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EDEL FRAWLEY

SHAME: THE MIST OF THE THERAPY ROOM

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SUPERVISOR: HEATHER MOORE

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TABLE OF CONTENTS

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In danger the holothurian splits itself in two: it offers one self to be devoured by the world and in its second self-escapes.

In the middle of the holothurian's body a chasm opens and its edges immediately become alien to each other.

On the one edge, death, on the other, life. Here despair, there, hope.

To die as much as necessary, without overstepping the bounds. To grow again from a salvaged remnant.

Here a heavy heart, there non omnis moriar, three little words only, like three little plumes ascending.

[Szymborska, 1983. pp. 115–116]

ABSTRACT

Shame is an innate affect built into human nature by evolution, with the purpose of protecting the self and social relationships. Adaptive shame is healthy and crucial for self-identity and navigating relationships with others. However, core shame or toxic shame can result from repeated inappropriate shaming during childhood. In this dissertation the author seeks to uncover the neurophysiological and psychological development of shame in order to determine how a therapist might recognise deep-rooted shame in their clients. The neurophysiological development is looked at through Stephen Porges' polyvagal theory. The psychological construct presented is informed by object relations theory and attachment theory. Defence mechanisms which are commonly used to control, avoid or deny shame are explored in order to identify patterns which might point the therapist towards the presence of core shame. The therapeutic implications of shame are explored along with a number of approaches which have been considered useful when working with shame.

INTRODUCTION

Helen Block Lewis (1971) first shed light on the importance of shame by differentiating self-conscious emotions including guilt and shame, which were previously understood to be the same emotions. Even though the importance of shame and its strong association with psychopathology (Cândea & Szentagotai-Tatar, 2013) is now recognised, there is only limited material available on "how to best recognize, manage, treat or capitalize on shame in the therapy hour" (Tangney & Dearing, 2011, p. 375).

Studies have made the distinction between different levels of shame, ranging from a mild 'normal' experience (Tangney & Dearing, 2011) to a "sickness of the soul" (Kaufman, 2004, p. 5). In the therapy room, shame is sometimes explicit for the client (Tangney & Dearing, 2011), sometimes it is conscious but concealed (Bauman & Hill, 2016) and it can also be a completely unconscious state of being (Tangney & Dearing, 2011). Regardless of how it presents, researchers and clinicians agree that shame is prevalent in clinical settings (Mollon, 2002).

Although there are some clinical guidelines available on how shame should be approached in a therapeutic setting (such as Dryden, 1997), the majority of literature available only briefly discusses the maladaptive nature of shame (Teyber, McClure, & Weathers, 2011). This is very concerning as shame can easily be missed or avoided in the therapeutic space (Tangney & Dearing, 2011) which can be very damaging for the client (Baldwin, 2014). Therefore through an exploration of the genesis and development of core shame, this paper aims to uncover how a therapist might identify manifestations of shame. Once shame can be identified, the therapeutic implications of working with core shame will be considered.

Chapter One will focus on the neurophysiological development of shame from the point of view of Stephen Porges' Polyvagal Theory. The close connection between shame and trauma will also be explored.

Chapter Two Although shame is a universal emotion (and is particularly prevalent in people who seek out therapy), people rarely present at therapy announcing that they are experiencing shame (Lewis, 1971). By exploring object relations theory and attachment theory, this chapter will focus on the psychological construct related to the development of shame and how therapists might leverage this knowledge to recognise conscious or unconscious shame. Recognition of shame through defence mechanisms frequently employed to avoid, control or deny shame will be explored as well as in the transference and countertransference enactments. More explicit cues of shame will also be discussed.

Chapter Three will look at the clinical implications of working with clients living through a lens of shame. It is important for a therapist to understand how shame has coloured their clients way of being as it will impact the therapeutic space. Recommendations for working with shame from a variety of theoretical orientations will also be shared.

As a trainee psychotherapist, it is hoped that this paper will clarify and highlight the complexity of core shame so that it will assist therapists working with shame based clients.

The aim and objectives of the dissertation may therefore be summarised thus:

Aim:

The purpose of this study is to clarify how to work with shame therapeutically supported by existing literature and to establish therapeutic parameters for a therapist to work within.

Objectives:

1. To identify how the therapist might safely and sensitively uncover a client's shame, particularly unconscious shame.
2. To establish therapeutic parameters for a therapist treating shame to work within.

CHAPTER 1: THE NEUROPHYSIOLOGICAL DEVELOPMENT OF SHAME

The sympathetic system (fight or flight) and the parasympathetic system (rest and digest) are the two branches of the autonomic nervous system (Davis, Eshelman, & McKay, 2000). Together these branches are responsible for the body's emotional experiences such as stress, fear, relaxation, courage and panic (Davis et al., 2000). Porges (2001) the founder of Polyvagal Theory, proposes that the body's emotional experiences and the responses of the autonomic nervous system (ANS) occur in hierarchical order based on mammalian evolution. The aim of the ANS is to protect, and it uses what Porges (2011) calls neuroception to continually evaluate risk. According to Porges (2011) neuroception is the process whereby neural circuits sense safety, danger, and life threat based on what is happening in and around the body, and subsequently triggers a response that optimizes survival. This takes place automatically without conscious awareness or using the cognitive part of the brain (Perez & Sundheim, 2018).

When mammals are feeling safe, their physiology shifts to a state that down-regulates their defences so they can function from their social engagement system (SES), via the upper part of the vagus nerve, the ventral vagus nerve (Geller & Porges, 2014).The ventral vagus nerve is responsible for gestures of social engagement such as the muscle movement of eye lids and mouth, middle ear muscles and head-turning muscles (Shahri, 2013). If threat is sensed it causes the SES to switch off, and in preparation for fight or flight the second complex in the hierarchy is activated i.e. the sympathetic branch of the ANS (Porges, 2011). If the threat is too overpowering for either a fight or flight response to secure safety, the most primitive part of the parasympathetic system engages via the dorsal vagus nerve (Shahri, 2013). The dorsal vagus nerve triggers an immobilisation response to threat by depressing activity, such as feigning death and dissociating (ibid.). During a traumatic event, when the victim moves down into this very primitive freeze or shutdown state, they feel paralysed; this is also known as fear induced tonic immobility (Möller, Söndergaard & Helström, 2017).

As humans have a natural "desire to make sense of our immediate experience, our life, and our world" (Chater & Loewenstein, 2016) what was a "wordless" neuroception, ends up as a story or a narrative to explain why a traumatic event occurred (Dana, 2018). Self-beliefs that a victim has and narratives they create about the event can become tangled up with the pain of the traumatic event itself (Rothschild, 2000). Levine (2012, p.60) states that "self-blame and self-hatred are common among molestation and rape survivors, who judge themselves harshly for not "putting up a fight", even where fight was not a viable survival option".

This is shame.

Shame and trauma are closely connected. Rothschild (2000) posits a strong correlation between trauma and the tendency to internalise feelings of shame. Additionally, a number of studies have found that shame and maladaptive shame regulation strategies may play an important role in the maintenance or exacerbation of symptoms of trauma (Moller et al., 2017). This may be partly due to shame preventing individuals from seeking the treatment that they need, because they feel the need to hide, to stay silent, to keep secrets, rather than seek the support they need (Bennett, Sullivan & Lewis, 2010).

Consider childhood abuse or developmental trauma; the relationship between childhood neglect, abandonment and emotional abuse and high levels of shame proneness associated psychopathology have been cited by many theorists (Bennett et al., 2010). When a child is at the hands of any form of abuse, they typically take on the guilt and shame of the adult and this is often carried into adulthood (Deblinger & Runyon, 2005).

Children who are physically harmed by their caregivers often deduce that they caused the maltreatment for misbehaving and being 'bad' (Celani, 1999). Herman (1992) postulates that the tendency for the child to self-blame in these situations may have a protective function in that it gives the child a sense of control over the abuse. However this strategy is often not very

effective as parents who engage in physically abusive behaviour tend to be inconsistent and unpredictable (Carlson, 1998), therefore the child's change in behaviour might not protect them. As the child continues to be physically punished despite having changed their behaviour, they then believe they are being punished because there is something fundamentally wrong with them (Deblinger & Runyon, 2005). The child is experiencing shame either because of their behaviour or as a result of the response of a significant other to them (ibid.). Shame "tends to create a lens of believing oneself to be bad or deeply flawed" (Robertson, 2019, p. 1).

Research suggests that the shame experience results from the activation of the shutdown state following the activation of the SES (Shahri, 2013). Consider the following example. If a little boy "misbehaves" by accidentally spilling his milk, and his overwhelmed mother yells at him and calls him a naughty boy and his response is to cry, this is his SES prompting him to re-engage with his mother by enticing her to protect him (Porges & Furman, 2011). If his mother's response is even more anger, the boy would then move from his SES down into fight or flight mode, particularly if this is becoming a pattern of response by his mother (ibid). In this case, the little boy is developing a disorganised attachment with his mother and neither his SES nor fight or flight will re-establish a safe reconnection with her. The boy will then experience fear induced tonic immobility (Porges, 2011) where he will adapt the "shaming stimuli" i.e. his mother's response or his rapid heartbeat (Porges & Furman, 2011).

At this point, the child has experienced a dorsal vagal "drop" from sympathetic hyperarousal to parasympathetic hypoarousal (Porges, 2011). The child is now in the shame state, which has striking resemblances to depression – there is a marked lifelessness, an "inner deadness" (Shahri, 2013, p. 59). The shamed boy's lifelessness matches his story that he is 'bad' i.e. the shame state is matching the messages he is hearing, such that he not only 'feels worthless' but believes he is worthless (van der Kolk, 2015). When the child engages with self-blame, this reinforces the state of shame which reinforces the state of the ANS system in this shut down

mode (Deblinger & Runyon, 2005). The freeze of shame has survival value for the boy, allowing him to get through this intolerable situation. However, even when this event passes, this trauma and associated shame is imprinted on the body leaving the little boy hyperaroused and fearful, thereby undermining his sense of safety and resulting in an impaired neuroception (van der Kolk, 2015; Porges, 2011).

Shame is externally imposed on to the victim, it comes from the outside in; it comes from people who have some power 'over' the victim (Roberston, 2019). Shame and fear induced tonic immobility are very similar experiences; both cause a host of uncomfortable feelings in the body, including an urge to run, hide or shutdown, feelings of rejection, disgrace and self-disgust (Moller et al, 2017). Shame becomes a way of being, and can often be physically noticed in the person's posture whereby they look smaller by tucking in their shoulders, or crossing their legs (Roberston, 2019). According to Levine and Frederick (1997) disgust is a natural biological signal to the body to start the healing process by trying to rid the body of shame. However Porges (2011) claims that as this involves moving back up into the aroused sympathetic nervous system, the uncomfortable feelings which come up with sympathetic arousal, such as anxiety, can be too overwhelming and the person can becomes stuck in the shutdown/shame state.

While the focus of this chapter was placed on the neurophysiological development of shame, the physiological and psychological aspects are intertwined. The next chapter will focus in detail on the psychological development of shame and its subsequent manifestations.

CHAPTER 2: SHAME AND PSCYCHOLOGICAL DEVELOPMENT

Adult shame is a very complex, multidimensional emotion that is universally experienced as distressing and painful (Taylor, 2015). It has been described as both adaptive and maladaptive, depending on circumstances (Leeming & Boyle, 2013; Dickerson, Gruenewald & Kemeney, 2004). According to Rodogno (2008) adaptive shame is an innate affect which can help with relationships by recognising and navigating social threats. Shame is crucial to an individual's social existence and self-identity (Tangney & Dearing, 2003). On the other hand, studies agree that maladaptive shame is painful and destructive, and likely to be the result of this natural affect taking on negative psychological meaning as a result of becoming entangled with frequent and inappropriate shaming experiences during childhood (Dickerson et al., 2004; Nathanson, 1994).

According to Geller and Porges (2014) effective therapy can only occur when a client is feeling safe and secure. Therefore, as shame is widespread in clinical settings (Mollon, 2002) it is extremely important that therapists thoroughly understand shame so that they can recognise it in their clients and in the therapeutic space. The school of object relations which is based on the belief that all humans are inherently relational (Danzer, 2015) can offer some valuable insights on the development and subsequent manifestations of shame.

The term "object" represents real external others in the world and also internalised images of others (Shahri, 2013). Object relationships are formed through interactions with significant others (objects) during development (ibid.). Klein focused on the impact of the earliest dyadic internalised relationships between the self and significant others, namely the child and mother figure, on the formation of a person's inner world including their motivations and behaviour (Mitchell, 1987). Fairbairn popularised Klein's theories and formally introduced the term "object relations theory" in 1952 (Shahri, 2013). However, contrary to traditional

psychoanalytic theory, Fairbairn argued that libido is not pleasure-seeking but object-seeking, thereby replacing the demonic infant with a needy infant (Celani, 1999). Fairbairn believed that the quality of internalised objects, the relationship between self and objects, shaped adult personality and the likelihood of developing psychopathology (ibid).

Shame Is an attachment emotion that develops from the emotional experiences a child has with their significant others (Schore, 2003; Lewis, 1981). When a primary caregiver fails to provide their child with adequate affective attunement, it can lead to the child experiencing themselves as unworthy and shameful (Hahn, 2000). Consider the example in chapter one of the little boy who is scolded by his mother for spilling his milk, who at this stage of development is beginning to recognise himself as an object of evaluation by another (Schore, 2003). Repeated attunement failures such as this can result in the creation of beliefs that one's affective needs are unacceptable (Basch, 1985 as cited in Schore, 2003). The same outcome can result from a toddler's disappointment in their caregivers attunement to pleasure (Broucek, 1982). Consider a toddler running to their caregiver expecting love, but is instead met with coldness, communicated with the absence of a smile and a stern face, denoting a negative emotional state to the child. Schore (2003) states that the:

> shock of shame results from the violation of the infant's expectation of affective attunement based on a memory of the last comfort with the mother that was energising, facilitating and rewarding for the grandiose self (p. 160).

However, it is as the child becomes distressed that their caregivers response becomes even more important (ibid.). If the child's distress or averted gaze successfully elicits soothing from their caregiver, this can initiate shame recovery and begin to build an internalised mechanism in the child to regulate shame states (ibid.). But, if the caregiver responds with rejection, and this is a repetitive pattern, this can activate polarised object relations of devalued and devaluing introjects (Hahn, 2000). The self's devalued introject feels that there is something

fundamentally wrong with them, that they are inferior and inadequate (ibid). The feeling of shame results from the self's identification with the contemptuous attitude of the devaluing object towards the self (Scharff, 2001). The therapist might notice this in their client's self-appraisals with words such as 'bad' or 'not good enough' (Cândea & Szentagotai-Tatar, 2013) .This internalisation can greatly threaten the emotional bond between the child and their caregiver resulting in an insecure attachment and an inability to regulate shame and other strong emotions (Schore, 2003). When a child has a secure attachment with their primary caregiver, they feel loved and valued by others which makes them feel safe and accepted (Goldblatt, 2013). However, when a child has an insecure or disorganised attachment, they feel unloved and unvalued, and their (social) self is threatened with rejection which has a strong bearing on their stress response (ibid.). This extremely painful experience can trigger complex defence mechanisms, but defences which can become more predictable for a therapist (Hahn, 2000).

In addition to the internalisation of shame, there is a second type of shame which constitutes the shame experience, that is external shame (Matos, Pinto-Gouveia & Duarte, 2013). External shame is defined as how an individual believes they are viewed in the minds of others, they might feel they are seen as inferior, as worthless or bad (Matos et al., 2013). It is important for the therapist to recognise this as clients who experience maladaptive external shame perceive the world including the therapeutic space to be unsafe, as they are constantly being judged and rejected (ibid.). In order to counteract how they believe they are seen, they try to positively influence their image in the mind of others, therefore the therapist might notice defensive strategies such as submissiveness or appeasement (ibid.). Gilbert (2003) posits that internal shame is a major defence mechanism used to defend against external shame. As internal shame involves critical self-blaming, it is employed to keep the self safe from external shame (Gilbert, 2003).

There are a number of other defence mechanisms that the maladaptive or toxic shame experience can activate (Gilbert, 2007). In Freud's theory of intrapsychic projection, he described it as a psychological defence mechanism whereby one "projects" what they do not like in themselves and hang it on another e.g. their undesirable thoughts & motivations. If projection is employed to defend against overwhelming shame, this would involve externalising one of the internal representations discussed earlier i.e. the devalued self or the devaluing other (Mollon, 1986). If the devaluing object is externalised, the therapist might notice withdrawal and avoidance responses, which would aim to protect the self from external others who are perceived as critical and condemning (ibid.). Thin-skinned narcissists who are shame prone may behave similar to this, they will be hypersensitive and easily hurt in therapy (Bernardi & Eidlin, 2018). On the other hand, if the devalued self is externalised, the sense of defectiveness and inadequacy will be deflected on to others, and the therapist might notice aggression in the form of envy or rage (Morrison, 2014). The client's inability to regulate anger or their lack of tolerance for negative affect may act as signals to the therapist (Schore, 2003). This type of personality is sometimes referred to as thick-skinned narcissism (Bernardi & Eidlin, 2018).

According to Schore (1994, p. 207) "narcissistic personality disorders who have difficulty modulating rage typically present a background with a parent who humiliates the child by harsh, continuous, or massive exposure". If a lot of anger is present in the environment, powerful shame from the past may emerge in the transference and trigger narcissistic rage or violence (Goldblatt, 2013). As the state of shame relates to the global self, the entire self feels under attack, and as a response, rage can be demonstrated by the client to hide feelings of helplessness and ward off this detrimental threat (Gilbert, 2010). As these individuals can end up isolating themselves from others, they can sometimes see themselves as self-sufficient, a

narcissistic response so that they feel they have control and power over their lives (Bromberg, 2001).

Due to the nature of shame and its power to disrupt social connection, projective identification can often be used to cope with the two opposite feelings that are created by the internal dyad of the devaluer and devalued (Hahn, 2000). Klein's concept of projective identification often comes with splitting, and it is an extension of Freud's projection, whereby feelings are cut off and either found or induced in someone else or an external source (Obholzer & Roberts, 2004). This can be a more effective defence than projection as it can satisfy a longing that lingers to re-establish object ties (Lewis, 1987). If this occurs in the therapeutic space, the client's externalised devalued or devaluing representations can trigger the therapist's unresolved shame which can lead to countertransference identifications and enactments (Goldblatt, 2013). If the therapist takes on the feeling of inadequacy, they might start making what they feel are embarrassing mistakes (Hahn, 2000). The therapist might also notice this in their own somatic expression, where they feel themselves blush or they start to avert their own gaze (ibid.).

In the case of severely traumatised clients, all of their interpersonal interactions might be shaped around perceived levels of criticism, or the experience of embarrassment or humiliation (Zaslav, 1998). Shame is often experienced as a secret, painful state of mind for victims of any form of abuse, shame can present as an attack on the self or a wish to hide or die (Gutierrez & Hagedorn, 2013). As a result, clients may withhold feelings of shame from their therapists either for fear of becoming overwhelmed and subsequently rejected, or because they have difficulty expressing their emotions (Tangney & Dearing, 2011). These clients may also have difficulty trusting their therapist (Goldblatt, 2013).

Consequently, Lewis (1971) called shame the 'sleeper' emotion in therapy because of its silent nature. However, there is consistency across the literature around general cues that might help

the therapist recognise that the client is experiencing underlying shame (Tangney & Dearing, 2011). Some of the more obvious and apparent bodily signals include downward head movements and a client's gaze aversion, which may indicate an urge to fight or flee against potential early trauma (Lewis, 1971). The therapist might also notice signs of discomfort through awkward laughter and a general resistance or avoidance of "here-and-now" material (Tangney & Dearing, 2011).

As this chapter has illustrated, the psychological development of shame is complex and the resulting defence mechanisms can be extreme. However, if the therapist can see past these defences and identify shame, the real psychotherapy work can begin (Guntrip, 2018). The next chapter will focus on the therapeutic implications for the therapist and client when shame enters the therapeutic space.

CHAPTER 3: THE IMPLICATIONS OF SHAME ON THERAPY

The very context of psychotherapy treatment lends itself to triggering shame from a myriad of sources (Tangney & Dearing, 2003). By being aware of the various angles that might bring up shame for clients, therapists might be able to enhance their effectiveness (Mollon, 2002). Although there has been a significant societal movement to lessen the public stigma associated with having psychological difficulties or mental ill health, clients themselves can feel self-stigma in presenting for a therapy which essentially offers to help them repair themselves (Crowe, Mullen & Littlewood, 2018). It is not surprising then that many people are secretive about attending therapy, as they fear others will judge them in the same way as they judge themselves, in need of repair and defective (Crowe et al., 2018). Once the client engages in therapy, the work itself has an intense focus on self and goes after what is most hidden and painful (Tangney & Dearing, 2011). This can feel very shameful for the client, they are exposing what they might feel is their worst self with somebody they see as having mastered their mental health (Mollon, 2002). This is further complicated by the shame associated with feeling ashamed (Lansky, 2003). Therapy related shame can also extend beyond the therapeutic space, affecting close family and friends (Tangney & Dearing, 2011). Family and friends often have concerns about the client and therapist discussing them and how they will be seen (ibid.). If the therapist is attuned to the client and has a good sense of the client's level of tolerance, sensitively inquiring about therapy associated shame can open up an opportunity for the therapist and client to regulate this distress together (Mollon, 2002).

In chapter two the relationship between the internalised angry shaming caregiver and the ashamed self was discussed. This internalisation can affect the "here and now" as these dynamics may be re-experienced in the therapeutic space (Mollon, 2002). As these dynamics can be intolerable for the client, they might try to attack and destroy the therapy. The client might do this by using projection or projective identification (ibid.). If the client manages to

induce the therapist into acting out their externalised introject i.e. complementary countertransference, this can result in a relational pattern that might feel very satisfying for the client, but which comes at a grave cost to them both (Hahn, 2000). In this situation, therapists are not aware of their own shame and the dyad develops as the therapist is unable to contain their own shame, so they avoid it (ibid.). As a result, the shame can go into hiding in the therapy space (Mollon, 2002). This has serious implications for therapy as the client's shame and defences are not explored, and important topics may be left outside the therapy room (ibid.). Lewis (1971) found that very often what was behind negative therapeutic reactions and gridlock was invisible and unacknowledged shame. The importance of this is well portrayed by Guntrip (2018) "Only when the therapist finds the person behind the patient's defences, and perhaps the patient finds the person behind the therapist's defences, does true psychotherapy happen" (p. 352).

However, if the therapist can attune to the countertransference, they might be able to detect their client's shame through states of feeling ashamed, of shaming or of feeling contemptuous (Mollon, 2002). For example, if the client projects their shame on to the therapist by attacking them for not making enough progress or for doubting their capabilities, and the therapist can contain these projections, it can help create an environment of safety for the client (ibid.). This can open up a valuable opportunity to help the client feel supported enough to find the courage to explore their shame (Jordan, Walker & Hartling, 2004). But if this fails to happen and the therapist also feels disappointed, the therapist needs to be very careful that they do not indirectly shame the client and create a disappointed therapist – disappointing client dynamic (Mollon, 2002).

According to Schore (2003) therapists treating clients with high levels of shame should focus on repair and closely attune at a nonverbal and emotional level, so they can help a client feel safe if they sense fear for example. Mollon (2002) advises that the therapist should aim to break

the client's pattern of projecting unwanted parts of their mind or personality into the therapist, by gently processing these split off parts so that there can be more integration. When therapy works, the client will gradually become more self-aware and self-accepting and as a result they will be less vulnerable to unconscious forces which drive repetitive patterns of emotion and behaviour (ibid.). However if this fails to happen, it can be very painful for both the client and therapist and it may result in a negative therapeutic reaction, or even termination of the treatment (Goldblatt, 2013).

Various approaches that therapists can use to help their clients cope with shame have been considered across the different theoretical orientations. There is common agreement amongst the orientations of the importance of the therapeutic relationship; that an environment of support, validation and empathy is necessary for the client to feel safe enough to allow themselves to acknowledge and experience feelings of shame (Tangney & Dearing, 2011). Rothschild (2000) claims that shame does not release like other emotions; instead of discharging, it seems to dissolve when the client is able to verbalise it and when it is treated with acceptance and empathy. Uncovering hidden shame and helping the client to express it verbally can help reduce the pain of shame (Tangney & Dearing, 2011). However, Greenberg and Iwakabe (2011) caution that this must be carefully managed as bringing the client's attention to shameful experiences can cause them to retreat further. Conversely, Cândea and Szentagotai-Tatar (2013) argue that given the relationship between shame and psychopathology, therapists should approach shame in a very explicit manner in the therapeutic process. Van Vilet (2008) claims that a therapist's ability to connect, refocus, accept and understand are crucial in supporting a client to move from a toxic globalised shame state to a healthy shame state.

Pascal-Leone and Greenberg (2007) also believe that it is only by confronting shame and working through issues in therapy will its impact be lessened and the globalisation of shame diminished. Rothschild (2000) considers forgiveness of others and of the self as a victim as an important factor in the recovery of shame while Fisher and Exline (2010) claim resistance to forgiveness as contributing to its defence. A number of cognitive behavioural therapy interventions aim to reduce shame inducing cognitions by challenging the processes that mediate the relationship between shame and psychological symptoms (Joireman, 2004). Cândea and Szentagotai-Tatar (2013) discuss supporting clients to acknowledge their worth rather than their short comings with a technique called the "shame attacking" exercise, which aims to support clients to overcome their underlying dysfunctional beliefs. However, Porges (2011) concept of neuroception implies that core shame requires more than cognitive challenging and perhaps looking at how shame healing might occur by engaging the social engagement system through facial expressions such as smiling and prosodic vocalisations. Many shame researchers advocate that developing self-compassion towards oneself, which is often missing in shame prone clients, is necessary for successful treatment (Gilbert, 2010; Brown et al, 2009). It is believed that 'self-soothing' and soothing from others can relax the stress system and subsequently shame based self- criticism can be replaced with compassionate self-correction (Gilbert, 2010).

CONCLUSION

The premise of the current research was to uncover the development of core shame in order to understand how it might manifest in the therapeutic space. The neurophysiological and psychological development of core shame were explored which revealed the parallels and interweaving processes that occur in the body and mind. The therapeutic implications and various approach of working with shame were then discussed .

Starting with the neurophysiology of shame in accordance with the polyvagal theory, an exploration of the autonomic nervous system (ANS) revealed how the body adapts as the level of threat is increased. The ANS responds to threat in a hierarchical order based on what it picks up through a completely unconscious process Porges called neuroception. As the level of threat increases, the response moves from the safety of the social engagement system (SES), down to the mobilised sympathetic nervous system (SNS) and if all else fails, to the immobilised parasympathetic nervous system. During the shame experience, the body goes into the immobilised shutdown state. While in this state beliefs, self-blaming and destructive narratives become entangled with the physiological state. Shame now lives deep in the body and attempts at ridding it and returning to the safety of the SES can be rebounded by the uncomfortable symptoms generated by the charged SNS encountered on the way.

In the second chapter, the psychological construct of shame was looked at through object relations and attachment theory. The focus was placed on the development of the internalised relationship between the devaluing object and the devalued self. The self often tries to cope with this dyad by unconsciously externalising either the devaluing object (i.e. judgemental or critical) or the devalued (worthless or inadequate) self. This results in the development of a false-self constructed by defence mechanisms, which try to ward off the painful feelings of shame. It is very important for the therapist to have this understanding of shame as clients do

not tend to present to therapy with the objective of working with their shame, very often they are completely unaware of it. Shame can emerge in the transference and countertransference enactments, it is often in the shadows of what the client presents. The therapist may also identify shame through more general cues such as the client's somatic expressions or resistances or changes to their own soma.

In the final chapter, the therapeutic implications of working with a client who is shame based were discussed. The very nature of psychotherapeutic treatment is shame inducing for a number of reasons, from the client's self-stigma for 'having' to attend therapy or the feeling of laying themselves bare in front of a completely dignified other. This chapter emphasises the importance of the therapist knowing their own shame, or the potential consequences of the client's shame resonating with their own unresolved shame. Finally, various approaches that have been found to be helpful when working with clients with deep-rooted shame were discussed. Even though there are a variety of ways in which shame can be worked with in therapy, the effectiveness of these shame-focused interventions is not clear (Tangney & Dearing, 2011). The selection of the optimal strategies and techniques for tackling shame for each unique client is unclear. In addition, further research might facilitate an understanding of how Porges' polyvagal theory might be integrated in order to work with core shame at a physiological and psychological level.

REFERENCES

Baldwin, E. N. (2014). Recognizing Guilt and Shame: Therapeutic Ruptures with Parents of Children in Psychotherapy. *Psychoanalytic Social Work*, *21*(1/2), 2.

Baumann, E. C., & Hill, C. E. (2016). Client concealment and disclosure of secrets in outpatient psychotherapy. *Counselling Psychology Quarterly*, *29*(1), 53-53–75. https://doi.org/10.1080/09515070.2015.1023698

Bennett, D, S., Sullivan, M, W., & Lewis, M. (2010). Neglected Children, Shame- proneness, and Depressive Symptoms. Retrieved April 28, 2020, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3771652/

Bernardi, R., & Eidlin, M. (2018). Thin-skinned or vulnerable narcissism and thick-skinned or grandiose narcissism: Similarities and differences†. *International Journal of Psychoanalysis*, *99*(2), 291.

Bromberg, P. M. (2001). Treating Patients with Symptoms—And Symptoms with Patience. *Psychoanalytic Dialogues*, *11*(6), 891. https://doi.org/10.1080/10481881109348650

Broucek, F. J. (1982). Shame and its relationship to early narcissistic development. *International Journal of Psychoanalysis*, 65(2), 369-378.

Brown, M. Z., Comtois, K., Linehan, M., Murray, A., & Chapman, A. (2009). Shame as a Prospective Predictor of Self-Inflicted Injury in Borderline Personality Disorder: A Multi-modal Analysis? *Behavior Research Methods*, *47*, 815–822.

Cândea, D., & Szentagotai-Tatar, A. (2013). Shame and psychopathology: From research to clinical practice. *Journal of Cognitive and Behavioral Psychotherapies*, *13*, 101.

Carlson, E. A. (1998). A Prospective Longitudinal Study of Attachment Disorganization/Disorientation. Child Development, 69(4), 1107–1128. https://doi.org/10.1111/j.1467-8624.1998.tb06163.x

Celani, D. P. (1999). Applying Fairbairn's Object Relations Theory to the Dynamics of the Battered Woman(*). *American Journal of Psychotherapy*, *53*(1), 60. https://doi.org/10.1176/appi.psychotherapy.1999.53.1.60

Chater, N., & Loewenstein, G. (2016). The under-appreciated drive for sense-making. *Journal of Economic Behavior & Organization*, *126*, 137–154. https://doi.org/10.1016/j.jebo.2015.10.016

Crowe, A., Mullen, P. R., & Littlewood, K. (2018). Self-Stigma, Mental Health Literacy, and Health Outcomes in Integrated Care. *Journal of Counseling & Development*, *96*(3), 267–277. https://doi.org/10.1002/jcad.12201

Dana, D. A. (2018). *The Polyvagal Theory in Therapy: Engaging the Rhythm of Regulation (Norton Series on Interpersonal Neurobiology)*. W. W. Norton & Company.

Danzer, G. (2015). Integrating Object Relations and Alcoholics Anonymous Principles in the Treatment of Schizoid Personality Disorder and Co-Occurring Alcohol Dependence. *Journal of Theory Construction & Testing*, *19*(2), 55–64.

Davis, M., Eshelman, E. R., & McKay, M. (2000). *The Relaxation & Stress Reduction Workbook*. New Harbinger Publications.

Deblinger, E., & Runyon, M. K. (2005). Understanding and Treating Feelings of Shame in Children Who Have Experienced Maltreatment. *Child Maltreatment*

Dickerson, S. S., Gruenewald, T. L., & Kemeny, M. E. (2004). When the Social Self Is Threatened: Shame, Physiology, and Health. *Journal of Personality*, *72*(6), 1191.

Dryden, W. (1997). Overcoming shame. London: Sheldon Press.

Fisher, M. & Exline, J. (2010). Moving Toward Self-Forgiveness: Removing Barriers Related to Shame, Guilt, and Regret. Social and Personality Psychology Compass. 4. 548 - 558. 10.1111/j.1751-9004.2010.00276.x.

Garland, C. (2010). *The Groups Book: Psychoanalytic Group Therapy : Principles and Practice*. Karnac Books.

Geller, S. M., & Porges, S. W. (2014). Therapeutic presence: Neurophysiological mechanisms mediating feeling safe in therapeutic relationships. *Journal of Psychotherapy Integration*, *24*(3), 178–192. https://doi.org/10.1037/a0037511

Gilbert, P. (2010). *The Compassionate Mind*. London, England: Constable.

Gilbert P. (2007). The evolution of shame as a marker for relationship security: A biopsychosocial approach. In J. L. Tracy, R. W. Robins, & J. P. Tangney (2013), *The self-conscious emotions: Theory and research*, (pp. 283-303). New York, NY: Guilford Publications.

Gilbert, P. (2003). Evolution, social roles, and differences in shame and guilt. *Social Research*, 70, 1205–1230.

Goldblatt, M. J. (2013). Shame in psychodynamic psychotherapy of post-traumatic states. *Scandinavian Psychoanalytic Review*, *36*(2), 104-104–111.

Greenberg, L. S., & Iwakabe, S. (2011). *Emotion-focused therapy and shame*. In R. L. Dearing, & J. P. Tangney (Eds.), Shame in the therapy hour (pp. 69–90). Washington, D. C: American Psychological Association.

Guntrip, H. (2018). *Schizoid Phenomena, Object Relations and the Self*. Routledge.

Gutierrez, D., & Bryce Hagedorn, W. (2013). The Toxicity of Shame Applications for Acceptance and Commitment Therapy. *Journal of Mental Health Counseling*, *35*(1), 43-43–59. https://doi.org/10.17744/mehc.35.1.5n16p4x782601253

Hahn, W. K. (2000). Shame: Countertransference identifications in individual psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, *37*(1), 10–21. https://doi.org/10.1037/h0087670

Herman, J. (1992). Trauma and recovery: The aftermath of violence- from domestic abuse to political terror. New York, NY: Basic Books.

Joireman, J. (2004). Empathy and the Self-Absorption Paradox II: Self-Rumination and Self-Reflection as Mediators Between Shame, Guilt, and Empathy. *Self & Identity*, *3*(3), 225-225–238. https://doi.org/10.1080/13576500444000038

Jordan, J. V., Walker, M., & Hartling, L. M. (Eds.). (2004). *The complexity of connection: Writings from the Stone Center's Jean Baker Miller Training Institute* (pp. x, 308). Guilford Press.

Kaufman. G (2004). *The Psychology of Shame: Theory and Treatment of Shame-Based Syndromes, Second Edition*. Springer Publishing Company.

Lansky, M.R. (2003) The "Incompatible Idea" Revisited: The Oft-Invisible Ego-Ideal and Shame Dynamics. *American Journal of Psychoanalysis,* 63, 365–376. https://doi.org/10.1023/B:TAJP.0000004741.67949.3f

Leeming, D., & Boyle, M. (2013). Managing shame: An interpersonal perspective. *British Journal of Social Psychology*, *1*, 140.

Levine, P. (2012). *In an Unspoken Voice: How the Body Releases Trauma and Restores Goodness*. Berkeley, California: North Atlantic Books.

Levine, P. A., & Frederick, A. (1997). *Waking the Tiger: Healing Trauma : the Innate Capacity to Transform Overwhelming Experiences*. Berkeley, California: North Atlantic Books.

Lewis, H. B. (1987). Shame and the narcissistic personality. In D. L. Nathanson (Eds.), *The many faces of shame* (pp. 93-132). NY: Guilford Press.

Lewis, H., B. (1971). *Shame and Guilt in Neurosis*. International Universities Press.

Marriott, S. (2007). Applying a psychodynamic treatment model to support an adolescent sentenced for murder to confront and manage feelings of shame and remorse. *Journal of Forensic Psychiatry & Psychology*, *18*(2), 248–260. https://doi.org/10.1080/14789940601116366

Matos, M., Pinto-Gouveia, J., & Duarte, C. (2013). Internalizing Early Memories of Shame and Lack of Safeness and Warmth: The Mediating Role of Shame on Depression. *Behavioural and Cognitive Psychotherapy*, *41*(4), 479–493. https://doi.org/10.1017/S1352465812001099

Mitchell, J. (1987). *Selected Melanie Klein*. Simon and Schuster. New York: The Free Press

Möller, A., Söndergaard, H. P., & Helström, L. (2017). Tonic immobility during sexual assault – a common reaction predicting post-traumatic stress disorder and severe depression. *Acta Obstetricia et Gynecologica Scandinavica*, *96*(8), 932–938. https://doi.org/10.1111/aogs.13174

Mollon, P. (2002). *Shame and Jealousy: The Hidden Turmoils*. London: Karnac Books.

Mollon, P. (1986). Narcissistic vulnerability and the fragile self: A failure of mirroring. *British Journal of Medical Psychology*, 59(2), 317-324.

Morrison, A. P. (2014). *Shame: The Underside of Narcissism*. Hillsdale, NJ: Routledge.

Nathanson, D. L. (1994). *Shame and Pride: Affect, Sex, and the Birth of the Self*. W. W. Norton & Company.

Obholzer, A. & Roberts, V. Z. (2004). *The Unconscious at Work: Individual and Organizational Stress in the Human Services*. London: Taylor & Francis.

Pascual-Leone, A., & Greenberg, L. S. (2007). Emotional processing in experiential therapy: Why "the only way out is through." *Journal of Consulting and Clinical Psychology*, *6*, 875.

Perez, L. M., & Sundheim, C. J. (2018). Mother-Infant Psychotherapy Informed by Polyvagal Theory. *Journal of Infant, Child & Adolescent Psychotherapy*, *17*(3), 145–153. https://doi.org/10.1080/15289168.2018.1482133

Porges, S. (2011). The polyvagal theory: Neurophysiological foundations of Emotions, attachment communication, selfregulation. New York, NY: Norton.

Porges, S. W. (2001). The polyvagal theory: Phylogenetic substrates of a social nervous system. *International Journal of Psychophysiology*, *42*(2), 123–146. https://doi.org/10.1016/S0167-8760(01)00162-3

Porges, S. W., & Furman, S. A. (2011). The Early Development of the Autonomic Nervous System Provides a Neural Platform for Social Behavior: A Polyvagal Perspective. *Infant and Child Development*, *20*(1), 106–118. https://doi.org/10.1002/icd.688

Robertson, K (2019). Introducing shame resilience to women who struggle with complex trauma and substance abuse. 159.

Rodogno, R. (2008). Shame and guilt in restorative justice. *Psychology, Public Policy, and Law*, *14*(2), 142–176. https://doi.org/10.1037/a0013474

Rothschild, B. (2000). *The Body Remembers Continuing Education Test: The Psychophysiology of Trauma & Trauma Treatment*. W. W. Norton.

Schore, A. (1994). *Affect regulation and the origin of the self*. New York, NY: Psychology Press.

Schore, A. N. (2003). *Affect Regulation and the Repair of the Self (Norton Series on Interpersonal Neurobiology)*. W. W. Norton & Company.

Shahri, H. (20113). Toward an Integrative Model for Developmental Trauma. *International body psychotherapy journal.* Retrieved 8 April, 2020, from https://www.ibpj.org/issues/articles/52-67%20SHAHRI%20IBPJ%20volume%2013,%20no.1%20spring%202014_v3.pdf

Scharff, D., E. (2001). Applying Psychoanalysis to Couple Therapy: The Treatment of a Couple with Sexualized Persecutory Internal Objects Resulting from Trauma. *Journal of Applied Psychoanalytic Studies*, *3*(4), 325–351.

Tangney J. P., & Dearing R. L. (2011). *Working with shame in the therapy hour:* Washington D. C.: American Psychological Association

Tangney, J. P., & Dearing, R. L. (2003). *Shame and Guilt*. Guilford Press.

Taylor, T. F. (2015). The influence of shame on posttrauma disorders: Have we failed to see the obvious? *European Journal of Psychotraumatology*, *6*. https://doi.org/10.3402/ejpt.v6.28847

Teyber, E., McClure, F. H., & Weathers, R. (2011). *Shame in families: Transmission across generations.* https://doi.org/10.1037/12326-006

van der Kolk, B. A. (2015). The body keeps the score: Mind, brain and body in the transformation of trauma. United Kingdom: Penguin Books

Van Vliet, K. J. (2008). Shame and resilience in adulthood: A grounded theory study. *Journal of Counseling Psychology*, *2*, 233.

Zaslav, M. R. (1998). Shame-Related States of Mind in Psychotherapy. *The Journal of Psychotherapy Practice and Research*, *7*(2), 154–166. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3330497/