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Shame --- the Good, the Bad and the Ugly: Therapist Perspectives

Karen L. Hulstrand
St. Catherine University

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by

Karen L. Hulstrand

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Committee Members
Lance Peterson LICSW, Ph.D. (Chair)
Stacy Husebo, MSW, LICSW
Mary Anna Palmer, LICSW, LMFT

Abstract

Shame is common and a universal part of the human condition. It is a factor in mental illness, and shame issues frequently arise in psychotherapy. There has been much theorizing about shame, but less research on how psychotherapists address this in their practice. This qualitative research study looked at how psychotherapists conceptualize shame, how shame issues present in psychotherapy, what approaches therapists find helpful in working with shame and the impact of shame in the therapy process itself. Eight psychotherapists were interviewed. Shame was found to be ubiquitous in psychotherapy. Psychotherapists mainly conceptualized shame as clients' negative beliefs about the self. Shame presented itself in clients' beliefs, relationship difficulties, somatic cues and defensive reactions to shame. In working with shame, therapists did not find it helpful to confront the beliefs directly. They did find that the importance of relationships in all their facets (to the therapist, family, groups, community, self, and God) was essential. Therapists described multiple approaches to managing shame in the therapy process itself. The good, bad and ugly aspects of shame were considered. Social workers are encouraged to pay attention to the dynamics of shame in their interactions. In addition, early childhood development and secure attachment need to be supported to develop an adaptive relationship with shame.

Keywords: shame, psychotherapy, social bonds, relationships

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Shame --- the Good, the Bad, and the Ugly: Therapist Perspectives

"Shame is like a subatomic particle. One's knowledge of shame is often limited to the trace it leaves." (Lewis, 1992, p. 34)

Shame has been considered to be ubiquitous in modern society, yet it can be largely invisible (Scheff, 1988). It is considered to be an intensely painful emotion and is associated with a desire to hide. "When asked to recall shameful eliciting events, individuals report wanting to 'hide,' 'escape,' 'disappear from view,' and 'shrink into the floor during the experience,' indicating the desire to flee the social situation and conceal the 'defective self' from social scrutiny" (Dickerson, Gruenewlad, & Kemeny, 2004, p.1196). It is perhaps due to this emotional intensity and desire to escape that shame, although ubiquitous, can make it seem somewhat hidden from view.

Lewis (1971), in her book *Shame and Guilt in Neurosis,* was one of the first to substantially explore shame by studying a series of psychoanalytical case studies. She stated "at least in our culture, shame is probably a universal reaction to unrequited or thwarted love. By its nature, it is a state with which it is easy to identify, and at the same time is painful, so that both the patient and the therapist turn away from it" (p. 16). She considered it a "sleeper" emotion and felt it was the cause of many of her clients not being successful in psychoanalysis.

Shame is considered a social emotion. As social creatures, we depend on others for love, affection and basic survival needs. When we are infants we are totally dependent on our caretakers. Cozolino (2014) states in his book, *The Neuroscience of Human Relationships,* "Gradually we are discovering that we are social creatures with brains and minds that are part of larger organisms called families, communities and

cultures. This awareness is making it increasingly clear that to understand a person, we need to look beyond the individual" (p. xiii).

It is in looking beyond the individual that we find shame. Shame is about social bonds and relationships and how we imagine we exist in the minds of others. How we exist in the minds of others is tied to our safety and survival. Cozolino (2014) states it this way: "For social animals like ourselves, the fundamental question of "Am I safe?" has become woven together with the answer to the question " Am I loveable?" (p. 285).

Social workers encounter shame issues with clients on an everyday basis. This is especially true in situations where there is a power differential. The child protection worker who is working with parents after a report has been filed, the caseworker who is trying to help someone in need find resources, and the advocate who is dealing with homeless clients all need to pay attention to the dynamics of shame. The dynamics of shame are especially important for social workers who work in mental health.

Shame has been associated with many mental health issues, including depression, anxiety, post-traumatic stress disorder, substance abuse, eating disorders, violent behavior and domestic abuse, among others (Dearing & Tangney, 2011). Shame arises frequently in psychotherapy. Therapists have to navigate shame both in themselves and in their clients. They have to deal with the overt expressions of shame, the subtle harder to detect aspects of shame and the defensive responses that clients enact to avoid feeling shame. Therapy can be inherently shaming with its intention of looking at one's self and exposing innermost feelings. There is also a power differential between the client and the therapist that can be shaming (Dearing & Tangney, 2011).

Van Vliet (2008) notes, "given the potential impact of shame on mental health, an understanding of how we rebound from this emotion is critical. Yet to date, there is little research in this area" (p. 234). This qualitative research project will explore the issue of shame in psychotherapy by interviewing practicing psychotherapists regarding issues surrounding shame as they present in clinical practice.

How do psychotherapists define shame and how does it present in their practice? What methods are helpful in helping clients to deal with shame issues? What are the commonalities and differences in working with shame between practitioners who practice with different populations and with different problems? These are questions to be explored through this research study.

Literature Review

Conceptualization of Shame

Definition of shame. In the Oxford on-line dictionary (n.d.) shame is defined as "a painful feeling of humiliation or distress caused by the consciousness of wrong or foolish behavior." The root of the word can be traced back to the Indo-European word kam/kem and refers to "hiding," "concealing," "covering up" (Karlsson & Sjoberg, 2009). Shame is described as a complex psychological construct with cognitive, emotional and behavioral elements. Those elements include self-attacking thoughts, emotional pain and behavioral elements (submissive facial and postural expressions, as well as social withdrawal actions). Blum (2008) describes this as an intense negative emotion with feelings of helplessness, incompetence, inferiority and powerlessness. It is a state where thought is inhibited and words are hard to find. Along with these negative,

often debilitating feelings there is an overwhelming impulse to hide or withdraw from social contact (Van Vliet, 2008).

Shame is sometimes divided into external shame and internal shame. External shame is a response to the external environment where there is the threat or actual experience of the self being seen as bad or inadequate. Internal shame is the experience of internally evaluating the self with the fear of exposure to an imagined audience. It can involve self-criticism and self-persecution (Gilbert, 2007).

Shame can be considered either as a state or a trait. Shame as a state is felt as a momentary emotion that passes. Shame as a trait is considered to become part of one's personality (Claesson, Birgegard, & Sohlberg, 2007). This is often due to repeated experiences in childhood where the thought becomes " something is wrong with me. I am bad and unattractive." (Claesson et al., 2007, p. 599). This is sometimes also described as "core shame" (Cozolino & Santos, 2014, p. 282). Someone who experiences frequent episodes of shame states is said to be shame-prone (Tangney, Stuewig, & Mashek, 2007). Because shame is used both as a character trait and as an emotional state that is temporary, researchers use different measuring tools and different approaches.

In addition to global trait shame, some theoreticians describe domain-specific areas of trait shame, such as shame regarding physical appearance, level of education, race/ethnicity, stuttering etc. An example of a common area of domain shame occurs in those dealing with eating disorders who frequently have body shame (Tangeny et al., 2007). Shame can also be noted around a specific role, such as the role of mother. Liss,

Schiffrin, & Rizzo (2013) noted that mothers who had a fear of negative evaluation had higher rates of shame.

Shame is frequently described as an intrapsychic variable, but some researchers feel that is a limiting viewpoint. Leeming and Boyle (2004) note that to understand the whole picture, shame needs to be seen within broader relational, social and cultural forces. They quote Gergan and Gergan (1988) regarding shame, "It is as if we have at our disposal a rich language for characterizing rooks, pawns, and bishops but have yet to discover the game of chess" (p. 382).

Self-conscious emotions. Shame is considered to be one of a family of emotions called the self-conscious emotions. The self-conscious emotions include shame, guilt, embarrassment and pride. Researchers have grouped them into the self-conscious emotions due to the self-evaluative process where the self evaluates the self (Tracy & Robins, 2006). The self is split and is both the agent and the object of observation, which can happen consciously or unconsciously (Tangney et al., 2007).

The self-conscious emotions are considered to be more complex than the basic emotions due to the cognitive elements involved (Tracy & Robins, 2004). Most researchers feel that shame is a complex emotion; however, not all researchers agree. Some researchers feel that shame is a basic emotion present from birth with a function of regulating attachment (Nathanson, 1992, Schore, 1994 as cited in Claesson et al., 2007). The basic emotions are anger, fear, disgust, sadness, happiness and surprise. These are considered "basic" because of their biologic basis, universality and pan-culturally recognized facial expressions (Tracy & Robins, 2006). The basic emotions are recognized solely on the basis of facial movements, whereas the self-conscious emotions

need both facial and body movements to be recognized (Tracy & Robins, 2004). The basic emotions are frequently studied in the laboratory using film clips to elicit the emotion. Film clips, however, do not work well for studying shame. In addition, there are ethical issues involved in attempting to elicit shame and shame is an experience that people are motivated to avoid feeling or admitting to (Tracy & Robins, 2006).

Shame, guilt, embarrassment and pride, in addition to being categorized as self-conscious emotions, are also sometimes referred to as the moral emotions or social emotions (Tangney et al., 2007). They are considered moral emotions as they play a role in regulating social behavior and norms (Leary, 2007). The negative feelings of shame and guilt are painful and create a desire to avoid them. This then works to keep people's behavior within the social norm (Beer, 2007).

Shame versus guilt. Shame and guilt are often used interchangeably and often confused. Lewis (1971), writing in her psychoanalytical analysis of shame, was the first to differentiate them in a clear way. She stated that, " The experience of shame is directly about the self, which is the focus of evaluation. In guilt, the self is not the central object of negative evaluation but rather the thing done or undone is the focus." (p. 30). Shame, therefore, is about the global self, whereas guilt is about a specific behavior. They are highly correlated and frequently felt at the same time. Shame is considered the more painful emotion as it involves the core self as opposed to one's behavior (Tangney et al., 2007). The emphasis in shame is "How could **I** have done that?" compared to guilt "How could I have **done that?**" Simply put, people feel guilty when " I did a bad thing" and shame when they feel " I am bad" (Leary, 2007, p.331).

Tangney et al. (2007) consider guilt to be the more adaptive emotion. Guilt has been shown to have a different action tendency than shame. Guilt promotes reparative strategies with corrective behaviors being undertaken, whereas shame promotes more hiding and withdrawal strategies (Tangeny et al., 2007). With guilt, people are more likely to apologize, repair and make amends (Tangeny, Stuewig, Mashek & Hastings, 2011).   With shame, it is hard to have an action/amending strategy because of its global nature. Tangney et al. (2007) note, "painful feelings of shame are difficult to resolve. Shame--and shame infused guilt-- offers little chance of redemption. It is a daunting challenge to transform a self that is defective at its core" (p. 353).

Guilt has been shown to be more associated with an other-oriented empathy. Shame in contrast, has been shown to interrupt the ability to be empathetic (Tangeny et al., 2007). Shame creates an inward focus, and that egocentric focus on the "bad self" disrupts any empathetic connection with the other (Tangeny et al., 2007). In research of criminal populations, guilt-proneness has been shown to be protective in severity of crimes committed and the rate of recidivism, whereas shame has not (Hosser, Windzio & Greve; 2008,Tangney et al., 2011).

In contrast to Tangney et al.'s (2007) conceptualization that guilt is always adaptive, some researchers note that guilt in ambiguous situations or guilt stemming from uncontrollable events can be maladaptive (Silfver, 2007). Ambiguous situations cause rumination, and that rumination does not help in deciding how to behave differently in the future. Uncontrollable events such as illness or survivor's guilt after a tragedy can also produce guilt that can be maladaptive (Silfver, 2007).

There is also controversy regarding Tangney et al.'s (2007) conceptualization that shame is always maladaptive. Rodogno (2008) theorizes that shame is adaptive in certain circumstances and that healthy people feel short episodes of shame and recover without difficulty. He notes that shame in acute instances versus chronic instances may have benefit in motivating change to help us to live up to our ideals. Shame may be the turning point that facilitates change. Instead of shame being the problem, he states that it may be the "inability to cope with shame in a constructive way, rather than shame itself" (p. 162) that causes problems. The other concern he brings up is that it is not clear that shame and guilt can be so easily separated emotionally and that one of the main instruments that is used to measure shame and guilt, the TOSCA, may have biases in the way the questions are composed.

To sum it up, looking at shame and guilt Tangney et al. (2011) note that there are "good ways and bad ways to feel bad" (p. 711). Which ways are "good ways to feel bad" and which ways are "bad ways to feel bad" is an area of ongoing research.

Biological and Developmental Underpinnings of Shame

Evolutionary / functionalist perspectives. Gilbert (2007) states that:

Evolution has designed us to be exquisitely social from the first days of our lives, with social-cognitive competencies that are very sensitive and focused on what others think and feel about us. We can understand that not only can others have negative feelings about us, which would lead them to criticize, harm, shun or even expel us from the relationship, but in addition social life is partly a competition where audiences, and our desired partners can choose in favor of someone else. (p. 303).

Humans are social beings and shame has been theorized to be part of a social threat warning system (Dickerson, Gruenewald & Kemeny, 2009). The behaviors associated with shame (gaze aversion to avoid eye contact, head down, slumped posture and hiding behaviors) are considered to be submissive and appeasement strategies to de-escalate or disengage from conflict (Gilbert & McGuire, 1988).

The first researcher who commented on the behavioral aspects of shame was Darwin (1872) who wrote, "We have seen that in all parts of the world persons who feel shame for some moral delinquency, are apt to avert, bend down or hide their faces, …" (p. 328). The submissive behaviors noted in shame are similar to the submissive postures of other animals and primates (Elison, Garofalo & Velotti, 2014). Submissive displays communicate that an animal will not fight for resources or dominance, which prevents aggression and helps group cohesion (Gilbert, 2000).

Shame is considered more complex than a submissive display, but several theorists feel that shame co-opted this previous adaptation (Elison et al., 2014). This fits with the principal of evolutionary continuity, which states that systems conserve and adapt old forms rather than designing new forms (MacLean, 1990 as cited in Gilbert & McGuire, 1988). Gilbert (1988) postulated that as group cooperation became more important, attraction hierarchies developed. As attraction hierarchies developed, they adapted the submissive signaling system used for physical threat and now used it additionally for social threat.

Shame as a signal of social threat conveys that one is too exposed, may have violated group standards or acted in a way that others will not support. Submissive behavior in response to a social threat conveys information, just as it does in response to

a physical threat. This submissive display can invoke responses that can help repair relationships, elicit sympathy and inspire forgiveness. In this way, shame can be adaptive by both signaling that there is a threat and by eliciting a submissive display that increases the likelihood of decreasing aggression and promoting social reconciliation (Gilbert, 2007). Shame can therefore be looked at as something that can be adaptive or maladaptive, depending on the circumstances. Adaptive shame can help navigate social threat and facilitate relationships. Maladaptive shame, on the other hand, can occur when shame is activated under inappropriate conditions or activated too often (Dickerson et al., 2009).   Maladaptive shame can activate defensive responses, withdrawal and other problematic behaviors. Frequent shaming experiences as a child frequently lead to maladaptive shame (Leeming & Boyle, 2013).

Psychobiological effects of shame. Shame, as discussed earlier, has been theorized to be part of the social threat warning system (Gilbert, 2007).   The activation of social threat has been shown to be a stressor. It has been found to have many physiological changes, which take place in addition to the emotional, psychological and behavioral aspects discussed previously (Dickerson, Gruenewald, & Kemeny, 2004). Social-threat has been shown to increase cortisol, proinflammatory cytokines and cardiovascular parameters such as heart rate and blood pressure. It has also been shown to activate the same neural pathways as physical pain.

Chronic social threat with increased negative cognitions and emotions has been shown to impact health outcomes. In a study of HIV positive gay men, those high on rejection sensitivity and HIV-specific shame had faster declines of their CD4 counts and

died on average two years earlier than those rated with lower rejection sensitivity (Cole et al., 2001 as cited in Dickerson et al., 2009).

 Cortisol. The hypothalamic-pituitary-adrenal (HPA) axis coordinates responses to stressors in the body. Cortisol, a steroid hormone, is released from the adrenals in response to stress. Elevation in cortisol can be adaptive. In acute situations, it is helpful in cases of physical injury and wounding. It redistributes certain immune cells to the skin and other organs where they may be needed in case of injury. It also increases energy availability by increasing glucose levels. However, if this system is repeatedly fired or chronically turned on it can cause health problems such as diabetes, cardiovascular disease, depression, etc. (Dickerson et. al., 2009).

 Dickerson et al. (2009) conducted a meta analysis of 208 studies of acute stressors and found that stressors that had a social-evaluative element (for example an audience was present) were found to increase cortisol four times higher than those that did not have a social evaluative element. Those participants in a social-evaluative situation, compared to those participants that were not in a social-evaluative situation, reported higher rates of shame but not higher rates of anxiety, appraisal of task difficulty, sadness or other emotions. For example, a study was done on people doing a speech and math stressor task with and without an evaluative audience. Only the group with the evaluative audience showed a robust elevation in cortisol. Both groups rated the task equally difficult. The rise in cortisol was noted to be magnified if the stressor was uncontrollable. For example, when social-exposed failure occurs, the cortisol response is noted to be even higher and showed slower recovery (Dickerson et al., 2009).

Proinflammatory cytokines. Social threat has also been shown to increase proinflammatory cytokines such as tumor necrosis factor alpha (TNF-α) and interleukin-6 (IL-6) (Dickerson et al., 2009). Inflammation after physical threat happens to ready the body to react to a possible wounding or infection. The same inflammation has now been shown to occur after social threat (Dickerson et al., 2009). One study that showed this had a group write a narrative of a traumatic experience of self-blame and another group wrote a neutral narrative. The group writing about self-blame reported increased levels of shame and had elevation of proinflammatory markers (Dickerson et al., 2009). Studies in nonhuman primates and other animals have corroborated this as well, showing that in addition to social threat, low rank and submissive behaviors also cause elevated levels of proinflammatory markers, cortisol and autonomic activity. As discussed previously, submissive behavior may be seen as a primitive analogue to shame behaviors in humans (Dickerson et al., 2012).

There is a bidirectional nature to proinflammatory cytokines and the central nervous system. The proinflammatory cytokines can influence what are called "sickness behaviors." These behaviors include malaise, reduction in activity, decreased exploration, decreased social activity, decreased food and water intake. These changes promote a disengaged behavioral state, which could be adaptive if healing is needed after a wound or infection and could also be adaptive with an uncontrollable social threat where disengagement would be safer. The modern problem, however, is that most social threats we encounter today are not physical and do not require healing from a wound or need increased energy stores. Therefore, these "sickness behaviors" that come from

proinflammatory cytokines in response to social threat/shame can be maladaptive in many circumstances leading to mental illness and other problems (Dickerson et al., 2004).

Physical pain. Shame, which is emotionally painful, is also physically painful (Elison, Garofalo & Velotti, 2014). Neurobiological findings have found that social pain and reactions to social threat such as shame are felt in the same alarm system area of the brain as physical pain is felt. People often describe social pain using physical pain words, i.e. "broken heart" or "hurt feelings." It turns out that social pain, pain experienced when social relationships are damaged, and physical pain share a common neural pathway. The somatosensory cortex and the insula are where the sensory aspects of physical pain are noted, but the distress and unpleasant feelings from the pain come from the dorsal part of the anterior cingulate cortex (dACC) (Eisenberger & Lieberman, 2004). Patients who have lesions in this area still have pain but it no longer bothers them. This dACC pathway is responsible for the alarm response and distressed reaction to physical pain, and it is the same area of the brain that is stimulated in response to shame and social threat.

In animal studies of mammals, this area of the brain is also responsible for the maternal response to distressed offspring. The same dACC area of the brain is activated and this distress feeling in the mother helps activate caretaking actions. (Eisenberger et al., 2009). These caretaking actions are part of attachment, and attachment has implications for shame.

As would be expected from this common alarm system pathway, enhanced sensitivity to one type of pain enhances the sensitivity to both types of pain. For example, young children who have physical pain are more distressed by separation from their

caregivers. The opposite is also true, increased social support reduces physical pain following surgery, reduces pain with cancer and reduces pain during childbirth (Eisenberger et al., 2004). Opioids have been shown to alleviate separation distress in many animal species and are theorized to be helpful with social pain (Eisenberger & Lieberman, 2004). It is not far from this to then see opioids alleviating shame issues and may have possible implications with the overuse of opioids currently.

      Attachment theory and shame. Attachment theory initially conceptualized by Bowlby has expanded from an emphasis on a secure base to a regulation theory involving early experience-dependent brain maturation. It is in this relationship between the primary caregiver and the infant that the brain develops and learns to self-regulate (Schore & Schore, 2008). This early linkage and the provision of "good-enough" caretaking is what enables a child to develop neural pathways that allow him or her to be in relationship and to be a member of a group (Cozolino, 2014). This developmental process happens through affective regulation with cycles of attunement, rupture and repair.

      Different theories exist for how shame is involved in this process (Mills, 2005). Many theorists consider shame to occur when there is disruption in the attachment bond between the infant and the caregiver. Bowlby in describing a child unwanted by parents stated, " he is likely not only to feel unwanted by his parents but to believe that he is essentially unwantable, namely unwanted by anyone" (Bowlby, 1973, p. 238 as cited in Mills, 2005)

      Nathanson (1992) theorized that shame is an "innate attenuator circuit" that is engaged when the infant is in a state of interest-excitement or enjoyment-joy and has an

experience that requires a fast unwanted inhibition of this affect (p. 134). He believes

that shame is experienced as early as two and a half months to three months. Nathanson

(1992) proposed that shame is responsible in the "still face" experiment for the distress

shown by the infant. The infant is noted to lose muscle tone in the neck and upper body,

have an increase of skin temperature in the face and become uncoordinated. Other

theorists disagree and feel the infant's response is due to anger and sadness rather than

shame (as cited in Mills, 2005).

Schore (1998) describes shame as, "the reaction to an important other's

unexpected refusal to co-create an attachment bond that allows for the dyadic regulation

of emotion." (p.65). A child whose excitement is met with disapproval or indifference

will elicit this shame response. Physiologically, he theorizes that shame is the inhibition

of excitement from the sympathetic-autonomic nervous system and engagement of the

parasympathetic nervous system, thus creating a shift from an energy-mobilized state to

an energy-conserving state. This is associated with negative affect, shame behaviors and

distress. For a child with an attuned caregiver this invokes feelings of sympathy, and in

response to the child's distress the caregiver will engage to repair the bond. Over time

the child learns to self-soothe and manage his/her own shame states. Cozolino (2014)

notes that repeated experiences of a rapid return from shame create an expectation that

challenging social interactions will have a positive outcome. In contrast, repeated

negative experiences lead to "core shame" and the belief that "I am bad."

Schore, (1998) notes that up to about 10 months, the interactions with an infant

are positive 90% of the time with affection, play and caregiving. In the 13-17 month age,

the caregiver is engaged in more socialization processes, with an admonishment every

nine minutes (as cited in Wingfield, 2011). It is during this time he believes that the

shame dynamic really comes into play.

Many theorists believe that true shame is not present until the cognitive ability to

conceptualize the self is present. There is some disagreement as to when that ability is

present, but there is general agreement that shame is present by age two and half to three.

It is also believed that the experience of shame continues to evolve further as the child

develops (Mills, 2005). Studies with adults show that adults who have insecure

attachment styles have more issues with shame-proneness then adults who have a secure

attachment style (Gross & Hanson, 2000, Wei, Shaffer, Young & Zakalik., 2005). This

has also been shown in children ages 9-13 (Muris et. al, 2014).

Negative parenting behaviors have been shown to contribute to shame proneness

in their children. These parental negative behaviors include indifference, rejection,

abandonment, authoritarian parenting, conditional positive regard, and negative

evaluation (Muris & Meesters, 2014). Physical and sexual abuse, as well as neglect have

been noted to cause shame in children. Sexual abuse in particular has been noted to

cause shame. In sexual abuse, children may be told that their "seductive" or "nasty"

behaviors are the cause of the abuse (Deblinger & Runyon, 2005).

There is a relationship between temperament and the development of shame.

Children who have more sensitivity or an anxious temperament have more inclination to

develop shame proneness (Lagattuta & Thompson, 2007, Cozolino, 2014).

Implicit memory, attachment and shame. The early experience of shame may be

difficult to study due to differences in implicit and explicit memory. Early memory of

attachment schema is encoded in implicit memory, mainly in the right cortex (Siegel,

2001, Schore, 2000). Implicit memory has emotional, behavioral, perceptual and somatosensory components. It is the way infants encode experiences. In contrast, explicit memory does not start developing until the middle of the second year when the hippocampus starts to develop (Siegel, 2001).   Explicit memory is autobiographical and has the sensation of "I am recalling something now"; it also has the quality of knowing that something is from the past. In contrast, implicit memory does not provide clues to its past origins, but rather directly shapes here-and-now experience. This difference in coding memory is what is responsible for what has been called "childhood amnesia" (Siegel, 2001).

Cozolino (2014) notes that early implicit memory and the development of attachment schema are implicated in the early formation of shame. This can be exacerbated if there is any early trauma or abuse. An early negative event will be encoded in implicit memory, with no explicit memory to understand the reactions stemming from that negative event. With no understanding of where the reaction might be coming from, it becomes experienced as a part of the self and an indication of the self as "bad." Implicit memory therefore can contribute to this unexplained feeling of "badness."

Styles of Coping with Shame

There has not been as much research on styles of coping with shame as on the emotion of shame itself. Blum (2008) notes that shame does not have to be destructive and has a socializing purpose. Shame as an emotion can be felt and then dissipated through making amends, connection or laughter. In contrast, less adaptive methods have been theorized as possible reactions to shame.

Lewis (1971) in her psychoanalytic analysis of shame discusses what she called "bypassed shame." She analyzed multiple case studies and reviewed word for word transcripts of many sessions. She felt that many people, to avoid the pain, would "turn the world upside down, rather than turn themselves inside out." (as cited in Scheff, 1988 p.405). She noted that many of the shame episodes were unacknowledged by either the patient or the therapist.

Compass of shame theory. Nathanson (1992) developed the Compass of Shame theory, with four poles, representing how people react to shame. Later, Elison, Lennon and Steven (2006) added a fifth pole for those with an adaptive response to shame. From these five responses Elison et al. (2006) developed the Compass of Shame Scale. The five poles are:

- "Attack Self" assesses inward-directed anger and self-blame (e.g. self-disgust)
- Withdrawal" assesses the tendency to hide or withdraw when shamed (e.g. avoid others)
- "Avoidance" assesses disavowal and emotional distancing or minimization (e.g. minimizing the importance of a failing grade)
- "Attack Other" assesses outward-directed anger and blame (e.g., blaming someone else for the failure or transgression)
- "Adaptive" assesses acknowledgment of shame and motivation to apologize and/or make amends (Tangney et al., 2007, p. 356)

The method of coping with shame either in an adaptive way or in a maladaptive method of defending against the pain of shame is an important aspect to understanding shame.

Psychopathology and Shame

Shame proneness and shame have been associated with mental illness and psychological problems. There has been an association with depression, eating disorders, bipolar disorder, social phobia and generalized anxiety disorder, substance abuse, violent behaviors, domestic abuse, post-traumatic stress disorder (PTSD), personality disorders (narcissistic, borderline etc.) and suicidal ideation (as cited in Tangney et al., 2007, Candea & Szentagotai, 2013).

Depression. Depression is a complex heterogeneous disorder with many factors. Kim, Thibodeau, and Jorgenson (2011), in their review of 108 studies, found that shame proneness was one of the factors associated with depression. Shame proneness was also found to be a mediator to depression symptoms in adolescent girls (De Rubeis. S. & Hollenstein T., 2009).

Depression is a common disorder, with approximately 20% of people experiencing this in their lifetime (as cited by Slavich, O'Donovan, Epel & Kemeny, 2010). One of the major risks for depression is having an acute major life event. Kendler, Hettema, Butera, Gardner, and Prescott (2003) found that a life event with social rejection caused a greater risk of depression than one that did not (as cited in Slavich, O'Donovan, Epel & Kemeny, 2010).   They noted that death of a partner, parent or child had a 9.9 risk for depression, a self-initiated separation had a risk of 10.2, and an other-initiated separation had a risk of 21.6. Being the one broken up with had a much higher risk than being the one to do the breaking up. The least risk was having someone die. This speaks to the importance of the effect of social rejection/shame on depression.

One of the factors involved in social rejection (or social threat) increasing depression risk has to do with inflammation. As discussed earlier, social threat/shame has physiological effects one of which is to increase inflammation. Inflammation is thought to be part of the pathophysiology of depression (Slavich et al. 2010). Social threat can increase cortisol, proinflammatory cytokines, and cause physical pain. In addition, social isolation and interpersonal stress has been found to upregulate the genes that promote inflammation (Slavich et al. 2010). Shame, therefore, can be thought of as causing inflammation, which increases the risk of depression.

Post-traumatic stress disorder (PTSD). PTSD has mainly been described as arising from an experience of intense fear. Fear is considered the dominant emotion in PTSD, but shame is also commonly noted along with guilt, sadness and anger (Lee, Scragg & Turner, 2001). Shame has been noted to occur both as a primary emotion, occurring at the moment of the trauma, as well as a secondary emotion occurring from appraisals after the event (Grey, Holmes & Brewin, 2001, Ehlers & Clark, 2000). *The Diagnostic and Statistical Manual of Mental Disorders* (5th Ed; DSM-5; American Psychiatric Association, 2013) in the fifth edition has now incorporated guilt and shame as persistent trauma related emotions. They note there can be persistent distorted blame of oneself and a persistent negative belief that " I am bad."

Matos and Pinto-Gouveia (2010) note that shame memories can have characteristics of trauma memories with intrusion, avoidance and hyperarousal symptoms. Shame proneness has also been associated with increased rates of dissociation (Talbot, Talbot, & Tu, 2004, Dorahy et al., 2013). These shame memories can have a "here and now" feeling of being in the present. This feeling of it happening "here and now" can

create an ongoing sense of threat. The self-criticism that can arise from shame also

contributes to this ongoing threat by one part of the self attacking another part (Ehlers &

Clark, 2000).

Shame dynamics have been particularly noted in interpersonal violence including

female-directed violent crime and sexual abuse, gender-neutral physical assault, child

abuse, combat exposure in war veterans and politically motivated violence (as cited in

Budden, 2009). Shame is part of the social threat system and is present in episodes of

social subordination. Interpersonal violence can trigger hard-wired appeasement

behaviors and responses (Lee, Sragg, & Turner, 2001). These appeasement/submissive

responses may elicit sympathy from the perpetrator and may keep the victim safer in an

unsafe situation. This may be adaptive in the acute situation, but can, however, be

detrimental to those who develop chronic symptoms.

Troop and Hiskey (2013) discuss this in terms of "mental defeat" compared to

physical defeat. They describe "mental defeat" as feeling weak, inferior and unworthy

and losing any sense of agency. Ehlers et al., (1998) noted that women who physically

did not fight during a sexual assault but who mentally kept planning how they could

minimize harm had less PTSD than those who felt mentally defeated. This feeling of

subordination and social threat is part of shame dynamics.

Shame in PTSD can be difficult to entangle from fear and other emotions

involved in trauma. It is important to uncover unacknowledged shame as it can prevent

adequate treatment. This is especially true as treatment for PTSD frequently involves

exposure therapy and shame prevents clients from engaging well with this approach

(Herman, 2011). Repeatedly revivifying experiences of shame without working to

change the cognitions may interfere with the effectiveness of exposure therapy (Ehlers &

Clark, 2000).

Another way that peritraumatic shame impacts PTSD is through preventing a

victim from accessing social support after trauma. Accessing and perceiving positive

support after a trauma is very important. A victim that perceives negative social support

after trauma is more likely to develop PTSD (as cited in Budden, 2009).

Violence. Anger and aggression have been recognized as a response to shame

(Elison, Garofalo & Velotti, 2014). Many theoreticians starting from Lewis (1971) have

described a feeling of shame that is overwhelming and is redirected or "bypassed" into

anger and blame. This redirection protects the self from feeling the shame. Increased

shame-proneness has been noted in perpetrators of interpersonal violence, in school

bullying, and in aggression between dating partners (as cited in Schoenleber, Sippel,

Jakupcak & Tull, 2014). Juvenile offenders with a history of abusive parenting who

converted shame to blaming others had more violent behavior than those who could

express and manage shame (Gold, Sullivan & Lewis, 2014).

Elison, Garofalo and Velotti (2014) theorize that one path from shame to violent

behavior arises from the path of shame to pain to anger. They note that social

threat/exclusion induces shame, which as discussed previously, is felt in the same alarm

area of the brain as physical pain. Physical pain has been shown to elicit anger,

frequently activating automatic scripts without higher cognitions. This then can lead to

violence. Therefore, they theorize that shame, through this link with physical pain, elicits

the same fight, flight or freeze response that activates the physical threat defense system.

This then creates the pathway from shame to pain to anger to violence. They go on to

note " aggression may be most common when individuals feel completely rejected (stigmatized or shamed), with no chance of regaining social connection, just as physically threatened individuals are most likely to fight when there is no opportunity for conciliation or withdrawal" (p. 450). DeWall, Twenge, Bushman, Im, and Williams (2010) state that even minor acceptance by a single stranger has been found to reduce aggression.

Shame and Culture

Research on shame has mainly been conducted on individualistic cultures (Silfver, 2007). Shame is considered to be universal, but the frequency, intensity, expression and implications of shame may vary between cultures (Furukawa & Hunt, 2011). Different cultures have different standards, and great variation on what will illicit shame (Leeming & Boyle, 2004). Shame within cultures may be used to enforce social order and may be more prominent in cultures that value social hierarchy (Goetz & Keltner, 2007). Leeming and Boyle (2004) state, "experiences of shame can be seen as episodes within culturally saturated social dramas" (p.384).

Stigma by society can be a source of shame. Stigma itself does not necessarily lead to internal shame in all cases (Leeming & Boyle, 2004). It is noted, however, that if stigma relates to a visible aspect of oneself, that it takes considerable work to resist experiencing shame. This may be because we can feel shame when we are aware that others judge us negatively, even when there is no personal belief that we have done anything wrong (as cited in Leeming & Boyle, 2004). In western societies, there is stigma of those who are less competent, less productive, disfigured or otherwise considered unattractive, deviant or immoral (Leeming & Boyle, 2004). Sexual desire,

sexual orientation and gender identity are frequent sources of stigma (Longhofer, 2013).

There is also stigma surrounding illnesses, such as mental illness, chemical dependency

and HIV/AIDs. The amount of stigma is also related to the amount of responsibility or

self-blame that is assigned for the condition. For example, obesity is considered to be

something controlled by eating and exercise and has high stigmatization as it is perceived

as being under someone's control (Lewis, 1989).

       Individualistic versus collectivist cultures. One main cultural difference

depends on whether the self is defined by an individualistic or a more collectivist

definition. In individualist cultures, there is typically a stronger boundary between the

self and the other, compared to a more interdependent boundary noted in collectivist

cultures. With a less distinct boundary, shame may be experienced by behaviors of

others (Lagattuta & Thompson, 2007). An example of this was a study done with

Chinese and American students. They were asked to rate how they would feel if they

were caught cheating and how they would feel if their brother was caught cheating. Both

groups felt the most shame for their own actions compared to their brother's, but the

Chinese students felt more shame when imagining their brother's actions than the

Americans students did (as cited in Goetz & Keltner, 2007).

       Cultures that are more interdependent may view shame in a more positive way.

This positive value is consistent with the interdependent goals of self-effacement,

adjustment to group standards and self-improvement (Wong & Tsai, 2007). In a study

with Hindu and American participants, the participants were given a list of three

emotions (shame, happiness and anger) and asked to pick out the emotion that was the

most different of the three. The American participants picked out happiness as being the

most different from shame and anger while the Hindu participants picked out anger as being the most different from happiness and shame.

Shame and Psychotherapy

There has been a lot of theorizing about shame, but surprisingly, not very much research done about treating shame or how to work with shame during therapy (Tangney & Dearing, 2011). One theme that emerges from researchers and clinicians is that shame is ubiquitous, especially in clinical settings. The source of shame can arise from the client, the therapist or the therapeutic interaction itself (Tangney & Dearing, 2011). It can also arise between parents and therapists when children are in therapy (Baldwin, 2014).

The very process of going to therapy can be shaming. By going to therapy, a client admits that something is wrong, and a lot of time in therapy can be spent getting insight into what's wrong. This dynamic is exacerbated by the power imbalance. The client during therapy exposes himself or herself without the therapist having to do the same. This can be exacerbated by an idealized concept of the therapist as a professional who does not have psychological problems. Additionally, the act of being given a diagnostic label can create shame, especially if there is stigma about mental illness (Tangney & Dearing, 2011). Shame itself can be a source of shame as clients are ashamed of being ashamed (Lewis, 1971).

Client disclosure is an important aspect of therapy, and clients are always having to decide how much to disclose. Clients struggling with issues of shame may have more concerns about being judged harshly and have less ability to form a close therapeutic alliance. Macdonald & Morley (2001), in an emotion diary study of 34 psychotherapy

clients, found that there was a 68% non-disclosure rate of emotional incidents. They

compared this to other studies of non-clinical samples and found that the non-disclosure

rate was 10%. Participants appeared to habitually non-disclose, and this was related to

anticipated negative interpersonal responses.

In addition to non-disclosure, which is a way of avoiding shame, clients can react

with any of the coping styles theorized in the Compass of Shame model. They can be

angry and attack either themselves or the therapist, and they can withdraw. In their study

of shame and the therapeutic alliance, Black, Curran and Dyer (2013) noted that the

withdrawal style of coping was especially at risk of not forming a working therapeutic

alliance.

The therapist can also bring his or her own shame issues into therapy. He or she

can struggle with feeling competent as a therapist, and that feeling of inadequacy can

impact the relationship. Emotions are contagious and therapists can catch shame from

their clients. Shame can be bidirectional (Tangney & Dearing, 2011). This is especially

impactful in areas where the therapist has similar shame issues to the client. The client

and therapist can collude together to avoid working on shame (Lewis, 1971).

Transference and counter-transference are common occurrences in working with shame.

Because of these issues, it is important to have good supervision.   (Goldblatt, 2013,

Tangney & Dearing, 2011). Of course, supervision is itself an area where shame can

arise, especially on the part of the supervisee (Talbot , 1995).

As this literature review shows, shame is a universal part of the human condition.

Shame is common and frequently arises in psychotherapy. Shame can be adaptive or

maladaptive. Maladaptive shame issues are frequently part of mental illness and need to

be addressed in psychotherapy. There has not been much research on how therapists address this in their practices. This exploratory qualitative study will look at these issues.

Conceptual Framework

Many theorists have discussed shame from differing viewpoints. Some of the main approaches have included evolutionary/functionalist, cognitive attributional and psychodynamic approaches, including object-relations theories and attachment theory.

Evolution/Functionalist Perspective

Emotions, including shame, have been conceived from an evolutionary perspective as part of the rapid response system. This rapid response is described as physiology, perception, actions and cognitive processes firing together to organize response to a rapidly changing environment.   Within this concept, shame has evolved to sustain close relationships to others by signaling the danger of demotion or exclusion (Koerner, Tsai & Simpson, 2011).

Charles Darwin described evolution on the basis of biological processes being shaped by natural selection (Forte, 2007). The functionalist viewpoint of shame credits evolution for shaping the shame response. Gilbert (2007) describes a system initially based on dominance hierarchies that elicited submissive displays to avoid aggression. As attraction hierarchies and increased cooperation became more important, the submissive display (considered to be a precursor to shame) is co-opted to become part of the social threat signaling system, which evolves into the shame response. This became functional and adaptive for increasing group cooperation and enforcing group norms.

Cognitive Attribution Perspective

Shame is a process of self-evaluating the self. This requires self-awareness and acceptance of standards against which one's behavior can be evaluated. It also requires the ability to perceive the psychological perspectives of the people around them (theory of the mind) (Lagattuta & Thompson). This requires cognitive abilities, and in children is thought to be present by age two and a half to three and becomes more sophisticated as they grow older.

Psychodynamic Perspectives

Psychodynamic theories originally defined by Freud placed emphasis on early experience as defining personality and that unconscious forces are important in this development. Freud described guilt as arising from the conflict between the drives of the id and the moral standards of the superego. He did not, however, discuss shame (Mills, 2005). Eric Erickson briefly mentioned shame in his developmental stages, describing the second stage from age 2-3 years as autonomy vs. shame and doubt (Forte, 2007). Helen Block Lewis (1971) was the psychoanalyst that wrote the most on shame; theorizing that shame was the reason some of her clients did not improve with psychoanalysis.

Object-relations. Object-relations theory was derived from classical psychodynamic theory by the work of British theorists Melanie Klein, W. R. D. Fairbanks, D. W. Winnicott, Harry Guntrip, Wilfren Brion, and John Bowlby. It was also advanced by American theorists Henry Stack Sullivan, Karen Horney, Erick Fromm and Alfred Adler (Forte, 2007). Psychodynamic theorists of the object-relations school of thought focused on the importance of relationships. Object-relations theory describes a

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"cognitive-affective internalization in which multiple representations of self and other

come to form the inner world." (Stadter, 2011, p. 46). (Classic object-relations theory

used ego and object but modern language frequently uses self and other.)

     Object relations describes internal mental representations of relationship rather

than the actual external relationship. This creates an inner world of process and

experience through which people interact with others. Two patterns emerge for the young

child, representations of self and representations of caregivers (Applegate, 1990).

Representations of caregivers reflect conscious and unconscious beliefs about the

responsiveness and trustworthiness of caregivers. Representations of self reflect

conscious and unconscious beliefs about the worthiness of self to receive such caring and

attention (Parker & Scannell, 1998). These relationship processes between self and other

alternate between experiences of union and experiences of autonomy (Applegate, 1990).

It is in these internal representations of the self that shame can arise (Stadter, 2011).

     Attachment theory. Attachment theory has been developed as an object relations

theory that describes parent-child caregiving bonds. A main concept of attachment

theory deals with the security versus insecurity of the infant (Forte, 2007). In the past,

attachment has been focused mainly on the mother-child relationship. Attachment

theorists describe the importance of a secure base. They describe this base for an infant as

" to which he can return knowing for sure that he will be welcomed when he gets there,

nourished physically and emotionally, comforted if distressed, reassured if frightened"

(Bowlby as cited in Forte, 2007 p, 306).

     Mary Ainsworth, a colleague of Bowlby, described four patterns of attachment.

She based this on a research protocol that studied videotapes of 12-month-old infants

whose mother absented herself and then returned. The four patterns include secure attachment as well as three patterns of insecure attachment: anxious-ambivalent, avoidant and disorganized (Forte, 2007).

Nathanson, Kaufman and Schore have theorized that shame occurs when the attachment bond is disrupted. They have combined attachment theory with affect theory. In addition, Schore has added neurobiological research to his theories of shame (Mills, 2005).

Methods

Research Design

This is a qualitative, exploratory study to further explore issues surrounding shame as they present in psychotherapy. The qualitative design allowed for this topic to be explored with psychotherapists in depth and in their own words. The data was obtained through qualitative interviews with clinical professionals who are experienced in psychotherapy with a range of clients.

Sample

The sampling technique was purposive with convenience and snowball methods used. Contacts of the researcher and committee members were approached to participate in the study. Criteria for participation included having a master's degree or higher in social work, psychology, or marriage and family therapy and being involved in a psychotherapy practice with at least five years of experience. An attempt was made to interview clinicians with different orientations and working with different client populations. Eight clinicians were interviewed from a variety of psychotherapy practices.

Protection of Human Subjects

Prior to conducting the interview, the respondents were presented with a consent form approved by the University of St. Thomas Institutional Review Board (IRB) (see appendix A). The consent form outlined the content, purpose, process and confidential nature of the study. Respondents were informed that there were no benefits to participating in the research. The consent form also noted that there may be limited risk of emotional distress in discussing shame and are advised on optional resources if needed. They were also advised they could withdraw from the study up to 10 days after participation in the interview. Contact information for the researcher and her advisor were provided in case of any additional questions or concerns.

Confidentiality was kept with all mention of names and identifying information being deleted from the findings. Information was stored on a password-protected computer and was deleted upon completion of the project.

Data Collection

Qualitative data was collected through interviews lasting from 30-50 minutes. A semi-structured interview was used with standard questions and a flexible format to gather the information (See appendix B). The University of St. Thomas Institutional Review Board approved the questions. The questions were open-ended and exploratory in nature, leaving space for the respondents to offer additional insights. Interviews were conducted in a private setting and were audio-recorded. Recordings were transcribed using a transcriptionist that signed a confidentiality agreement. Upon completion of the project, recordings will be destroyed.

Data Analysis

The interviews were analyzed using content analysis techniques as described by Berg and Lune (2012). Open coding was used to minutely review the transcripts. Themes were developed from the coding and organized into findings illustrated by direct quotes from respondents. An inductive grounded-theory method was used to move from the specifics to the more general themes (Berg & Lune, 2012).

Findings

This qualitative study looked at the issues of shame in the context of psychotherapy practice. The question of how therapists define and conceptualize shame, how they see it present in their practice and what methods are helpful in working with shame were explored. From this, major themes were developed regarding how therapists define, recognize and work with shame issues and in addition, how shame impacts the therapeutic relationship.

Participants

Eight therapists who had been in practice an average of 25 years were interviewed, with a range between 11 and 40 years. All the therapists were female. Three therapists were clinical social workers, five were licensed psychologists (four had their master's in Counseling Psychology and one was a Doctor of Clinical Psychology). One of the social workers had a dual degree in Social Work and Marriage and Family Therapy, and one of the licensed psychologists had an additional Marriage and Family Therapy certificate. Many of the therapists had done training in additional methods, including psychodynamic approaches, attachment, emotionally focused therapy, mindfulness, EMDR, DBT, sand

play therapy, developmental needs meeting strategy, experiential child-directed play

therapy and somatic approaches to trauma including Somatic Experiencing.

Definition of Shame

The respondents defined shame as a core belief of being wrong, bad or defective.

Most of the respondents differentiated shame from guilt, which they described as feeling

bad about something you did as opposed to shame, which they defined as feeling bad

about who you are.

> *I define shame as the feeling that somebody has that there is something wrong*
> *with them, that they are defective…that they need to hide that or conceal it.*
> *They want to cover it up because the feeling of wanting people to know about that*
> *is overwhelmingly painful and scary.*
>
> *Shame to me is really a core belief and acceptance of one's lack of*
> *worthwhileness, of being somehow deficient and often not even able to identify*
> *why, and finding themselves or believing themselves to be unacceptable."*
>
> *Core belief is, I don't exist, I don't have worth, I don't have value, I'm cracked*
>
> *Something has been done to me that makes me feel unworthy, unloved,*
> *unimportant, uncounted. And that shame gets to the very core of who you are. So*
> *I think people with shame basically feel, I don't count. And if you're homeless*
> *and you're a prisoner, or you're a refugee, don't you just feel like nobody really*
> *cares about you? You don't really count.*
>
> *Belief that at my core I am unwanted and unlovable.*

These core-identity beliefs were the main way that therapists responded when asked to

define shame. In contrast to this trait aspect of shame, there were only a few brief

mentions of shame as a feeling state. One respondent described shame as a bad feeling of

"physical ickiness that goes throughout your whole body." Another respondent

differentiated shame that is situational from shame that is more chronic and persistent.

One therapist also mentioned that shame can be a survival response, "*I think it is not helpful to think of shame as pathological, so to be curious about how has it been self-protective…and to go out from that direction.*" She also described shame as a something that could arise from a boundary violation, "a *person of power…projects that shame on to the person who has been experiencing it.*"

Presentation of Shame

The respondents felt that shame was common in therapy ("*it comes up everywhere.*") Several therapists noted that shame was particularly prevalent when there was early developmental trauma. The respondents described several ways that shame presented in therapy.

Self- identity. Shame presented in the beliefs that clients had about themselves and the world. This came through in the statements clients made about themselves, both self-critical statements and blanket statements about others not caring about them.

Self –critical statements: *I'm stupid, I'm weak, I'm terrible, I'm not meant to be here, what's wrong with me.*

Blanket statements: *Nobody likes me, nobody cares about me, I'm invisible, I'm all alone.*

Shame was also noted to come up in feelings of not deserving things. One example noted by a therapist who works with clients struggling with eating disorders was as follows:

[They] *feel they don't deserve to eat, or don't deserve to eat those foods, or I don't deserve all the whole continuum of comfort, pleasure.*

Another therapist described clients that

*feel that things other people deserve they don't deserve. They have a special
set of rules for themselves that are all negative.*

Secrets. Another area that shame presented was in what one therapist called " *no-
talk rules.* " She described clients that manifested shame around topics that "*they can't
let anybody know about.* " Many times this was around past abuse and addiction issues
that clients felt "*if I let people know…they're going to abandon or reject me or judge me.* "
She particularly noticed this in clients struggling with chemical dependency and eating
disorders. The saying, *"we are as sick as our secrets"* is an expression she felt fit with
shame. She noted these *"no-talk rules"* and *"secrets"* perpetuate the shame her clients
experience.

Defensive responses. Shame is a painful emotion and can present as a defensive
response that bypasses shame itself. The therapists noted different manifestations of this,
including anger, withdrawal, dissociation and perfectionism. Perfectionism was the
defense noted by the most therapists.

Perfectionism. Perfectionism is a common way to defend against shame and
several therapists described seeing this presentation in their clients.

*Key piece in how they present is that anxiety of always saying, what can I do to be
better? What can I do?   Chasing…*

This constant chasing after being worthy, the constant need to be better is the defensive
mechanism that protects against shame, against being seen as unlovable. The fear of
shame is an ongoing anxiety driving the need to be perfect. Shame itself may be
bypassed and only the anxiety and chasing feeling consciously registers.

*Perfectionism and shame are intertwined and perfectionism is culturally defined
as OK, kind of like social drinking…Perfectionism can really feed the shame.*

> *Perfectionism is a way to keep away from shame. The perfectionism tends to be future and shame tends to be past, so there's this balancing of future/past in an anxious way...there really isn't a place for self in there.*

Anger, withdrawal and dissociation. Shame presenting as anger, withdrawal or dissociation was not mentioned with much frequency by the respondents. The one therapist that mentioned them the most was a therapist that did couples and family therapy. She particularly noted defensive responses to shame arising during couples therapy. She described this as one partner saying something about a need that is not being met and that triggering shame and a defensive response in the other partner. She gave an example of a wife saying, "*it would really help me if you could do the dishes*" and the husband, instead of hearing a request to do the dishes, hears a shame message of "*you're a horrible husband, I hate you.*" This shame then elicits a defensive anger and the husband attacks the wife or goes into a defensive withdrawal. She also described episodes with clients where dissociation happens as a defensive response to shame.

> *Shame messages are just so powerful that as soon as you touch it … totally collapses or dissociates.*

Relationship difficulties. Relationship issues also were a common place for shame to present. Therapists noted that shame could create a difficulty with intimacy. One therapist described clients with "*an inability to let people get close because then they discover how bad I really am.*" Another therapist described clients with a feeling of "*I'm going to hurt other people by exposing them to see me or interact with me.*"

Shame also presented in the therapy relationship and process itself, which one therapist described in regards to pacing, "*when I have moved too fast or got too close*

because there would be a sudden stop, their eyes go down and you know, I had to back

off a little."

Somatic presentation. Shame was described as presenting somatically with a

"disconnect from eye contact, pulling into the self, descriptions of a burning belly,

flushing of the cheeks, a racing heart." One therapist noted, *"when first getting to the*

shame, there aren't any words." Another therapist noted *"I see a lot of collapse where*

their body just kind of shuts down and kind of caves in on itself."

Approaches to Working with Shame

There were some common themes in how therapists worked with shame, but also

diversity in some of the approaches used

Cognitive. Therapists discussed that cognitive therapy alone or talking alone was

not sufficient in working with shame. Many of the therapists discussed that earlier in

their careers they tried to directly confront the negative beliefs that shame elicited but

found it unsuccessful. It may be that by challenging and arguing with a client's beliefs,

the client does not feel validated which leaves the client even more isolated.

> *I don't think you can think yourself out of shame. I don't think that can happen*
> *just through cognition.*

> *I can't talk anybody out of their shame, and I've given that up a long time ago.*
> *Even insight is not enough. Insight about where shame came from…like it can*
> *be helpful to have that insight, but it isn't going to change it.*

> *I spent a fair amount of time trying to challenge those beliefs in this way, that way,*
> *the other way…and it was incredibly unhelpful.*

I think it does not hurt to say, you know, I see it differently. But I don't think I expect that will be curative. I just expect that to be informational more than anything else, so that they don't think that I'm joining them in the idea that they're…irreparably flawed.

Therapists talked about the difference between arguing with a client about their self-image and looking for the "*cracks in the stories they have been told and, I think, believe about themselves.*" Another therapist looks for "*if there's ever any part of them that questions this assumption that they are so damaged or so undeserving…and tries to help build that piece.*" Using EMDR is helpful for another therapist in "*creating an alternative narrative…belief that I have value and purpose, that I can be in the world.*"

Normalizing. Normalizing experience was another important approach to changing the narrative for one therapist. She gave an example of working with a refugee who had been raped and tortured:

I've heard this story from other women…different pieces…different ways… but you're not the only one. In studies we have done with people who have experienced this, this is the list of symptoms people have, this is the list of feelings that people go through. Response: 'Wow yeah, that's just how I felt that,' or 'I'm at this stage and I haven't gotten here yet.'

Externalizing. Another therapist uses narrative therapy and externalizes the voice of shame. She finds this helpful with both couples and individual therapy.

I can hear the voice of shame and I am not going to let that voice trick you or treat you like this, or say those horrible things to you.

She noted, in couples therapy, this will unite the partners against the externalized voice of shame rather than one partner being against the other. She also uses this with kids calling it the "*bad guy voice.*" With adults she will talk about the voice under the shame voice, "*that knows what's true and who knows what's real.*

Resourcing. Resourcing in various forms was a common theme therapists discussed. They worked to build on strengths and positive self-image. One therapist noted that connecting to the world and encouraging *"a sense of life energy and life force"* is an antidote to shame.

> *Listening when people are talking about some positive self regard or some sense of I .. that feels life affirming. From the beginning of working with people, I'm looking for that…when I hear that, I'm going to try to stretch that out, reinforce it, like really create more resource around that for us to use later.*

> *We encourage people to get out and walk around the lake, plant a garden, you know, get a parakeet, get a fish. You know, things to help people sort of find that nurturing piece to them. You know, learn to cook. Learn to garden, you know, things that connect you to the world.*

Relationship. Shame is a social emotion, and therapists discussed the importance of the therapy relationship and other relationships in the client's life to create new social experiences. Many therapists noted that this was a long process, and that many of their clients with the most shame issues have been in therapy for multiple years.

> *I think nothing I intended to do was helpful, but just simply being in a relationship over time and experiencing my interest and positive regard…that started change.*

> *helping a person see themselves through…the power of the positive or empathic relationship with the therapist.*

> *Gently reveal their secrets and to find out that they feel held and supported and cared about rather than shamed and invalidated and judged.*

> *I know that you have value with this world. I'm conveying that to you with my very being and I'm seeing you with that…with my eyes and with my body. I don't even have to say it. And that creates an affect of change experience repeated over time.*

Working with parents on giving character affirmations…in the moment…so that the child can take it in a little more….For example instead of saying "that's really nice," to say, "that was very caring of you."

Laughter is a great way to join people. Laughter takes the pain away. And so part of it is to just be the person you are and to be real…. This work is all about relationship, relationship, relationship.

Group work. Some of the therapists interviewed work with groups, and those that did felt groups were a very good approach to working with shame issues.

We sometimes have groups…and I think they start to heal a little…Sort of rebuilding of who you are and beginning to find people you can trust.

They start hearing other people say, yeah I have trouble with that, too. So they start realizing that it's not a personal thing, that it's kind of human suffering that we all struggle with. So in some ways, it's almost easier to work within a group.

Community. One therapist discussed the importance of connection with and contribution to the larger community. She works with refugees, severe and persistently mentally ill clients, homeless clients and clients who have been incarcerated. She noted that the feeling that "*I don't count"* is particularly strong in these populations. She discussed the societal messages people get about who they are.

If you're poor in this country, nobody wants to hear from you. Nobody wants to deal with you. If you're dirty and homeless, if you're mentally ill and talking to yourself on the bus…a new immigrant here and you can't speak the language and you dress differently, people who are handicapped, there is the shame.

Working with this population she noted the importance of connecting people to the community, the importance of finding ways that her clients can contribute and have purpose. She worked with one client that contributed by gardening with kids for a school

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and another that taught bike repair and started a biking group at the shelter. These were

turning points for these clients.

> *You have something to contribute. You need to think about, what is that? Is it telling your story? Is it reaching out and helping other people? Is it volunteering? What is your piece?*

> *So it's just finding your place in the Universe again, you feel like you're giving back and there's that fair exchange and your wounds don't weep all the time.*

Mindfulness. Some of the therapists noted that mindfulness was a helpful skill in

working with shame issues. Using mindfulness helped their clients facilitate an observer

stance and increased curiosity and attention to here and now experience.

> *They were able to realize that those were just thoughts passing through and not attach themselves to them.*

> *Internal resources that help me know that I am here, I'm connected to something of value that feels like self.*

> *explore…with some curiosity and compassion, sort of all of those mindfulness tools*

Compassion. Compassion was discussed by many therapists as being helpful in

working with shame. Clients' compassion for themselves as a child and for their past self

was especially mentioned.

> *Working with compassion. I really pay attention for when I hear it…I would say that I track toward that a lot….When I hear that, I'm going to try to stretch that out, reinforce it.*

> *If they can come to look at their past self and have some compassion for what happened to that person, that child or whatever, that compassion is an antidote to shame.*

Go back to when they were young and injured and to embrace that injured piece of them and to learn to speak kindly to them.

Using creative imagery to give that original memory a different way of getting help. Example: imagining their adult self-present or someone else in their environment being able to care for this baby in the way she deserves to be cared for.

Spirituality. Shame comes with a sense of disconnection that can have spiritual aspects. Working on this spiritual level was mentioned by some of the therapists. One therapist works with many Christian clients and she will talk about the Bible and God's love. She discusses that God does not make exceptions in his love. Another therapist that works with a very diverse population discussed having cultural awareness of spiritual beliefs and working with Imams, Hmong spiritual healers and Native American spiritual healers. She noted that some people need some type of ceremony to ask for forgiveness from their relatives or from God. She also stated this was an area she felt therapists were not very well trained in.

Another piece is spiritual healing. For many people there's a spiritual wounding that goes with this and trying to help people find the world a good place, that most people are good, that there are things you can trust in to heal that core belief system.

If you see an accident…you don't ask questions about what kind of person they are, you just help. And so, then we work on, if there's this intrinsic value for human beings across the board and you are one of them, you're a human being also.

You are one of the universe's creatures, you exist, you are valuable."

I talk a lot about every single one of us is the only one of us who will ever be.

Somatic work. Shame has a somatic component that the therapists who had

trained in somatic approaches mentioned being attentive to, particularly in trauma work.

> *So being able to track the sensations in the body and to be able to name it looks like you're being very still…they can't move, they can't make eye contact…possibility of being able to move out of…if we can get some movement there, then we can get to the beliefs…what the image is about.*

Play therapy. Half of the therapists interviewed work with children in addition

to adults. Those that work with children discussed the importance of play therapy. Two

of the therapists use non-directive play therapy where the child directs the play. They

noted that shame comes up either as self-harm or comes up as a projection onto the

therapist.

> *In play…they will shoot at themselves, they will chop themselves up, they will say really bad stuff about themselves or most often it comes out as projection on to me as them. The will put me in the corner, put me on the floor and say "you're horrible, your never going to be any better than this, nobody is going to love you."*

By creating a space for these feelings the therapist noted,

> *when they feel like we get it, we get how grim this is for them, they often add a component of resolution at some point, where we can finally start to fight back.*

Another therapist talked about the importance of the relationship in play therapy, as well

as attunement in creating new neural pathways.

> *Bring some child out of their internal experience and have them engaging. We want them to have the felt experience of pleasure, of joy in the exchange, of laughter and some silliness, where it's safe and attuned.   Lay down tracks for a new neural pathway.*

Shame in the Therapy Process

      Power differential. Therapy itself can be shaming. The client exposes himself

or herself in a unilateral fashion and can place the therapist in the position of the expert.

The process of being given a diagnostic label itself can also be shaming. The therapists

discussed how they worked within this dynamic, using self-disclosure judiciously, pacing

appropriately, using compassion and being collaborative with the client.

> *I try and join with them…not sharing inappropriate details with my client, but*
> *enough for them to know that I'm human too.*

> *Sometimes this comes up in self-disclosure and being careful about that, but I will*
> *talk about, you know, I didn't come by this career by accident.*

> *Sharing the fact that I am a human being too. Using examples in my life.*
> *Support them in working on the things that they want to. I don't have an agenda.*
> *So holding both self-acceptance and desire for change.*

> *Therapists' responsibility to deal with their own judgmentalness…what is your*
> *level of compassion? You're asking the client to have compassion for themselves.*
> *Do we have compassion for them?*

> *I think that the way shame happens in a therapeutic relationship, is going too far,*
> *too deep, too fast…talking about something someone isn't ready for…and so I*
> *think the best I can do is be respectful about that.   To state very clearly that is my*
> *intention is not to go to a place that overwhelms…that over-exposure is where*
> *shame pops up. Not asking people to override.*

      Therapist shame. Therapists have shame issues in their own lives and can also

have shame about their professional skills. Transference and counter-transference issues

can arise. The therapists all discussed the importance of self-awareness, supervision,

consultation groups, doing their own therapy, being able to admit their own mistakes and

staying resourced themselves.

And we all have our own shame issues. I have my own shame story, I have my own shame experience…It makes us good and it is also something to work on.

Oh, you know you get that thing in your stomach, it just like, it's too close.

I think it's a huge amount of work on the therapist to understand how their stuff enters into the room. It's not like you can get rid of your stuff, but you have to be more aware of what it is.

Not expecting the client to like me all the time, to take care of me.

All eight of the therapists had some type of peer supervision, consultation or group supervision. Many of them had done or were participating in ongoing therapy. They stressed the importance of this to their ability to be able to resonate and work at the level their clients need.

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I was stuck so she was stuck. So I had to figure out how I could get unstuck before she could get unstuck.

I have a supervision group and we meet monthly, and I go there because it helps me clear my head and keep clean. And I've been to therapy before and I continue to go.

If you find yourself not wanting to tell your consultation group about a particular client or situation, you're wanting to hide yourself, that's probably your shame of some sort that's coming up.

The therapists also talked about the importance of being OK with their own humanity. Knowing that they make mistakes, and knowing that their mistakes are mistakes and not their intention. They also talked about good self-care, staying resourced and having good boundaries.

*Usually I say that I've made a mistake… to take some responsibility and then to
try and shift back to a more resourced position. I wasn't intentionally trying to
hurt someone,…it's a mistake. I need to stay resourced, to stay grounded and
open hearted.*

*So staying resourced myself…I think in very basic way, taking care of myself so
that I have enough rest and I'm not hungry and I'm meeting my needs and I have
lifestyle…that feels really important to me. I need to notice and stay present in
my body and stay grounded. I really need to know where your boundaries are,
where I am and where you are.*

Discussion

Shame is ubiquitous and is an important factor in mental health issues. How

therapists define, understand and work with shame is an important aspect of their work in

psychotherapy. This qualitative study explored how therapists conceptualize shame, how

it presents in their practices and how they work with shame issues. It also discussed

shame in the therapeutic relationship itself.

Definition of Shame

The importance of defining shame in order to more fully dialogue about it cannot

be underestimated. Shame is defined as a complex psychological construct with

cognitive, emotional and behavioral elements. Shame can be defined as a state or as a

trait. Shame develops as a trait due to early developmental experiences that lead to

beliefs that "something is wrong with me, I am bad and unattractive." (Claesson et al.,

2007, p. 599). Shame as a state is considered a transient complex emotion that arises in

social situations and helps regulate social behavior, as well as appeasing and helping

facilitate relationship repair (Gilbert, 2007).   Difficulties arise in discussing shame

because of different ways people think about it and different meanings that people attach

to it. Additionally, it is a word used in popular culture as well as in scientific thought, and that adds to the multiple dimensions in the conceptualization of shame.

All eight of the respondents in this study defined shame as a trait with core beliefs about identity and self. They described shame as a feeling of being *"defective, broken, unwanted, unlovable, unimportant, uncounted etc*." Two therapists made a brief mention of shame as a state, in addition to defining shame as a core-identity trait. More therapists alluded to shame as a state on a later question when they talked about shame coming up in the therapeutic relationship, and also when they talked about the somatic aspects of shame. Shame as a state in the therapeutic relationship was noted especially around errors in pacing, i.e. going too fast or too deep, and when the therapist had been directive versus collaborative. They noted somatic signals in their clients with eye aversion, slumping, wordlessness and general shutting down. In describing relational interactions, the state aspect of shame became more prominent.

One reason shame as a state was not discussed more by the therapists in their definition of shame may be due to the fact that shame is a very painful emotion. As a painful emotion, the defenses against feeling shame may be so strong both in the client and in the therapist that this aspect of shame may be more unconscious. In contrast, it may be that shame as a core identity is so pervasive in many clients that this finding stands out more in therapists' minds.

Most of the respondents differentiated shame from guilt along the same definition that Tangney (2007) defines it, as shame being about the self and guilt being about a specific behavior. They felt that shame was more difficult to deal with than guilt.

Shame – the Good

Shame as a social emotion has been considered to be helpful in regulating social behavior and norms (Leary, 2007). This has been theorized to be an evolutionary adaptation that enables us to live in groups and be sensitive to how others perceive us. Adaptive shame is theorized to help navigate social threat and facilitate relationships. Observing shame behaviors in another elicits sympathy and increases the likelihood of repair of the relationship (Gilbert, 2007).

One key factor in whether shame may be adaptive or maladaptive is the quality of parenting and attachment from early developmental experiences. Shame arises in the socialization process of child development and is present by age two and a half or three. Schore (1998) theorizes that shame arises any time there is unexpected failure of an attachment figure to regulate emotion through their dyadic bond.   Schore (1998) describes this as an inhibitory response that moves a child from an energy mobilized sympathetic state to a parasympathetic energy conserving state, which causes distress in the child. If this distress state is repaired in a rapid fashion, then the child will have an expectation that challenging social interactions will have a positive outcome (Cozolino, 2014). The repeated repair of shame creates an ability to manage shame and handle challenging social situations. In this case shame could be seen to be adaptive. If there are frequent shame episodes with no repair, this may lead to maladaptive shame and identity issues.

Discussing shame as having an adaptive aspect is not a universal idea. As discussed earlier, part of this is due to how shame is defined. Tangeny et al. (2007) notes that guilt is adaptive but shame is not due to the global nature of shame and the action

tendency to hide and withdraw. In addition, there are also interesting cultural differences regarding how shame is viewed. The United States as an individualistic culture has a more negative view of shame than cultures that are more collective and interdependent (Wong & Tsai, 2007).

In this research study, none of the respondents directly discussed any adaptive benefits of feeling shame. This relates to how they defined shame as a trait. One therapist did make a brief mention of it not being helpful to think of shame as pathological but rather "*to be curious about how it has been self-protective.*"

Shame – the Bad

The respondents all felt that negative issues from shame were extremely common. One major way shame presented was with self-critical identity issues. The therapists' clients described themselves as being "*broken, weak, wrong, terrible, stupid, etc.*" Their clients also described the feeling of isolation that shame brought, "*nobody likes me, nobody cares about me, I'm all alone, I'm invisible, I'm unlovable, etc.*" This also translated into clients feeling that they did not deserve things that other people did. One therapist described this as her clients having "*a special set of rules for themselves that are all negative.*" In eating disorders, this looked like "*I don't deserve to eat.*" In others, one therapist described it as her clients *"don't deserve the pleasure and comfort that others deserve."*

Another negative issue with shame that the respondents noted were the relationship issues. The respondents all described difficulties that their clients have with relationships. This finding makes sense because shame is a social emotion, and having difficulties with this would affect the relationship field. The action tendency of shame is

to hide or withdraw (Tangeny et al., 2007).   This tendency showed up in the therapists'

clients as keeping secrets and not wanting people to get too close "*because they would*

discover how bad I am."

Some of the negative effect from shame is due to the defense against feeling

shame. Nathanson's Compass of Shame theory delineates four different ways to defend

against feeling shame with his four poles of the compass: attack self, attack others,

withdraw or avoid (Nathanson, 1992). Elison, Lennon, and Steven (2006) later added

adaptive as a fifth pole.

In this study, the most frequent mention of defense against shame had to do with

perfectionism, which was mentioned by some of the therapists. This would correspond

with the avoid pole in Nathanson's theory. Perfectionism is a way of avoiding or

defending against feeling shame. It is future related and has an anxiety component to it.

One of the therapists noted that perfectionism is culturally accepted and this increases the

tendency to implement it as a defense against shame. Another way to avoid is to

dissociate when shame is touched upon, and this was also mentioned.

The only therapist that mentioned anger as a defense against shame was the

therapist who did couples work. She noted that this would occur frequently when one

partner criticized the other partner. She felt that the criticism would trigger shame, which

would lead to anger. This corresponds to the attack other in Nathanson's theory and ties

in with the literature on shame-proneness being related to increased episodes of anger and

violence (as cited in Schoenleber, Sipppel, Jakupcak & Tull, 2014).

Shame – the Ugly

Shame has significant psychobiological effects, with increases in cortisol, proinflammatory cytokines and cardiovascular parameters such as heart rate and blood pressure. These effects can be part of the etiology of shame's association with mental illness. Chronic social threat/shame has also been shown to impact health outcomes such as HIV (Cole et al., 2001 as cited in Dickerson et al., 2009). Shame has been associated with depression, bipolar disorder, anxiety, post-traumatic stress disorder, substance abuse, eating disorders, violent behavior, domestic abuse, personality disorders, and suicidal ideation (Dearing & Tangney, 2011). These are the issues that therapists commonly see. As one therapist noted, *"I don't think I have had one client who has not had some shame stuff."* The significant association of shame with mental illness emphasizes the importance of learning more about shame and how to work with shame issues.

Working with Shame

There has been a lot of theorizing about shame, but much less research on working with shame in therapy (Tangney & Dearing, 2011). The respondents discussed what was helpful and what was not helpful in their work with clients' shame issues. The respondents were in agreement that just directly confronting clients' belief about their unworthiness or defectiveness was not useful. One therapist noted that even insight into what caused their shame although helpful, did not change the shame. They did feel, however, that it was important to support any part of clients that questioned their negative self-image or showed a belief in their value or connection to others. As one therapist put it, *"looking for the cracks in the stories…they believe about themselves."*

Therapists discussed a diversity of approaches to working with shame that they felt were helpful: normalizing a client's experiences, externalizing the voice of shame, resourcing, fostering relationship with the therapist, fostering relationship with family and others, group work, community involvement, mindfulness, compassion, spirituality, somatic work, and play therapy when working with children. When looking at the common factors in these diverse approaches, the unifying principle seems to be working on connection and relationship building.

Relationship. All eight of the therapists discussed the importance of relationship in working with shame issues. Relationship was mentioned as a key factor in their client's improvement. This makes sense because shame is about social threat and disconnection. The experience of connection is an experiential antidote to shame. Most of the approaches that therapists felt were helpful had an element of improving connection and relationship.

In individual therapy, this improvement of connection happens through the relationships with the therapists themselves. The therapists utilized positive regard, empathy and resonance with the clients' non-verbal body language to foster a safe, caring relationship. They created a space where secrets could be revealed without judgment and with the client feeling supported. Many therapists stated forming this relationship with some of their clients with severe shame issues was a long process over multiple years.

Fostering relationship with partners, children and other family members was noted to be important. Couples work with attention to couple dynamics, including externalizing the shame and uniting the couple against the externalized shame voice was

used. Helping parents work on parenting was also noted to be important. Forming a relationship with a pet was mentioned as helpful.

Group therapy is another place that relationship was fostered. In a group, clients may realize they are not the only one struggling with shame issues. This puts them in touch with their common humanity. Even without group therapy, sharing research or other clients' stories can help normalize feelings and symptoms, so clients realize they are not alone.

Relational work was also done in connecting clients with the wider community. Finding a place in the community, finding a purpose and way to contribute is important for feeling connected. Feeling that the wider community thinks you count and that you have value counters shame.

In addition to working with clients on their relationships with others, the inner relationship with self was an important area that therapists worked with. Three of the main principles that were mentioned were mindfulness, compassion and working somatically with the body. Mindfulness creates a space to witness and be present. It is in this ability to witness and be present that compassion can arise; compassion for that injured piece of themselves, for their past pain and separation. This attending to the self by the self creates an inner relationship with self that can be caring and loving in contrast to the self-critical voice of shame. Working with the body somatically helps foster a relationship with self through the body that creates more safety and ability to connect.

Spiritual relationship is the final relationship piece that the therapists discussed. The uniqueness of every person and the inherent value of every person was emphasized. Working in the framework of the clients' religious and spiritual beliefs and cultural

background was also discussed. One therapist noted that having more training, especially in the cross-cultural aspects of spirituality, would be helpful.

Shame in the Therapy Process

Shame arises in the process of doing therapy itself. Therapists discussed how they handle the inherent power differential in therapy by being collaborative, using judicious self-disclosure, pacing carefully, and being compassionate. They discussed the importance of managing their own shame issues by working on self-awareness, using supervision and consultation groups, doing their own therapy, being able to admit their own mistakes and staying resourced with good self-care and support.

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Conclusion

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Shame has been defined in multidimensional ways. It is described as a self-conscious emotion, a social emotion, a psychological construct with cognitive, emotional and behavioral components, an aspect of identity, a characterological trait, an evolutionary adaptation to facilitate group cohesion, a social threat warning system, a submissive appeasement display to repair relationship, a disruption in the attachment bond, a innate attenuator circuit, and an inhibitory response that shifts activation from the sympathetic to parasympathetic nervous system. In addition, shame is a common word used frequently in popular culture and has cultural context.   It is universally felt to be distressing and painful to experience and has been described to be both adaptive and maladaptive. This all makes the dialogue about shame complex.

Shame is culturally thought to be very negative and this is how the respondents in this study mainly thought of shame. The question of the adaptive versus maladaptive aspects of shame requires a more clear definition of shame to fully explore. Different

researchers have different opinions on whether shame can be adaptive based on how they conceptualize shame and what research tools they use. Adaptive shame is theorized to be an acute short-lived emotion that facilitates relationships. Maladaptive shame is associated with negative core-identity issues, maladaptive defenses against shame and increased risk of mental illness.

 One major downside to having a purely negative view of shame is that then it is easy to be ashamed of feeling shame. Shame as a hardwired emotional response is part of our human design. Making peace with shame as an acute emotion and learning to work with it might be the healthiest option.

Perhaps if we worked with shame as an emotional state somewhat like we work with fear, it might help in making peace with shame. Fear warns us of danger; we then use further evaluation to assess the threat. Is it a stick or a snake? Shame warns of us social danger. Have we harmed our social bonds or not? Are these important social bonds to us or don't they matter? Fear increases adrenaline and helps us to fight or to flee. Shame also affects us biochemically and helps us stop making the situation worse by stopping our actions and helping us withdraw. It also helps repair relationships by communicating with our distress that we take ownership of our offense. Responding appropriately to fear increases our safety. Responding appropriately to shame increases our social safety.

The problem with fear is that it can arise at inappropriate times such as in a phobia, or it can turn into chronic anxiety. The problem with shame is that it can arise at inappropriate times or it can foster a negative self-identity. We are meaning making beings, and the story we make of these emotions influences whether they are adaptive or

maladaptive. A maladaptive fear story describes the world as a dangerous place. A maladaptive shame story describes ourselves as unlovable.   Both fear and shame can destroy the present by projecting themselves into the future. Fear can turn into chronic anxiety and shame can turn into perfectionism or withdrawal. The fear of shame and the defenses that we implement against it may be worse than the shame itself, one example being violence against others.

Whether shame is adaptive or maladaptive is most likely due to the influence of early developmental experiences. The importance of good-enough parenting, and the importance of good-enough peer relationships need to be emphasized. The repair of shame may be the most important factor in how shame is managed. It is in the rapid return from the distress of shame that an infant learns to tolerate distressing emotions, learns to manage shame and creates an expectation that challenging social interactions will have a positive outcome. Attachment is intimately connected with shame issues.

Shame is ultimately about relationship. Shame is about our connection with others. As intensely social beings who evolutionarily equate the question, "Am I loveable?" with the question, " Am I safe?" shame highlights the essential nature of belonging and relationship (Cozolino, 2014, p. 285). The results of this study showed that relationship in its many forms was the most important aspect in working with shame. This included the relationship with the therapist, the relationship with family and others, the relationship through group work, the relationship with self, the relationship with the community and the relationship with God. The experiential antidote to shame seems to be establishing healthy relationship connections in many different forms. For an

individualistic culture such as ours, with as many difficulties as we have with shame, this dependence on relationship may require a shift in our perspective.

Strengths and Limitations

The qualitative nature of this study is a strength in allowing a more exploratory and in-depth approach to the experiences of psychotherapists. This allowed psychotherapists to express their experiences in their own words. The flexible approach in the interviews also allowed for exploration of themes that arose.

Limitations of this study stem from the small sample size of participants. This small size makes it difficult to generalize to a broader application. There may also be some bias in face-to-face interviews that may have impacted the process. Additionally as discussed previously, the multiple dimensions in the conceptualization of shame make it more difficult to interpret the information obtained.

Implications for Social Work Practice

Social work is about people and their relationships. Social workers interact with people at their most vulnerable, when they suffer from mental and physical illness, poverty, homelessness and other life crises. We work with people who have suffered from stigma and oppression. We need to be aware of how challenging shame can be in these situations. Shame difficulties increase when someone feels subordinate or there is a power differential. Social workers need to be aware of how challenging shame can be in any situation that causes a disruption in social bonds. Paying attention to the signals of shame is essential, including paying attention to defensive reactions to shame. We need to hold our clients in a collaborative relationship with respect and compassion. As

human beings, we also have our own relationship with shame that requires us to be self-aware.

Shame issues are important to consider at the micro, mezzo and macro level of social work. At the micro level, we need to be aware of how our relationship with the client impacts shame issues. At the mezzo level, we need to be aware of the importance of working in the community to increase social cohesiveness. At the macro level, it is important to advocate for the honoring of social bonds and relationship in the policies we support. This is especially true for supporting parents, infants and young children as their early experience lays down the pathways that affect shame in their maturing brains.

Future Research

In order to dialogue more effectively about shame, the definition and conceptualization of shame needs to be clarified. Different researchers approach it in different ways and this makes for a complex conversation. More research on the neurobiology of shame will be helpful here in teasing out exactly what is happening biologically with shame issues.

Shame as an emotion is discussed as if it has only one level of intensity. We describe anger as on a continuum from mild irritation to anger to full blown rage. Does shame have a continuum? How would it be described if it did?

More work on deciding if shame is adaptive or maladaptive and under what circumstances would helpful. There is a definite need to understand early childhood development regarding shame. How do we support effective parenting?

People are theorized to have many defenses to bypass feeling shame. More work to understand this and how this impacts mental health and other issues would be helpful.

School bullying and mass shootings are one area where research on this aspect of shame might have great impact.

Shame has many cultural implications. Cross-cultural research on shame issues would add insight. How do more collectivist cultures interact with shame versus more individualistic cultures? In what way does culture create more or less negative shame issues?

How do we help clients who are dealing with problems with shame, including core-identity issues and relationship difficulties? Further research with therapists who work with different populations would be helpful, including therapists who work with clients who have suffered from stigma and oppression. Interviewing therapists who work with couples and families and therefore have a chance to observe shame dynamics as they occur would be another avenue of research.

Finally, are we looking at the trees when we should be looking at the forest? Do we focus on shame in the individual without looking at the bigger system in which shame functions? In describing the state of research on shame, Gergan and Gergan (1988) note, "It is as if we have at our disposal a rich language for characterizing rooks, pawns, and bishops but have yet to discover the game of chess" (as cited in Leeming and Boyle, 2004, p. 382). Future research could explore the game of chess and look at shame with a more systematic lens.

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Appendix A – Consent Form

CONSENT FORM
UNIVERSITY OF ST. THOMAS

Shame the Hidden Emotion: Therapist's Perspectives

690149-1

I am conducting a study abou*t* shames issues as they present in psychotherapy*.* I invite you to participate in this research. You were selected as a possible participant because you are an experienced therapist with an active psychotherapy practice*.* Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Karen Hulstrand, MSW student (advisor Lance Peterson, Ph.D., LICSW, University of St. Thomas, School of Social Work).

Background Information:

The purpose of this study is: To explore issues surrounding shame as they present in psychotherapy. This is a qualitative, exploratory study to add to the understanding of how shame presents in therapy and what methods are helpful in addressing shame issues.

Procedures:

If you agree to be in this study, I will ask you to do the following things: Participate in a one time 45-60 minute interview. This interview will be audiotaped and transcribed. Audiotape and transcribed material will be destroyed after the project is finished.

Risks and Benefits of Being in the Study:

Being in the study has minimal risks. Discussion of shame issues could have a small possibility of eliciting emotional distress. If this were to happen you may receive phone-counseling help through Crises Connection 612-379-6363 or be seen at the Walk-In-Counseling Center (www.walkin.org), 612-870-4169.

The direct benefits you will receive for participating are: No direct benefits.

Confidentiality:

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way.   The types of records I will create include a recording of the full interview, notes from the interview and a transcript of the audio interview.   A transcriptionist who has signed a confidentiality agreement will transcribe the interview.   These will be kept on a password-protected computer and the

recording, project notes and transcript will be destroyed/deleted by June 1st, 2015 on completion of the project. The consent forms will be kept for three years in a locked file cabinet and then destroyed.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of St. Thomas. If you decide to participate, you are free to withdraw at any time up to and until 10 days after the interview. You may withdraw by calling or e-mailing me at the contact information noted below. Should you decide to withdraw data collected about you will not be used. You are also free to skip any questions asked during the interview.

Contacts and Questions

My name is Karen Hulstrand. You may ask any questions you have now. If you have questions later, you may contact me at xxx-xxx-xxxx or my advisor Lance Peterson xxx-xxx-xxxx. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6038 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to have my interview audiotaped.   I am at least 18 years of age.

_____   _____
Signature of Study Participant   **Date**

_____
Print Name of Study Participant

_____   _____
Signature of Researcher   **Date**

Appendix B – Interview Questions

1. How many years have you been in practice?

2. What is your degree and what has your training been?

3. Do you have any particular therapeutic orientation or have training in any specific

approaches?

 4. How do you define/conceptualize shame?

5. How do you see shame present in your practice?

6. What approaches have you found to be helpful or not helpful in working with a

client's shame?

       Probe – examples?

       Probe – alternative approaches?

7. In psychotherapy there is a power differential, which can increase possibilities of

shame. In what way do you observe this in your practice?

8. To what extent have you experienced transference or countertransference in working

with shame?

                                 Probe: Examples?

9. How do you manage your own shame in the context of doing psychotherapy?

10. Do you have any additional thoughts about shame? Any questions I have not asked?