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From humiliation to feeling depressed: The role of shame, self-disgust and hated self

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Da humilhação a sentimentos depressivos: O papel da vergonha, da auto-aversão e do auto-criticismo

Resumo

A humilhação é uma emoção intensa, relacionada com a experiência de ser, ou de se percepcionar como sendo, rebaixado, ridicularizado ou desvalorizado. O acto de ser humilhado é considerado pela pessoa como um ataque externo à identidade do Eu que, para além de sentido como injusto, conduz a um desejo de vingança. Frequentemente, após uma experiência de humilhação, a pessoa tende a sentir-se inferior e impotente, acreditando que os outros a vêem da mesma forma. Estas auto-avaliações podem levar a que a pessoa sinta ódio e aversão por si, criticando-se e desenvolvendo uma relação de auto-ataque. Estudos têm analisado o papel da vergonha, da auto-aversão e do auto-criticismo como preditores de sintomas depressivos, contudo o efeito mediador destas variáveis na relação entre experiências de humilhação e sintomas depressivos continua por explorar.

O presente estudo teve como objectivo analisar as propriedades psicométricas da versão portuguesa da escala Experiências de Humilhação (EH) através de uma Análise Factorial Exploratória, numa amostra de 423 participantes (68.3% do género feminino e 31.7% do género masculino). Para além disso, foi também investigado o papel da vergonha, da auto-aversão e do auto-criticismo na relação entre experiências de humilhação e sintomas depressivos.

Os resultados da análise da EH revelaram boas propriedades psicométricas. Por outro lado, foi também demonstrado que experiências de humilhação podem levar a que as pessoas acreditem que os outros as percepcionam como inferiores, tornando-se auto-críticas e desenvolvendo sentimentos de auto-aversão. Consequentemente, esta visão rígida acerca de si pode levar a

sintomas depressivos. O modelo explica 51% dos sintomas depressivos.

De modo geral, os nossos resultados indicam que a EH é um instrumento válido e fidedigno e evidencia o papel mediador da vergonha, da auto-aversão e do auto-criticismo na relação entre a humilhação e os sintomas depressivos.

Palavras-chave: Humilhação, Análise Factorial Exploratória, Vergonha, Auto-aversão, Auto-criticismo, Mediação.

From humiliation to feeling depressed: The mediator role of shame, self-disgust and hated self

Abstract

Humiliation is an intense emotion related to the experience of being or perceiving oneself as being debased, scorned or ridicule. The experience of humiliation is felt as unfair and as an external attack to the identity of the self that conduct people to seek revenge. Often, people feel powerless and inferior and start to believe that the others are looking down to the self. These self-evaluations may lead people to develop a self-hatred, self-disgust and self-attacking relationship. It is already known that shame, self-disgust and self-criticism can predict depressive symptoms. Moreover, humiliation has been considered an important risk factor for depression. Nonetheless, the mediator role of these variables in the relationship between the experience of humiliation and depressive symptoms remains unexplored.

The present study aims to conduct an Exploratory Factor Analysis of the Portuguese version of the Experiences of Humiliation Scale (EHS) and to evaluate its psychometric properties, in a sample of 423 participants (68.3% females and 31.7% males). Furthermore, the role of shame, self-disgust and hated self (self-criticism) in the relationship between humiliation and depressive symptoms was also explored.

Results revealed that EHS has good psychometric properties. Moreover, results from path analysis showed that experiencing humiliation may lead people to believe that others look down to the self, to become self-critical and to develop feelings of self-disgust. In turn, this harsh view of the self may lead to depressive symptoms. The model accounted for 51% of depressive symptoms.

Overall, our findings indicate that EHS is a valid and reliable measure of humiliation experiences and highlight the mediator role of

shame, self-disgust and self-criticism in the relationship between humiliation and depressive symptoms.

Key Words: Humiliation, Exploratory Factor Analysis, Shame, Self-disgust, Self-criticism, Mediation.

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Introduction

Humiliation has been defined as a "deep dysphoric feeling associated with being, or perceiving oneself as being, unjustly degraded, ridiculed, or put down", especially when one's identity has been demeaned or devalued (Hartling & Luchetta, 1999, p.264). The experience of humiliation involves the feeling of being scorned and devalued in relation to others (Kendler, Hettema, Butera, Gardner, & Prescott, 2003; Klein, 1991), leading to feelings of being powerless to escape or to defend the self (Gilbert, 1997).

Humiliation is an extreme and intense emotional reaction to being lowered in the eyes of the others through scorn, derision, ridicule, torture or other degrading treatment (Elison & Harter, 2007; Gilbert, 1997; Hartling & Luchetta, 1999; Klein, 1991). The act of being humiliated is perceived as an attack to the identity of the self (Hartling & Luchetta, 1999), that threatens and damages one's personal integrity and involves the invasion of one's personal space (Klein, 1991). It is a painful feeling caused by being humbled of one's dignity, self-respect or self-concept (Gilbert, 1997; Lazare, 1987). Moreover, it includes a loss of status generated by a hostile other, that often occurs in public (Elison & Harter, 2007).

Although the feeling of being humiliated is personal, the process involved is collective. It occurs in a triangle dynamic that Klein (1991) defined as the Humiliation Dynamic. This interaction happens between the person who experiences humiliation – the victim; the person who creates the feeling of being humiliated – the humiliator; and the witnesses - the ones who testimonies the humiliation. The humiliator is considered to have powerful feelings, whereas the victim starts to feel powerless, violated and debased by someone who is perceived as more powerful (e.g., Hartling & Luchetta, 1999). On the other hand, the magnitude of the humiliation increases regarding the size and the importance of whom is in the

audience (Elison & Harter, 2007). It is a win-lose context that occurs in a ranking relationship, reflecting the unequal power of those involved (Hartling & Luchetta, 1999; Klein, 1991).

Humiliation and Shame

Several authors consider that humiliation might be included in the family of self-conscious emotions (Elison & Harter, 2007; Galsworthy-Francis, 2012; Kaufman, 1996; Tangney & Fischer, 1995), together with shame, guilt, pride and embarrassment. Self-conscious emotions reflect emotional states that occur in social interactions where people can be evaluated and judged (Tangney & Fischer, 1995).

Although humiliation and shame are often used interchangeably, literature has been highlighting that these emotions share common characteristics but reflect different emotional states (e.g., Galsworthy-Francis, 2012; Gilbert, 1997; Hartling & Luchetta, 1999; Klein, 1991; Trumbull, 2008). Both emotions are extremely painful, involve a sensitivity to put down, increased arousal and feelings of injury. Moreover, both emotions lead to rumination on the harm done by others and a desire to protect the self (Gilbert, 1997). In fact, experiences of humiliation can also involve feelings of shame. However, humiliation can exist without shame, since it is not necessary to feel ashamed of one's self in order to feel humiliated (Klein, 1999).

Humiliation is related to the feeling when experiencing ridicule, contempt or disparagement because the victim perceives the humiliation as undeserved. The focus is directed to the humiliator and to the injury he has done towards the self. It is an external attack where the humiliator is viewed as bad (Elison & Harter, 2007; Gilbert, 1997; Klein, 1999). On the other hand, in shame-based experiences, it is the self who is privately and publicly seen as negative or bad (Gilbert, 1997). Shame has been considered as a poisoning experience

towards the self (Gilbert, 2002; Kaufman, 1996). Also, shame does not necessarily involve an external attack in order to originate internal judgments. People believe they deserve their shame and that they have created a negative view of the self in the other's mind as someone inferior, worthless or defective. They believe that others are looking down on the self even though this may not necessarily correspond to other's real perception. This perception of the self as someone with negative characteristics, or with a lack of positive ones, leads to fears of rejection or exclusion (Gilbert, 2002, 2007; Klein, 1999) and can predict depressive symptoms (e.g. Matos & Pinto-Gouveia, 2010; for a review see Kim, Thibodeau, & Jorgensen, 2011). Furthermore, shaming self-evaluations are often associated with self-criticism and self-hatred and can generate feelings of self-disgust. This proneness to self-criticism is associated with depressive symptoms (e.g. Castilho, Pinto-Gouveia, & Duarte, 2013; Gilbert, 2002, 2007; Gilbert & Miles, 2000). In sum, shame is an internal process of a negative evaluation of oneself, while humiliation is an interpersonal process (Trumbull, 2008).

Experiences of humiliation are enduring. The memory of being humiliated tends to perpetuate in the victim (Klein, 1991). Therefore, people struggle with the impact that humiliation had on them, despite the fact that the focus remains on the injury that others made (Gilbert, 1997).

The humiliated person often reports feeling eliminated, helpless, confused, diminished, full of anger and vulnerable to others. This vulnerability is felt either in the moment of the humiliation or in future possible humiliating situations, which leads to the tendency to protect one's self (Klein, 1991). Moreover, experiencing humiliation frequently involves rumination on the harm done by others that, consequently, will activate defensive strategies (Gilbert, 1997), such as isolation and social withdrawal, but also anger and anxiety responses (Hartling & Luchetta, 1999; Trumbull, 2008). These

defensive strategies are similar to the ones presented in shame situations (Gilbert, 1997). Nevertheless, while humiliation tends to lead to seek revenge in an attempt to counterhumiliate the aggressor, in order to reestablish the status and justice (Gilbert, 1997; Lazare, 1987; Trumbull, 2008), the same does not happen in shame.

Humiliation may cause direct wounds towards the self, leading to negative internal states and to psychopathology (Galsworthy-Francis, 2012; Trumbull, 2008). Also, research has found that experiencing humiliation is an important risk factor for depression (Brown, Harris, & Hepworth, 1995; Kendler et al., 2003; Farmer & McGuffin, 2003). Moreover, humiliation may conduct to maladaptive patterns that include depressive and anxiety symptoms, immobilization, isolation or even self-destructive behaviors (Klein, 1991).

After an experience of humiliation, some characteristics of the self can be felt as defective and, thus, these parts may be internalized and become a source of self-disgust. (e.g., Gilbert, 1997, 2015). Disgust is a basic emotion which intents to avoid or eliminate what is considered dangerous. If someone recognizes those characteristics of the self as disgusting, one can start feeling inferior, develop critical thoughts and self-hatred feelings. Therefore, self-disgust seems to be linked to a more critical, self-hated and self-attacking relationship (Carreiras & Castilho, 2014).

Literature has been highlighting that self-disgust and self-criticism are considered antecedents of depressive symptomatology and intense psychological suffering (Carreiras & Castilho, 2014; Castilho et al., 2013; Gilbert, Clarke, Hempel, Miles, & Irons, 2004; Powell, Simpson, & Overton, 2013). Nevertheless, the mediator role of shame, self-criticism and self-disgust in the relationship between experiences of humiliation and depressive symptoms remains unexplored.

Measures of Humiliation

In 1999, Hartling and Luchetta developed the Humiliation Inventory, the first self-report scale to evaluate the internal experiences of humiliation as a separated construct from shame. This measure comprised two subscales. The *Cumulative Humiliation* subscale assesses the humiliation experienced from the past till the present, while the *Fear of Humiliation* subscale measures the fear of a further experience of humiliation (Hartling & Luchetta, 1999).

However, the Humiliation Inventory does not include questions related to eating disorders, neither distinguishes between the frequency and the intensity of humiliating events. Thus, in order to improve and overcome this restriction, Goss and Allan (2010) developed a new measure of humiliation: The Experiences of Humiliation Scale (EHS). This 24-items scale refers merely to previous humiliating experiences and the frequency and intensity in which people experienced them. Furthermore, the instrument comprises two scales: How Often and How Humiliating. In the original version, the *How Often* scale is composed of 5 dimensions: *Less Serious Humiliation; Appearance, Shape & Weight; Serious Mental Humiliation; Physical Humiliation* and *Rejection*; while the How Humiliating scale included 4 dimensions: *Less Serious Humiliation; Appearance, Shape, Weight & Eating; Serious Mental & Physical Humiliation* and *Rejection*. The EHS showed good psychometric properties on both clinical and non-clinical samples and seems to measure a separate construct of shame (Galsworthy-Francis, 2012).

The first aim of the present study was to conduct an Exploratory Factor Analysis for each scale of the EHS separately (How Often and How Humiliating) and evaluate the psychometric properties in the Portuguese population. Another goal was to explore the relationship between experiences of humiliation and depression, anxiety and stress, eating psychopathology symptoms, self-disgust,

self-criticism and external shame. Furthermore, the current study also pretends to investigate the mediator effect of external shame, hated self (self-criticism) and self-disgust in the relationship between experiences of humiliation (How Humiliating scale) and depressive symptomatology.

Method

Participants

The present sample is comprised of 423 participants, 289 females (68.3%) and 134 males (31.7%) with ages ranging from 18 to 60 years old (M = 32.17; SD = 11.33). The participants have a mean of 13.93 years of education (SD = 3.07), 35.5% are students and 38.1% belong to social middle class. Regarding marital status, 60.8% are single while 27.2% are married.

Procedure

The data collection respected ethical principles and the assessment protocol was approved by the ethical committee of the Faculty of Psychology of the University of Coimbra. Participants were informed about the aims of the study, as well as their voluntary participation. Confidentiality was assured and a written informed consent was provided. After that, participants completed the protocol composed of several self-report questionnaires that took approximately 20 minutes.

Measures

Demographic Data. Participants were asked about their age, educational level and marital status.

Experiences of Humiliation Scale (EHS; Goss & Allan, 2010) measures the frequency and intensity of previous humiliating experiences (Galsworthy-Francis, 2012). The scale is composed of 24

items describing potential humiliating experiences such as “being made to feel like an outsider”, “having negative comments made about your shape and weight” or “being treated disrespectfully”. For each sentence responders have to rate how often they had that experience and how humiliating it was for them. All items are rated using a 5 point Likert scale, from 1 (*never*) to 5 (*extremely/most of the time*; Galsworthy-Francis, 2012). The subscales scores are calculated through the sum of all items.

The original EHS demonstrated good internal consistency both on clinical (α = .94 for both How Often and How Humiliating scales) and non-clinical populations (How Often α = .91; How Humiliating α = .94; Lewis, 2010 cit. in Galsworthy-Francis, 2012).

Other as Shamer Scale (OAS; Goss, Gilbert & Allan, 1994; Portuguese version by Lopes, Pinto-Gouveia & Castilho, 2005) is a self-reported instrument with 18 items that assess external shame through a 5 point Likert scale. Higher scores reflect higher levels of external shame. Both the original and the Portuguese versions presented good psychometric properties (α = .92; Goss et al., 1994; Lopes et al., 2005).

Self-Disgust Scale (MSDS; Castilho, Pinto-Gouveia, Pinto, & Carreiras, 2014) aims to assess the self-disgust in relation to different aspects of the self: cognitive, emotional, physiological and behavioral. This measure includes four subscales: defensive activation (physiological component), cognitive-emotional (cognitive and emotional component), avoidance (behavioral component) and exclusion (behaviors used to eliminate and exclude disgusting characteristics of the self). In the present study only the cognitive-emotional subscale was used as we intended to assess emotions and thoughts that reflected an aggressive and hostile relation with the self. The MSDS includes 33 items, scored on a 5 points Likert scale. The subjects are asked to respond accordingly to the frequency of the experience (0 - *never* and 4 - *always*). In the original study all

subscales showed good internal consistencies values: α = .95 for defensive activation; α = .97 for cognitive-emotional subscale; α = .77 for exclusion and α = .84 for avoidance (Carreiras & Castilho, 2014).

Forms of Self-Criticizing and Reassuring Scale (FSCRS; Gilbert, Clarke, Hempel, Miles, & Irons, 2004; Portuguese version by Castilho & Pinto-Gouveia, 2011) is a self-report scale that assesses how people tend to self-evaluate, whether through critical or reassurance answers towards failure and error situations (Coelho, Castilho, & Pinto-Gouveia, 2010). It includes 22 items, divided into three subscales: Inadequate Self, that measures feelings of inadequacy in relation to self (e.g., "I think I deserve my self-criticism"); Reassured Self, which reports a positive attitude of warm, comfort and compassion towards the self (e.g., "I still enjoy being myself") and Hated Self that evaluates a more destructive and aggressive response, characterized by a feeling of disgust and anger directed to the self (e.g., "I have been so angry with me that I want to hurt myself."). Items are rated on a five-point Likert scale (0 - *anything like me* and 4 -*extremely like me*). The instrument presented good psychometric properties in the original study (α = .90 for Inadequate Self; α = .86 for Reassured Self; and α = .86 for Hated Self; Castilho & Pinto-Gouveia, 2011)

Eating Disorders Examination Questionnaire (EDE-Q; Fairburn & Beglin, 1994; Portuguese version by Machado, Martins, Vaz, Conceição, Bastos, & Gonçalvez, 2014) is a self-report version of the Eating Disorders Examination (EDE) interview that assesses eating disordered attitudes and behaviors over the past 28 days. Higher scores reflect higher eating disordered symptoms. The scale is divided into four subscales: weight concerns, shape concerns, eating concerns and restraint (Fairburn, 2008). In the present study only the EDE-Q total score was used in order to assess the severity of eating psychopathological symptoms. The EDE-Q has been shown to have good reliability, both in the original and in the Portuguese versions

(Fairburn, 2008; Machado et al., 2004).

Depression Anxiety Stress Scale (DASS-21, Lovibond & Lovibond, 1995; Portuguese version by Pais-Ribeiro, Honrado, & Leal, 2004) is a self-report measure that assesses psychopathological symptoms, namely: depression, anxiety and stress. It includes 21 items, 7 items for each dimension. Subjects are instructed to respond to what extent they experienced each symptom in the previous week, using a frequency of a four-point scale (0 - *did not apply to me at all* and 3 - *was applied to me most of the time*; Pais-Ribeiro et al., 2004). The original version showed adequate internal consistencies values (.81 for depression and stress dimensions and .83 for anxiety; Lovibond & Lovibond, 1995), similar to the ones found in the Portuguese version (.74 for anxiety, .85 for depression and .81 for stress dimension; Pais Ribeiro et al., 2004).

Data Analysis

Exploratory factor analysis and psychometric properties were performed using IBM SPSS Statistics version 22. Path analysis was conducted using AMOS Software.

In order to explore the factorial structure of EHS, two separate *Principal Component Analysis* (PCA) were conducted with Varimax rotation. To ensure the adequacy of data, Kaiser-Meyer-Olkin (KMO) and Bartlett's Test of Sphericity were analyzed. The retention of factors was performed based on eigenvalues greater than 1 (Kaiser's criterion) and on analysis of the scree-plot. Items were retained based on communalities above .30 and factor loading above .50 (Tabachnick & Fidell, 2007).

Cronbach's alphas (cut-off of .70 is considered suitable; Field, 2013) and the item-total correlations (values below .30 were considered to eliminate) were performed to evaluate the reliability (Tabachnick & Fidell, 2007).

Gender differences were tested using *independent sample t*

tests (Field, 2013). The Cohen's d test and effect size were also calculated (Pallant, 2005).

Pearson correlation coefficients were executed to examine the association between EHS and other measures in study (DASS-21; EDE-Q; MSDS; FSCRS; OAS). The magnitude of correlation coefficients was reported based on Pestana and Gageiro (2003) criteria.

Preliminary data analysis was executed to examine the adequacy of the data.

Finally, a *path analysis*, a structural equation modeling (SEM), was performed in order to test the mediator effect of external shame, hated self (self-criticism) and self-disgust in the relationship between experiences of humiliation (how humiliating scale) and depressive symptomatology. Path analysis is an appropriate and well-known statistical methodology that permits the simultaneous examination of structural relationships and allows the examination of direct and indirect paths at the same time (e.g., Schumacker & Lomax, 2004). The Maximum Likelihood method was used to estimate all model path coefficients and to compute fit statistics. Several goodness-of-fit measures were used to assess overall model fit and recommended cut-points were used (Brown, 2006; Kline, 2005): *Chi-Square* ($\chi 2$), *Normed Chi-Square* ($\chi 2$/d.f.), *Comparative Fit Index* (CFI $\geq$ .90, acceptable, and $\geq$ .95, desirable; Hu & Bentler, 1998), *Tucker-Lewis Index* (TLI $\geq$ .90, acceptable, and $\geq$ .95, desirable; Hu & Bentler, 1998), *Goodness of Fit Index* (GFI $\geq$ .90, good, and $\geq$ .95, desirable; Jöreskog & Sörbom, 1996), *Root Mean Square Error of Approximation* (RMSEA $\leq$ .05, good fit; $\leq$ .08, acceptable fit; $\geq$ .10, poor fit; Brown, 2006; Kline, 2005) with 95% confidence interval.

Bootstrap procedure (with 2000 resamples), with 95% bias-corrected confidence interval was performed to test mediation effects. This method is considered one of the most reliable and powerful procedures to test the significance of the direct, indirect and total

effects (Maroco, 2010). If zero is not included on the interval between the lower and the upper bound of the 95% bias-corrected confidence interval then the effect is considered statistically significant ($p < .05$; Kline, 2005).

Results

Exploratory Factor Analysis

To explore the factorial structure of EHS, two Principal Component Analysis (PCA) were conducted separately for both scales (How Often and How Humiliating). The two dimensions were analyzed separately, following the same procedures used in the original version (Lewis, 2010 cit. in Galsworthy-Francis, 2012).

Regarding to How Often scale, the KMO (.94) and Bartlett's Sphericity Test (χ^2 (276) = 5493.121; $p < .001$) indicated good adequacy of data. The How Humiliating dimension also demonstrated good values of KMO (.94) and of Bartlett's Sphericity Test (χ^2 (276) = 5615.263; $p < .001$).

First, the structure regarding to How Often scale was analyzed. According to Kaiser's criterion (eigenvalue <1) a four factor solution emerged. However, the fourth factor only explained 4.90% of the variance and had only 1 item, which is considered weak and unstable (Costello & Osborne, 2005). Thereby, a new analysis was performed forcing a three factor solution. This solution explained 55.27% of the total variance. Nonetheless, item 14 ("Having negative comments made about the way you look") loaded in two factors (cross-loading item) and item 7 ("Being harassed") showed an item-total correlation (.25) below the recommend value of .30 and did not contribute to scale's internal consistency (Field, 2013). For the above mentioned reasons both items were deleted and a new factor analysis was performed.

This final solution accounted for 57.22% of the total variance,

with a KMO of .94 and the Bartlett's Sphericity Test (χ^2 (231) = 5012.737; $p < .001$). The first factor, composed of 14 items, explained 44.46% of the variance and was named *Serious Mental and Physical Humiliation & Rejection*. The second factor, named *Less Serious Humiliation* explained 7.65% of the variance and enclosed 4 items. Lastly, the third factor, *Appearance, Shape & Body*, was responsible for 5.10% of the variance and consisted of 4 items.

Regarding the How Humiliating scale, the initial factor analysis revealed a three factor solution. However, only 1 item saturated on the third factor. Hence, a new factor analysis forcing a two factor solution was conducted. This solution explained 52.09% of the total variance. However, item 7 was eliminated since it revealed a low communality (h^2= .137) and was not retained in any factor. Thus, the final two factor solution was responsible for 53.40% of the total variance. KMO value was .91 and Bartlett's Sphericity Test (χ^2 (990) = 16625.660; $p < .001$), confirming the adequacy of the data.

The first factor, composed of 18 items, was named *Humiliation* (including items regarding less and more severe humiliation and physical attacks) and explained 45.79% of the variance. On the other hand, the second factor explained 7.61% of the variance, comprised 5 items and was named *Appearance, Shape, Weight & Eating*. Table 1 presents all factor loadings and communalities, as well as factors eigenvalues and explained variance.

Table 1

Factor Loadings and Communalities (h^2) for EHS How Often scale and EHS How Humiliating Scale (N=423)

Item	F1	F2	F3	h^2
EHS - How Often Scale				
2. "Being made to feel like an outsider"	.58			.61
4. "Being put down"	.54			.60
8. "Being cruelly criticised"	.68			.56
9. "Being shown up in public"	.58			.40
11. "Being made to look weak or stupid"	.68			.61
13. "Being rejected"	.60			.61
15. "Being called names or referred to in derogatory terms"	.55			.57

16. “Being bullied”	.50			.48
17. “Being discounted”	.69			.65
19. “Being cruelly disciplined”	.62			.43
20. “Being treated as invisible”	.59			.46
21. “Being treated like a child”	.53			.39
22. “Being treated disrespectfully”	.66			.55
23. “Being assaulted by another person”	.74			.56
1.“Being teased”		.73		.69
3. “Being laughed at”		.80		.71
5. “Being ridiculed”		.58		.60
12. “Having joke made at your expense”		.70		.55
6. “Having negative comments made about shape and weight”			.81	.74
10. “Having negative comments made about how or what you eat”			.62	.45
18. “Having your shape or weight compared negatively with other”			.80	.70
24. “Being made to feel unattractive because of your shape or weight”			.77	.68
Eigenvalues	9.78	1.68	1.12	-
Explained variance (%)	44.46	7.65	5.10	-
EHS - How Humiliating Scale				
1.“Being teased”	.58			.49
2. “Being made to feel like an outsider”	.69			.52
3. “Being laughed at”	.63			.51
4. “Being put down”	.71			.59
5. “Being ridiculed”	.69			.57
8. “Being cruelly criticised”	.77			.63
9. “Being shown up in public”	.65			.45
11. “Being made to look weak or stupid”	.70			.54
12. “Having joke made at your expense”	.60			.45
13. “Being rejected”	.67			.53
15. “Being called names or referred to in derogatory terms”	.59			.48
16. “Being bullied”	.62			.44
17. “Being discounted”	.77			.64
19. “Being cruelly disciplined”	.55			.33
20. “Being treated as invisible”	.60			.47
21. “Being treated like a child”	.56			.42
22. “Being treated disrespectfully”	.70			.54
23. “Being assaulted by another person”	.62			.40
6. “Having negative comments made about shape and weight”		.84		.74
10. “Having negative comments made about how or what you eat”		.64		.46
14. “Having negative comments made about the way you look “		.74		.68
18. “Having your shape or weight compared negatively with other”		.80		.68
24. “Being made to feel unattractive because of your shape or weight”		.79		.71
Eigenvalue	10.53	1.75	-	-
Explained variance (%)	45.79	7.61	-	-

How Often and How Humiliating scales were highly correlated (r = .83). All subscales were positive and significantly correlated, reflecting moderate to high associations (see table 4).

Descriptive Statistics and Reliability Analysis

Concerning descriptive statistics and scale's reliability, table 2 provides the means, standard deviations, item-total correlations, Cronbach's alpha if item deleted and Cronbach's alphas for How Frequent and How Humiliating scales, as well as the respective subscales.

Both EHS scales revealed good internal reliability (How Often α = .94; How Humiliating α = .95). Regarding the How Often subscales, *Serious Mental and Physical Humiliation & Rejection* showed a Cronbach's alpha of .92, .82 for *Less serious humiliation* and .81 for *Appearance, Shape & Body*. Additionally, the How Humiliating subscales also presented adequate internal consistencies: .94 for the *Humiliation* dimension and .87 for the *Appearance, shape, weight & eating* dimension.

Item-total correlations were all above .30 and all items contributed for both scales' internal consistency.

Table 2

Means, standard deviations, corrected item total correlations, Cronbach's α and Cronbach's α if item deleted for both EHS scales and its dimensions (N=423)

Item	*M*	*SD*	Corrected item total correlation	Cronbach's α if item deleted
EHS - How Often Scale	**35.41**	**12.07**		**.94**
Serious Mental and Physical Humiliation & Rejection	**21.53**	**8.05**		**.92**
2. "Being made to feel like an outsider"	1.82	.93	.71	.92
4. "Being put down"	1.70	.91	.70	.92
8. "Being cruelly criticised"	1.49	.80	.68	.92
9. "Being shown up in public"	1.52	.81	.55	.92
11. "Being made to look weak or stupid"	1.60	.81	.73	.92
13. "Being rejected"	1.56	.82	.73	.92
15. "Being called names or referred to in derogatory terms"	1.53	.79	.70	.92
16. "Being bullied"	1.35	.79	.62	.92
17. "Being discounted"	1.54	.82	.76	.92
19. "Being cruelly disciplined"	1.30	.64	.49	.92
20. "Being treated as invisible"	1.52	.85	.62	.92
21. "Being treated like a child"	1.59	.87	.56	.92
22. "Being treated disrespectfully"	1.57	.76	.69	.92
23. "Being assaulted by another person"	1.45	.76	.61	.92
Less serious Humiliation	**7.39**	**2.83**		**.82**
1."Being teased"	1.90	.85	.70	.75
3. "Being laughed at"	1.96	.94	.72	.74
5. "Being ridiculed"	1.52	.77	.58	.80
12. "Having joke made at your expense"	2.01	.94	.59	.80
Appearance, Shape & Body	**6.49**	**2.72**		**.81**
6. "Having negative comments made about shape and weight"	1.78	.95	.72	.72
10. "Having negative comments made about how or what you eat"	1.72	.90	.50	.82
18. "Having your shape or weight compared negatively with other"	1.46	.76	.66	.75
24. "Being made to feel unattractive because of your shape or weight"	1.52	.79	.66	.75
EHS - How Humiliating Scale	**40.00**	**17.50**		**.95**
Humiliation	**31.41**	**14.30**		**.94**
1."Being teased"	2.13	1.24	.65	.94
2. "Being made to feel like an outsider"	1.98	1.18	.68	.94
3. "Being laughed at"	1.95	1.14	.68	.94
4. "Being put down"	1.95	1.29	.73	.93
5. "Being ridiculed"	1.72	1.17	.72	.93
8. "Being cruelly criticised"	1.70	1.23	.74	.93
9. "Being shown up in public"	1.68	1.17	.62	.94

11. "Being made to look weak or stupid"	1.78	1.14	.69	.94
12. "Having joke made at your expense"	1.80	.99	.63	.94
13. "Being rejected"	1.74	1.16	.68	.94
15. "Being called names or referred to in derogatory terms"	1.60	1.02	.64	.94
16. "Being bullied"	1.47	1.05	.62	.94
17. "Being discounted"	1.71	1.13	.76	.93
19. "Being cruelly disciplined"	1.41	.90	.52	.94
20. "Being treated as invisible"	1.68	1.16	.64	.94
21. "Being treated like a child"	1.69	1.12	.60	.94
22. "Being treated disrespectfully"	1.83	1.19	.68	.94
23. "Being assaulted by another person"	1.59	1.05	.55	.94
Appearance, shape, weight & eating	**8.59**	**4.49**		**.87**
6. "Having negative comments made about shape and weight"	1.83	1.19	.75	.83
10. "Having negative comments made about how or what you eat"	1.65	1.03	.53	.88
14. "Having negative comments made about the way you look "	1.82	1.13	.72	.83
18. "Having your shape or weight compared negatively with other"	1.60	1.06	.72	.84
24. "Being made to feel unattractive because of your shape or weight"	1.68	1.14	.75	.83

Descriptive data for gender

To explore the differences between female and male participants, independent *t*-tests were conducted (table 3). Concerning the How Often scale, no differences were found regarding scale's total score, *Serious Mental and Physical Humiliation & Rejection* and *Less Serious Humiliation* dimensions. Also, no gender differences were detected in the *Humiliation* dimension from the How Humiliating scale. Nevertheless, there were gender differences on the How Humiliating scale ($t_{(421)} = 2.561$, $p = .011$), on *Appearance, Shape & Body* dimension from How Often scale ($t_{(421)} = 2.019$, $p = .044$) and on *Appearance, Shape, Weight & Eating* subscale from How Humiliating scale ($t_{(421)} = 3.839$, $p < .001$), with females reporting higher scores than males. According to Cohen's guidelines (1988 cit. in Tabachnick & Fidell, 2007) the magnitude of the differences found is considered to represent low effects.

Table 3

Means (M), standard deviations (SD), t-test differences and Cohen's d for effect size by gender for How Often and How Humiliating scales and its dimensions (N = 423)

	Male (*n* = 134)		Female (*n* = 289)				
	M	*SD*	*M*	*SD*	*t(df)*	*p*	Cohen's d
EHS How Often	34.44	11.45	35.86	12.34	1.125 (421)	.529	na
Serious Mental and Physical Humiliation & Rejection	16.55	6.20	17.04	6.51	.725 (421)	.838	na
Less Serious Humiliation	10.23	3.58	10.53	3.98	.740 (421)	.491	na
Appearance, Shape & Body	6.12	2.40	6.66	2.85	1.897 (421)	.037	.20
EHS How Humiliating	37.06	14.86	41.37	18.47	2.367 (421)	.017	.25
Humiliation	29.55	12.55	32.27	14.98	1.826 (421)	.094	na
Appearance, shape, weight & eating	7.51	3.48	9.09	4.82	3.419 (421)	<.001	.36

na = non applicable

Convergent and divergent validity

In order to explore the relationship between EHS scales (How Often and How Humiliating*)* and their subscales and other measures, Pearson's correlation coefficients were performed (table 4). These analyses were conducted between EHS (How Often, How Humiliating and its subscales) and DASS subscales, EDE-Q Total, cognitive-emotional subscale (MSDS), FSCRS and OAS.

The How Often and the How Humiliating dimensions and its subscales presented low to moderate correlations with shame, self-disgust, inadequate and hated self, eating psychopathology symptoms, depression, anxiety and stress. On the other hand, humiliation was negatively correlated with reassured self.

Table 4

Cronbach's α and Pearson Product-moment coefficients between dimensions and subscales of EHS and all study's variables.

	α	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1	.94	1															
2	.92	.95**	1														
3	.82	.88**	.77**	1													
4	.81	.72**	.58**	.48**	1												
5	.95	.83**	.76**	.75**	.63**	1											
6	.94	.82**	.78**	.78**	.52**	.98**	1										
7	.87	.59**	.47**	.43**	.80**	.78**	.64**	1									
8	.94	.58**	.54**	.55**	.37**	.58**	.60**	.37**	1								
9	.87	.45**	.39**	.44**	.32**	.48**	.47**	.39**	.57**	1							
10	.89	.39**	.36**	.37**	.25**	.43**	.44**	.29**	.58**	.60**	1						
11	.85	.31**	.28**	.30**	.21**	.32**	.32**	.23**	.49**	.62**	.69**	1					
12	.89	.41**	.36**	.39**	.31**	.44**	.42**	.35**	.56**	.55**	.72**	.74**	1				
13	.82	.37**	.34**	.36**	.23**	.39**	.39**	.28**	.47**	.58**	.56**	.47**	.51**	1			
14	.69	.28**	.26**	.27**	.16**	.28**	.29**	.17**	.39**	.55**	.57**	.46**	.42**	.65**	1		
15	.88	-.26**	-.26**	-.20**	-.20**	-.28**	-.27**	-.20**	-.42**	-.35**	-37.**	-.24**	-.31**	-.29**	-.41**	1	
16	.94	.26**	.21**	.17**	.38**	.31**	.25**	.42**	.36**	.40**	.35**	.33**	.43**	.31**	22**	-.25**	1

Note. $^{**}p < .01$. 1. How Often; 2. Serious Mental and Physical Humiliation & Rejection; 3. Less Serious Humiliation; 4. Appearance,Shape & Body; 5. How Humiliating; 6. Humiliation; 7. Appearance, Shape, Weight & Eating; 8. OAS; 9. Cognitive-emotional (MSDS) 10. Depression; 11. Anxiety; 12. Stress; 13. Inadequate Self; 14. Hated Self; 15. Reassured Self ; 16. EDE-Q;

Path analysis

Fistly, the skewness (sk) and kurtosis's (ku) values were calculated in order to evaluate the normality of the variables. No variable presented severe violations to the normal distribution (SK <| 3 | and Ku <| 10 |) (Kline, 1998). Furthermore, Mahalanobis distance statistic (D^2) was used to analyze data for multivariate outliers. Though some cases presented values that indicated the presence of outliers, extreme values were not detected and the outliers were maintained. It has been suggested that when outliers are included, data is more likely to be representative of the population (Kline, 2005; Tabachnick & Fidell, 2007).

The aim of path analysis was to test the mediator effect of shame, hated self and self-disgust on the relationship between the experiences of humiliation (How Humiliating) and depressive symptoms. Initially, the hypothesized model was tested through a fully saturated model (i.e., zero degrees of freedom), consisting of 15 parameters. For this fully saturated model, model fit indices were neither examined nor reported, as fully saturated models have a perfect model fit. The first model accounted for 51% of depressive symptoms. Only one path coefficient was not statistically significant: the direct effect of humiliation → depressive symptoms (*t* statistics = .363; *p* = .128). Then, the model was respecified with the nonsignificant path being removed (Figure 1).

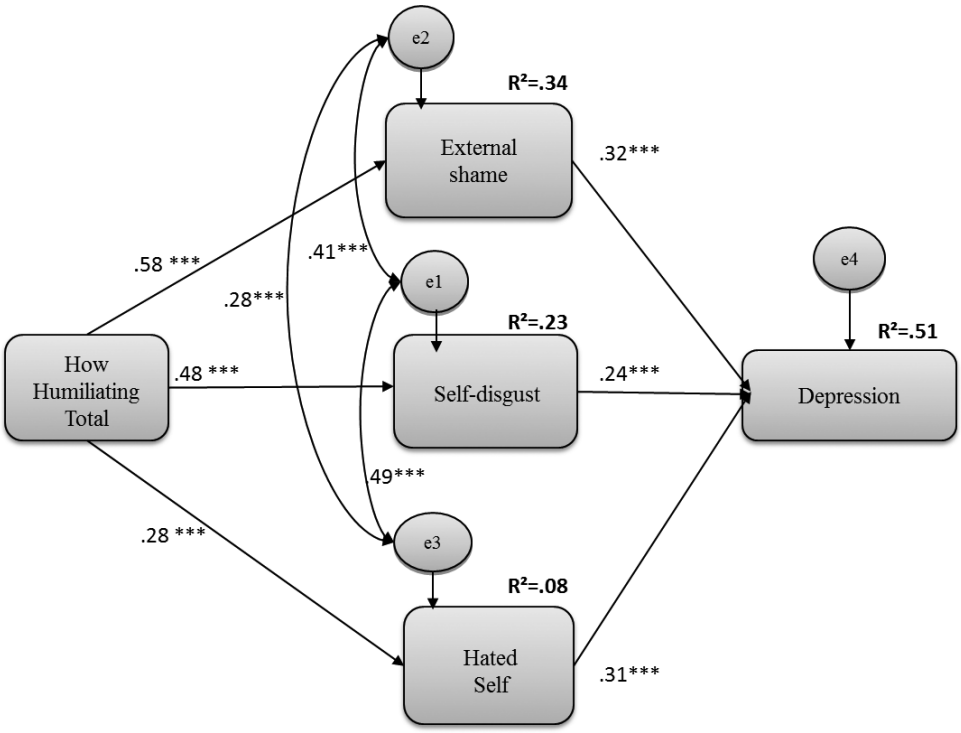

Figure 1. Final Path Model. Standardized path coefficients among variables are presented. All path coefficients are significant p = <. .001.

The final model presented an excellent model fit, with a non-significant chi-square of $\chi^2(1, N = 423) = 2.315$, $p = .128$. Moreover, the recommended goodness of fit indices (Kline, 2005) also indicated a very good model fit (χ^2/d.f. = 2.315; GFI = .998; CFI = .998; TLI = .984; RMSEA = .056, [CI = .000; .154]; p = .316).

Mediation Analysis

The examination of the unstandardized solution indicates that all individual path coefficients of the final model were statistically significant. Regarding the analysis of direct and indirect effects, no statistically significant direct effect was found between EHS and depressive symptoms (β = .065) based on the bootstrap 95% CI (-.017; .151, p = .130). Results indicated that EHS accounted for 34% of shame, with a direct effect of .58 (bEHS =8.80; SEb = .60; Z = 14.74;

$p < .001$); 23% of self-disgust, with a direct effect of .48 (bEHS = 4.20; SEb = .38 ; Z = 11.20; $p < .001$); and 8% of hated-self variance, with a direct effect of .28 (bEHS = 1.15 ; SEb = .19 ; Z = 6.01; $p < .001$). Moreover, shame (β = .32; bshame = .12; SEb = .02; Z = 7.71; $p < .001$), self-disgust (β = .24; bself-disgust = .15; SEb = .03; Z = 5.16; $p < .001$) and hated-self (β = .31; bhated self = .42; SEb = .06; Z = 7.58; $p < .001$) directly predicted depressive symptoms. Self-disgust was moderately correlated with shame (r = .43) and hated self (r = .49). Shame presented a positive yet low correlation (r = .28) with hated-self.

In relation to the mediation analysis, an indirect effect of EHS on depressive symptoms was found through external shame, self-disgust and hated-self. More specifically, this indirect effect was positive (β = .390) based on 95% CI (.304; .472, $p = .001$).

Overall, the model accounted for 51% of depressive symptoms.

Discussion

Humiliation is a painful emotion related to the experience of being, or perceived oneself as being, put down, ridicule or devaluated. The person feels the humiliation as an external attack by someone seen as more powerful and, therefore, starts to perceive himself as inferior, debased and powerless (e.g., Hartling & Luchetta, 1999). The experiences of humiliation are felt as unfair and the humiliator is seen as the focus of injury, which leads to seek revenge (Elison & Harter, 2007; Gilbert, 1997). Nevertheless, being humiliated is an experience that tends to remain in the memory of the victim, and may lead to negative internal states and psychopathology (Galsworthy-Francis, 2012; Klein, 1991).

The primary purpose of the present study was to analyze the psychometric properties of the Portuguese version of the Experiences

of Humiliation Scale (EHS). Additionally, it was intended to test whether external shame, hated self (self-criticism) and self-disgust had a mediator effect on the relationship between experiences of humiliation (how humiliating scale) and depressive symptomatology.

The factorial structure of both EHS scales was explored through two separate Exploratory Factor Analysis, one for How Often and another for How Humiliating scale. Our results did not fully support the results found in the original version.

Regarding the How Often scale the results revealed a three factor solution that explained 57.22% of the total variance. The *Serious Mental and Physical Humiliation & Rejection* subscale comprised 14 items and explained 44.46% of the total variance. Items included in this subscale report experiences where the victim could have felt devalued, scorned, powerless, bullied or even punished. This subscale contains the items that belonged to the subscales *Serious Mental Humiliation*, *Physical Humiliation* and *Rejection* in the original version. It seems that in our sample participants did not distinguish between these more severe types of humiliation. The second factor, named *Less Serious Humiliation* explained 7.65% of the total variance and was constituted of 4 items that report situations where the person experienced ridicule, teasing or mocking. On the other hand, the third subscale explained 5.10% of the total variance, comprised 4 items and was named *Appearance, Shape & Body*. This subscale refers to items concerning experiencing humiliation through one's shape, weight or eating behaviors. Both the second and third factors correspond to the original factors from EHS (How Often dimension). However, two weak items were identified. The item 14 loaded in two factors and the item 7 did not contribute to the scale's internal consistency, thus both items were removed from the How Often scale.

Concerning the How Humiliating dimension, a two factor solution revealed to be the more appropriated, explaining 53.40% of

the total variance. The first factor, denominated *Humiliation* was responsible for 45.79% of the total variance and enclosed 18 items. This subscale englobes items from different types of humiliation: less severe humiliation, more severe humiliation and physical attacks. This factor includes the items that belonged to the subscales *Serious Mental Humiliation & Physical Humiliation, Rejection* and *Less Serious Humiliation* in the original version. It seems that in our sample, regardless the type of humiliation, participants did not distinguish between them when classifying the intensity of those experiences. The second factor was comprised of 5 items, explained 7.61% of the total variance and was named *Appearance, shape, weight & eating.* Similar to the results found in the How Often scale, item 7 revealed a low commonality and did not load in any factor. For this reason, this item was removed from the scale.

The EHS revealed good internal reliability for How Often and How Humiliating scales, as well as for all the subscales of each dimension. Furthermore, all items contribute to the internal consistency of the scale, presenting good values of item-total correlations. These results were consistent with the ones found in the original scale (Lewis, 2010 cit. in Galsworthy-Francis, 2012). Thus, it is possible to ensure that this instrument is a reliable measure of humiliation.

As expected, the scales How Often and How Humiliating were positive and highly correlated. Also, all subscales had moderate to high positive associations. Interestingly, the subscales *Appearance, Shape & Body* (from How Often scale) and *Appearance, shape, weight & eating* (from How Humiliating scale) showed the lowest associations, although still high. It seems that experiences of humiliation regarding one's body and eating behaviors may be a different and more specific type of humiliation. In fact, it had already been suggested that humiliation regarding eating behaviors must be considered as separate from a more global type of humiliation

Galsworthy-Francis (2012).

Regarding gender, differences were found between females and males. However, these differences represented low effects. As expected, males appear to perceive their experiences as less humiliating, which may be related to social norms. Furthermore, it seems that females experience more humiliation associated with one's body and eating behaviors. This difference was expected and may be due to women's pressure to beauty and thinness in Western societies.

Results from the convergent validity revealed positive and low to moderate associations between humiliation and other study variables. Humiliation was, as expected, associated with a harsher and critical view of the self, with feelings of self-disgust and with a negative perception of the self. Interestingly, although humiliation and shame were moderately associated, reflecting the similarities between these emotions, our results seem to support the existent literature (e.g. Gilbert, 1997) suggesting that humiliation is a distinct construct of shame. On the other hand, humiliation was negatively associated with reassuring self. It seems that having more experiences of humiliation or having experiences that were very humiliating relate to peoples' inability to have a positive and warm attitude towards themselves.

Moreover, humiliation is linked with eating behaviors and anxiety, stress and depressive symptoms, which may suggest that humiliation can be a potential underlying experience related to the development of these psychological symptoms. In fact, these findings are consistent with previous researches (e.g., Klein, 1991; Galsworthy-Francis, 2012) that suggest that fear of being exposed to further humiliations may lead to anxiety symptoms and that past experiences of humiliation may be a characteristic present across different eating disorder symptoms.

Literature has been highlighting the role of humiliation as an important risk factor to depression (e.g., Farmer & McGuffin, 2003; Kendler et al., 2003). Furthermore, shame, self-criticism and self-

disgust have also been related to depressive symptoms (e.g., Castilho, Pinto-Gouveia, & Duarte, 2013; Matos & Pinto-Gouveia, 2010; Powell, Simpson, & Overton, 2013). Nevertheless, the mediator role of shame, self-disgust and self-criticism on the relationship between experiencing humiliation and depressive symptoms remained unexplored. Our model adds to the existing research by suggesting that the relationship between humiliation and depressive symptoms is fully mediated by feelings of shame, self-disgust and self-criticism. Overall, the mediation model accounted for 51% of depressive symptoms. Thus, it seems that it is not the experience of humiliation that leads to depressive symptoms but the impact that it has on the self to self relationship. Our findings point out that humiliation may lead people to believe that others look down to the self and, therefore, to develop a harsh and self-attacking internal relationship, where some characteristics are perceived as disgusting. In turn, this critical, severe and non supportive view of the self leads to depressive symptoms.

In fact, victims of humiliation often report to feel inferior, eliminated and powerless (Klein, 1991). Hence, the internalization of those experiences can result in perceiving some characteristics as contaminated and to become a source of disgust and foster a self-attacking relationship with oneself (Gilbert, 1997; 2015).

However, the current study contains some limitations that should be considered. First, it is a cross-sectional design which limits casual conclusions between studied variables. In order to assess causal relation and test-retest reliability, a longitudinal study should be performed in future researches. The EHS factorial structure should be further explored through a confirmatory factor analysis.

Moreover, only self-report measures were used which may not reflect clear and accurately peoples experiences. Additionally, the use of a convenient and non gender homogenous sample can also limit the generalization of the results.

Thirdly, this model can be considered limited as it is possible

that several other processes may contribute to the development of depressive symptoms. Nonetheless, we intentionally restrained this model in order to specifically explore the role of humiliation, shame, self-disgust and self-criticism in depressive symptoms.

Overall, results from the present study provide evidence that EHS is a valid and reliable measure of humiliation experiences. Also, it offers a new and significant insight on the pathways from humiliation to depressive symptoms. Results point out that this relationship is mediated by shame, self-disgust and self-criticism. Finally, our findings enclose several clinical implications. Interventions with people that suffer humiliating experiences should focus on developing more effective strategies (such as acceptance and compassionate based competencies) to deal not only with depressive symptoms but also with feelings of shame, self-disgust and self-criticism.

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