have a pronounced sense of shame, humiliation, and devastation as a result of the discrepancy between the dictated stereotypes of masculinity ("strong, sexually assertive, and able to defend himself") and the actual feeling of being a "victim" [38]. Higher rates of sexual avoidance and sexual dysfunction were also found [39].

Many of sexually abused men choose to hide the incident and even deny this experience to occur even for themselves. However, they still experience pronounced shame regardless of whether they identify the experience as abuse and consider themselves a victim or do not identify themselves in this way. Moreover, the studies have shown that men who did not identify themselves as abuse victims experienced a greater sexual distress [40]. Some researchers note that men who have been sexually abused report more sexual problems than women with a history of similar experience [41].

There are studies supporting an association present between shame and guilt and hypersexual behavior, including compulsive sexual behavior [35, 39, 42]. Moreover, a positive correlation was found between shame proneness and hypersexuality, as well as between guilt proneness, and motivation to change and preventive behavior [42].

CONCLUSION

The analysis of previously published data has shown that the problem of sexual shame and guilt remains unresolved. There is a need for specific psychotherapeutic programs for the management of sexual shame and guilt in sexual dysfunction and marital-sexual disharmony. Additionally, preventive programs are required to address excessive sexual shame and guilt during childhood and adolescence, emphasizing parents' education on their role in sexual education.

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СПИСОК ЛИТЕРАТУРЫ | REFERENCE

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