The Hidden Paradox of Shame: It is everywhere but nowhere to be seen

A Psychotherapeutic Exploration into the Manifestation of Shame in the Therapeutic Relationship

By

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Shame, it, draws us unconsciously into a much more vulnerable place where we're talking about feeling small, because that's what it is, feeling really isolated. Small, unworthy, unlovable, unremarkable expendable, forgettable, disposable, and shame talks to all of those experiences – Maria (participant in the Research Study)

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ABSTRACT

Though often hidden, shame is a powerful and painful emotion that underlies many of the issues that clients bring to psychotherapy. The focus of this study is on the manifestation of shame in the therapeutic relationship. Through a qualitative investigation with seven experienced therapists the study sought to uncover how shame presents and impacts the therapist client dyad. Using a thematic analysis approach to the findings, themes of attachment, embodiment, and the unconscious enactment of shame in the transferential and countertransferential relationship were identified. The rich data illustrated the difficulty in working with shame when clients are often highly defended and shamed about their shame. Amongst the findings, the study identified the body both as a container and source of shame, the defences used in shame, and how the expression of shame differs for men and women. Through an awareness of the presence and manifestation of shame, there exists the possibility for therapists to open up a space for it to be brought in and normalised.

CHAPTER 1: INTRODUCTION

1.1 Background and Context

Shame is ubiquitous; it has no limits and no boundaries. It is present in every part of life; it spreads out across all socio-economic, gender, sexuality, culture, ethnic, religious, and age divisions. Shame is a painful experience for most while for some it may be unbearable with the consequent desire to flee or withdraw from it (DeYoung, 2015, p.xii). Halling (1994, p.74-75) refers to the etymological meaning of shame as a wound in addition to a form of cover or concealment.

It is important to distinguish between appropriate shame and core or chronic shame: the former develops in childhood and relates to adaptations in behaviour that form part of the social learning of being in a group, whereas the latter refers to the earliest experiences of feeling worthless and unlovable (Cozolino, 2016, p.122). The subject of this study is the manifestation of core or chronic shame in clients in the therapeutic relationship. The debilitation of chronic shame is powerfully described by Kaufman (1980) as similar to a paralysis, where eye contact becomes unbearable, movement is restricted, the head is hung low and speech is suppressed (Cited in Lee & Wheeler, 2006, p.4).

Shame plays a significant role in many of the problems that clients bring to psychotherapy. The possibilities for shame are almost endless as it may come from so many sources: early attachment, abuse, family relationships, eating disorders, addictions, sexual orientation, economic and social status, physical or mental issues,

ageing, cultural[1] and ethnic backgrounds and more recently from social media platforms. Shame can negatively impact on the therapeutic relationship when clients are ashamed to talk about their experiences and seek to conceal them from the therapist, the notion that shame itself is shameful (Gilbert, 2007, p.125, Lee & Wheeler, 2006). Lewis (1971, Para 2) described, "unanalyzed shame in the patient-therapist relationship [as] a special contributor to the negative therapeutic reaction". In the therapeutic relationship it may not be apparent that a shame is at the heart of a client's distress and indeed DeYoung (2015, p.117) points out that the term 'shame' is not often named as such. Yet, there is a paradox in shame insofar as the need for self-expression increases the risk of exposure whereas the desire for invisibility suppresses shame; how these competing needs are negotiated can determine whether shame is healthy or chronic (Sanderson, 2015, p.12).

Consequently, it may be difficult for therapists to identify underlying conditions as shame-based. Because of shame about shame, clients may have strong defences in place to keep it concealed and to avoid being re-shamed (Sanderson, 2015, p.190). While it may not be named or directly referred to by the client, shame may be represented externally, internally, explicitly and implicitly. In addition, within the transference and countertransference of the therapeutic relationship shame issues may arise for both therapist and client. The purpose of this study is therefore to add to the literature about the manifestation and impact of shame in the therapist client dyad.

[1] In Western individualistic societies shame is personal whereas in collectivist societies shame belongs to the family or group (Walker, 2014, pp.38-39).

When shame is identified, addressed and worked with its power is reduced, enabling clients to transform their lives together with their relationships with others, themselves and with their own shame (DeYoung, 2015, p.176). However, as Sanderson (2015) points out there is very little or no training for therapists in the area of shame identification or the skills to work with it. Nathanson (1996, p.13) opines that the study of shame was critical to the development of competence as a psychotherapist as it revealed "everything that is beautiful and everything that is ugly within the human soul " (cited in Ayers, 2003, p.9). In the recommendations to this study the author will propose that the topic of shame be included as an integral component in the training for psychotherapy students.

The literature review below will examine some of the main perspectives on shame identified from the research. The review will trace the development of writing about shame. Starting with Freud and the use of shame and guilt as defences, the review will go on to note the paucity of literature on shame until the early 1970s with the publication of *Shame and Guilt in Neurosis* by Helen Block Lewis. The discussion will then investigate the difference between shame and guilt, two words that are often used interchangeably. The notion of shame as adaptive will also be unpacked. The origins of shame in early attachment experiences will be explored with reference to the neurobiological theory of development and affect regulation theory. The study will examine the many ways in which shame may be manifested. For example, Gilbert characterised shame as being about self-identity and distinguishes between external and internal shame; the inquiry will explore the nuances of both and will also distinguish how these differ from explicit and implicit shame. The study will also

consider the defences used in shame as theorized by Nathanson's (1992) Compass of Shame. The notion that men and women might not manifest or express shame in the same way is a further strand of the study. Finally, the review will investigate how shame in the therapeutic relationship impacts on the therapist.

1.2: Aim and Objectives

Aim

The aim of the study can be summarised as an exploration into the manifestation of shame in the therapeutic relationship.

Objectives

Following on from the purpose of the study outlined above, the writer has identified three primary objectives as follows:

- To explore the origins of shame in the therapeutic relationship;
- To investigate how shame is manifested and is recognised in the therapist client dyad;
- To examine if and how shame impacts on therapists.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

Shame is a very broad topic and there is a wide amount of literature available on its many aspects. The researcher selected the themes that in her view were most representative of the literature; the difference between shame and guilt, the adaptive function of shame, shame in early attachment experiences, types of shame, defences against shame, gender expression of shame, and the potential for therapists' shame. The review will seek to unpack these themes with reference to the main contributors from the literature.

2.2 Definitions of Shame

Shame is central to the therapeutic process but by its very nature is often hidden and the language of shame can be as opaque as the emotion itself. Shame may be referred to as guilt, embarrassment, mortification, humiliation, or indeed anything other than the word itself. It is useful therefore to start with some definitions of what is meant when exploring the concept of shame. The American Psychological Association Dictionary of Psychology defines shame as "a highly unpleasant self-conscious emotion arising from the sense of there being something dishonorable, immodest or indecorous in one's own conduct or circumstances" ("Shame", n.d.). The psychotherapeutic literature further emphasises the impact of shame on the self, for

example, Tomkins (1963, p.118) referred to it as a "sickness of the soul, an inner torment" and Lewis (1992, p.81) "a global attack on the self-system" (cited in Sanderson, 2015, p.21). Judgment of and by both the self and others plays a key part in shame and hence the desire for it to be concealed.

2.3 Distinguishing Between Shame and Guilt

The extensive literature on shame can be broken into a number of key themes. The first of these is the difference between shame and guilt. The two terms are often used interchangeably when, in fact, they are two distinct emotions. The focus of shame is on the self whereas the focus of guilt is on behaviour. The study of guilt and shame can be traced in the first instance to Darwin who noted the distinct emotional way in which shame was expressed by "persons who feel shame for some moral delinquency, are apt to avert, bend down, or hide their faces, independently of any thought about their personal appearance" (1872, p. 157, cited in Dempsey, 2017, p.1). In Freud and Breuer's 1895 book *Studies on Hysteria*, shame was characterised in a number of ways: as an emotion, as a defence, as a form of signal anxiety instigating a defence response, and as having an emotional regulating status when the ego is presented with an idea that is threatening to its security (Lansky, 1999, part II). Freud, however, did not write extensively on shame as a distinct emotion, focusing instead on the nature of guilt as the conflict between forbidden desires and the ever-watchful moral standards of the superego (Tangney and Dearing, 2002, p.113). While Freud referred to shame in other papers up to 1914 including 'On Narcissism', it was scarcely mentioned

thereafter. Indeed Lansky (1999, part II) acknowledged that little was written about shame in the psychoanalytic literature until 1971 with the publication of *Shame and Guilt in Neurosis* by Helen Lewis, which linked shame with the self. Lewis (1971) started to write about shame when she saw how failure in therapy was often connected to the difficulties of acknowledging and dealing with shame in treatment (DeYoung, 2015, p.24). Lewis (1971, para.13) identified an important distinction between shame and guilt, which were traditionally grouped together; in shame the self is evaluated negatively whereas in guilt it is the behaviour, which is negatively judged: "Shame is about the self; guilt involves activity of the self".

For Lewis (1971) the feelings associated with shame and guilt were separate; in shame, the experience is of worthlessness, humiliation and exposure whereas the feelings that accompany guilt are related to behaviour and remorse, which may still be painful but are not focused on diminution of the self (Tangney and Dearing, 2002, p.19). Nathanson (2002, p.19), who has written extensively about the defences used in shame, refers to shame as being about 'the *quality* of our person or self' whereas guilt is what is triggered emotionally by our actions or violation of a code of conduct. He refers to the notion of reparation for wrongdoing in guilt as a means of discharge, such as apologising, restitution, or serving time in prison, but no such system exists in shame (Nathanson, 2002, p.19). Thus, guilt is often categorised as adaptive while shame is perceived to be maladaptive when, in fact, shame also has an adaptive function. Sanderson (2015, p.32) neatly sums up the different focus between guilt and shame as "I did something bad" versus "I am bad". The intrinsic feelings of the self as bad are synonymous with the experience of shame.

2.4 The Adaptive Function of Shame

Turning now to a consideration of the adaptive function of shame, Tangney and Dearing (2002, p.126) point to the dearth of evidence linking an inhibitory function such as decreased likelihood for transgression to shame and one might wonder therefore what is its evolutionary adaptive purpose. This may relate to an earlier stage of human development when shame was a means of communicating acceptance of a relative rank in the dominance hierarchy or as an acknowledgement of wrongdoing to ameliorate potentially aggressive interactions (Tangney and Dearing 2002, p.127). Meanwhile, Sanderson (2015, p.22-23) posits a spectrum of shame model in which healthy shame and chronic shame are at either end. She suggests that the healthy aspect of shame has a social and regulatory function in modifying behaviour in groups, and promoting cooperation, acceptance and compassion. Chronic shame, on the other hand, has the reverse impact, inhibiting relationships and mediating behaviours that may lead to aggression, rage and violence (Sanderson, 2015, p.23). While the impact of shame in the therapeutic space may present at any point on the shame spectrum, Sanderson (2015, p.22) cautions against pathologising all shame experiences until its effects on the client have been fully explored.

2.5 Shame and Early Attachment Experiences

Moving now to shame and early attachment experiences, the relationship with the primary caregiver has a powerful impact on the infant's physiological and

psychological development (Matos and Pinto-Gouveia, 2014, p.217). Cozolino (2016, p.10) refers to the centrality of the shame experience in early social and emotional development. Bowlby (1969), Gerhardt (2004) and others propose that internal working models of self are developed from these early experiences and on which future relationships are modelled (Sanderson, 2015, p.43). Helen Lewis (1971) characterises shame as an emotion linked to a failure in early attachment; a rupture in the development of the social bond by primary caregivers, the basis from which functioning and stability in later life is developed, creating affect or emotional dysregulation (Yard, 2014, p.44). The young infant's sense of self is valued and confirmed when the experience with the primary caregiver is positive; conversely, shame stems from a response of disappointment, disgust, inattention or anger from a parent or caregiver (Sanderson, 2015, p.11; Cozolino, 2016, p.121). The consequent emotional misattunement between the child and caregiver can trigger a swing from sympathetic to parasympathetic dominance and this is interpreted by the emerging psyche as rejection, abandonment and shame (Cozolino, 2016, p.11). In order to protect himself and the relationship, the young child may split off his rage and anger and turn it against himself by becoming the "bad object" (Klein, 1930, cited in Nolan and Nolan, 2002, p.12). While the use of splitting may be a survival mechanism the lifelong price for this may be a legacy of shame (Heller & LaPierre, 2012, pp.138-139).

The publication of *Understanding and Treating Chronic Shame* (DeYoung, 2015) introduced a new perspective on shame and attachment. This is a relational and neurobiological approach, influenced by Helen Lewis and by John Bowlby's

attachment theory but also incorporating affect regulation theory. The definition of shame that DeYoung (2015, p.18) arrives at is "*Shame is the experience of one's felt sense of self disintegrating in relation to a dysregulating other*". Unpacking this, she explains that the experience of chronic shame is an annihilating force on the self, resulting in fragmentation or disintegration combined with the failure by another to provide the level of emotional support, connection and containment required for healthy functioning and development (DeYoung, 2015, pp. 20, 21). DeYoung (2015, p.19) argues that our sense of well-being is dependent on having an integrated self supported by relationships with others; therefore, use of the word 'disintegrating' captures the essence of how shame feels. Similarly, DeYoung takes the term 'dysregulating other' from affect regulation theory, which explores the way in which emotions are regulated by the self and with others; shame, either for children or adults is a failure of the other to respond to the individual's emotional needs. The notion of shame as an affect is a recurring motif throughout the literature. Tomkins' affect theory (1987) argues that affects are the "primary innate biological motivating mechanism" (cited in DeYoung, 2015, p.22). According to Nathanson (1992, p.211) shame is the affect, which draws attention to the core of the self and at every stage of development, the affect script has the power to impede what we like in ourselves. Affects become feelings and emotions, which are linked to memories and associations, as Nathanson (1992, p.50) succinctly explains: "Whereas affect is biology, emotion is biography". The emotional pain of shame ranging from intense rage, anger, humiliation, self-loathing, is difficult to capture in language as it is ultimately "non-verbal and visceral" (De Young, 2015, p.24).

Recalling Bowlby's attachment theory, DeYoung (2015, pp. 48, 49) traces how the disintegration/shame experience is internalised by the dysregulating other in avoidant, ambivalent disorganised/disoriented patterns of attachment. DeYoung (p.36) links traditional attachment theory with Schore's Affect Regulation Theory as a modern day attachment theory. Schore (2003) has written extensively about the way in which attachment patterns impact the early development of neural pathways in the brain. He refers to the core of the self …[as being] in the patterns of affect regulation" (Schore, 2003, p.46). Attunement with the primary caregiver, through right-brain-to-right-brain communication, plays a critical role in regulating the infant's emotional states (Schore, 2003, pp. 256-257). When the infant does not receive the positive response that is expected, Schore (2003, p.160) explains how he is thrown into a shocked state that he is as yet unable to regulate. For the child, the first experience of shame is akin to an assault on the ideal ego, the impact of which Schore (2003, p.163) claims is associated with all subsequent shame experiences; the rupture in the attachment relationship is such that "the neoevolving, emotionally fragile, differentiating nascent self collapses, triggering physiological upheaval…"

The response by the primary caregiver to the infant's shame affective state is critical in order for repair of the shame state and for the infant to learn to internalise a means of auto regulation (Schore, 20013, p.165). Repeated and unrepaired failures in right-brain to right-brain attunement between the infant and primary caregiver links early attachment experiences to shame.

2.6 Different Types of Shame

Turning now to the different types of shame, Gilbert (2007, p.124) while describing the essence of shame as being about the self and self-identity distinguished between internal and external shame. He posited internal shame as the shame we feel, judge, avoid, conceal and seek to control about ourselves, and external shame as what we perceive others to find unacceptable or rejectable in us (Gilbert, 2007, pp. 127, 131). Shame is also described as a self-conscious emotion because of this internal and external evaluation of the self (Matos and Pinto-Gouveia, 2010, p.300). Gilbert's evolutionary and biopsychosocial model for shame begins with the need for belongingness and attachment at a young age, moving on to personal experiences of shame including bullying, criticism and abuse which become internalised to the extent that the self is shame-filled with feelings of being or having done something bad. External shame is at the centre of the model where the world is perceived as being unsafe and defensive strategies are employed; the humiliation response may be to turn to anger and aggression while the internalised shame response will turn shame back on the self through negative self-evaluation (Gilbert, 2007, p, 141, 142). When there is a fusion of external and internal shame the individual experiences both the world and the internal self as hostile leading to fragmentation and possible break-down as there is no safe place either internally or externally to seek help (Gilbert & Proctor, 2006, p.354).

In relation to explicit shame, early shame experiences may be encoded as traumatic memories in the autobiographical memory and when triggered evoke a similar

response to trauma in hyperarousal and fight flight freeze responses (Matos and Pinto-Gouveia, 2014, p.221, 222). Lewis (1995) opined that while there was no canonical facial expression for shame a number of facial expressions and behaviours indicated its presence (cited in De France, Lanteigne, Glozman and Hollenstein, 2016, p.770). Thus explicit shame may be perceived in a client's hyperarousal state that is difficult to contain and is expressed through the collapsed body, broken eye contact, covering the face with the hands, blushing, sweating and a desire to make themselves small in the room (DeYoung, 2015, p.63). Other indicators may include temporary lapses in speech fluency such as stammering, withdrawal, disengagement, long periods of or complete silence and fidgeting; both of the latter cues serve to communicate stress to the observer and may be an attempt to avoid being re-shamed (De France et al, p. 771 2017).

The above exploration of attachment and shame is relevant also to implicit shame. Schore (2003, p.257) described how early attachment experiences are encoded as internal working models that become representations for later relationships; the term 'working' denotes how the individual unconsciously uses these models to relate to others and interpret new experiences. Implicit shame is essentially unconscious shame; painful and intense feelings are forced out of conscious awareness and any residual reactions are numbed through dissociation (Sanderson, 2015, p.28). Cozolino (2016, p.95) points out one of the roles of implicit memory that applies to shame is that "past shaming experiences prime conscious awareness to anticipate rejection". Furthermore, implicit shame that is inaccessible may not be experienced as shame at

all with the consequent loss of empathy and compassion or the ability to experience feelings of shame about destructive actions and behaviours (Sanderson 2015, pp.28).

Helen Lewis (1971) referred to implicit or unacknowledged shame as 'bypassed shame' (Scheff, 1987, p.110). Lewis systematically analysed transcripts of psychotherapy and found far more cues for shame than all of the other examined emotions combined (Eterović, 2020, p.1). In the therapy sessions shame was never referred to by the therapist and client; instead it was either acted out as overt and undifferentiated shame, it was displayed but not identified or named as shame or it was bypassed where the feeling may be activated but avoided; in both scenarios, shame was invisible (Scheff, 1987, p.110, Sanderson, 2015, p.28). As Ikonen and Rechardt (1993, p.123) opined, "Shame that is by-passed remains shapeless, and, as such, it may be encountered over and over again with all its consequences" (cited in Eterović, 2020, p.3).

2.7 Defences Against Shame

There are many ways that clients defend against shame, including, anger, aggression and dissociation. Nathanson (1992, p.30) theorized that when the shame affect is triggered all sources of shame are brought to mind and he proposed a model of defences entitled 'The Compass of Shame' in which the responses to shame may be characterised (see Figure 1). Nathanson's (1992, p.312) model proposes that each individual has their own script for defending against shame, which will depend on the situation and the individual's personal style. The four points of the compass each represent an affect management system through which shame is handled.

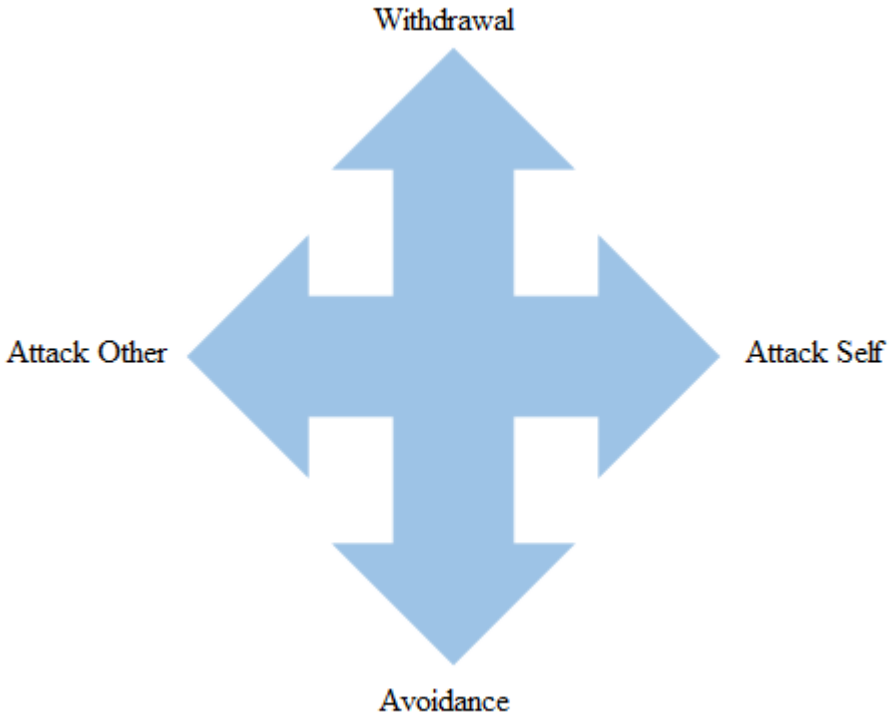

Figure 1: The Compass of Shame

In withdrawal the individual tries to limit their exposure to the intolerable situation and feelings evoked by shame and escape is the only means of respite (Nathanson, 1992, p.313). Social isolation is a big part of withdrawal often leading to depression and loneliness but Sanderson points out that because individuals who use withdrawal as a defence have a high awareness of shame they are often willing to engage with therapy (2015, p.107). Avoidance may relate to a person's previous experience of shame that cannot be faced and often strategies such as denial or disavowal of shame are used to avoid exposure (Sanderson 2015, p.111). Avoidant behaviours such as alcohol or drug abuse, promiscuous behaviour or extravagant lifestyles are deployed to detract from shame (Nathanson, 1992, p.313). For others, the defence is to attack the self, but it is a choice, under their control, and enables relationships to be

maintained as they, rather than others, have identified the shame moment. Humour is used in this style of defence as a form of deflection and a means through which attachment can be maintained (Sanderson, 2015, p.108). In attack other, the individual's self esteem has been reduced to the extent that they feel endangered and attack is a form of response that they are familiar with. It is a disavowal, which can take the form of anything from sarcasm, bullying, and blaming to anger, rage and destructive behaviour (Nathanson, 1992, p.313-314).

The rationale behind the Compass of Shame was to illustrate how people develop ways of dealing with shame without directly addressing it (Taylor, 2015, Para. 16). In one study, carried out in 2013 by Black, Curran and Dyer, about the impact of shame states and coping styles on the therapeutic and intimate relationships, the degree to which different behaviour strategies in the Compass of Shame were utilised was assessed. Withdrawal, which in Nathanson's model was a means through which an individual distances themselves from feelings of shame because they are too overwhelmed, was found to be the main impediment to the development of both effective therapeutic and intimate relationships (2013, p.651-653). Nathanson (1992, p.30) argues that much of the way shame is managed relates to our personality type and goes so far as to say that "Character formation, the essence of self-definition, is immutably linked to shame".

2.8 Gender and Shame

Turning now to gender and shame, the review will seek to investigate if the existing research shows that male and female shame differs in origin, expression and representation. According to Freud (1933, p.132) shame was considered "to be a feminine characteristic *par excellence*", which "has as its purpose, we believe concealment of genital deficiency" (cited in Severino, McNutt and Feder, 1987, p.94). While Severino et al (1987, p.104) do not agree with the gender specificity of Freud's statement, they argue that ego is firstly a body ego and shame is related to that early preverbal and preoedipal internalised self-image; though experienced and managed differently by men and women the origins of shame are linked to the individual's body image.

The notion of shame and the body, particularly a woman's body is a theme across much of the literature reviewed. Nurka (2012, p.313, 314) refers to a 2001 study in Britain of female genital slang words where the researchers (Braun and Kitzinger) found that 'female genitalia were significantly more likely to be described euphemistically' compared to men's genitalia, suggesting an incessant linking of female genitalia to shame. Nurka (2012, p.316) cites a number of references to the embodiment of shame in women, where words such as 'slut' and 'whore' are applied indiscriminately to female sexual activity but not to the male libido. Stepien (2014, p.2012) also refers to the societal perceptions about sexual conduct where women are regarded as disgracing themselves in shameless behaviour but for men such behaviour is a reinforcement of power and dominance.

Sanderson (2015, p.84) also considers the body as a powerful source through which both men and women experience shame. She posits that for women the focus of shame is on physical attributes such as attractiveness and weight. Men have similar shame about body size and weight but also about strength, muscularity and hair loss. According to Sanderson social media platforms have become a new medium for shame with increased scrutiny of physical appearance leading to greater demand for cosmetic surgery by both sexes.

Other earlier writers, for example Lewis (1981), Tangney (1994), Reimer, (1997) claim that empirical evidence shows women to be more shame prone than men (cited in Ferguson, Eyre and Ashbaker, 2000). In addition, Ferguson et al (2000, p.134) argue that boys and girls are socialised with different expectations, behaviours and emotions suited to their respective roles; consequently there is more tolerance in Western society for women to access and express feelings of shame than there is for men. An interesting study carried out in 2013 illustrated how women's shame proneness has continued into the workplace. Using a self-assessment method Ludwig and Thoma (2013, p.21) found the women in the study to be much more likely than the men to avoid shame by downgrading themselves in case other people observed that they had overestimated their abilities, which carried much greater social and societal disapproval.

Finally Stepien (2014, p.7, 9) puts forward the view that the discussion about male shame has only recently come to the forefront, as men are more likely to hide their shame than admit it. As an emotion that has the potential to emasculate men, she

states, that shame "when applied to the idea of masculinity based on performance, has to be masked and suppressed to protect male identity" (p.7).

2.9 The Therapist's Shame

In this final part of the review the researcher will explore how in the literature shame in the therapeutic relationship may belong to the therapist as well as to the client. It is important to recall that the therapeutic relationship has been described as the most important factor in effective psychotherapy (Clarkson, 2003, Cooper, 2008). Clarkson (2003, p.67) refers to the significance of the transferential and countertransferential relationship into which the unconscious feelings and fears of both the therapist and client are consigned. The earlier discussion referred to shame being characterised by its concealment. Wallin (2007, p.261) stated that what cannot be articulated by clients "will tend to be evoked, enacted or embodied". The therapist's desire to be empathetic, supportive and understanding may be met by rage by the client that such a response is available now but was not there when they needed it in their early experience with the primary caregiver (Clarkson, 2003, p.77). The therapist's countertransference may be triggered by what is happening for the client and/or his or her own unexpressed and acknowledged feelings (Jacobs, 2017, p.120). Sanderson (2015, p.210) suggests that the therapist's shame may be triggered by the client's shame. Hahn (2000, p.19) explains it in a different way, stating that the therapist's countertransference in the intersubjective relationship develops when the client's experience of shame resonates with the therapist's own feelings of shame. In his

2004 paper, Hahn refers to the association of shame with negative therapeutic reactions (previously identified by Helen Lewis in 1971). Recognising the hiddenness of shame in the therapeutic encounter, Hahn points out the feelings of inadequacy that arise for the therapist when therapy is not progressing as well as expected. This misattunement may, Hahn (2004, p. 7, 10) argues, be due to the way in which shame is managed or indeed avoided. Sanderson (2015, p.219) alludes to the possibility of shaming the client when the therapist is feeling inadequate or shame defences are triggered. Within the therapist client dyad also lies the possibility for the client to shame the therapist, the attack-other defence mechanism is employed to get rid of shame and transfer it to the therapist (Sanderson, 2015, p.222).

Morrison (2008, para.9) maintains that an exploration of a client's shame inevitably evokes shame in the therapist. Morrison (2008, para.6) contends that the toxicity of shame can lead to a mutual collusion in the therapeutic relationship to avoid the contagion of shame. He points to a number of sources of shame for the therapist: having a similar experience as a client to which shame is attached, being told repeatedly by a client that neither the therapist or therapy are helpful, the therapist's own feelings of failing a client, an abrupt or unplanned end to therapy with a client, or a recognition by a therapist that he or she wants or needs something from a client.

DeYoung (2015, p.151) also refers to what is happening in the intersubjective place between therapist and client. She refers to the way in which the client's unconscious, non-verbal, shamed vulnerability is enacted in the transference because the client is unaware and/or has dissociated from their experience (2015, p.152, 153). In this

scenario, however, it is possible for the therapist to enact her vulnerability and defences against shame and for the enactment to become mutual (DeYoung, 2015, p.154). Working through such a scenario requires commitment and collaboration by both therapist and client together with mutual trust in the process and relationship (DeYoung, p.155).

Given the potential for the therapist's shame to be evoked as described above, it appears, as a number of writers identify, that one of the first requirements of working with shame is for therapists to have acknowledged and worked through their own shame issues (for example, Hahn, 2000, 2004, Johnson, 2006, DeYoung, 2015, Sanderson, 2015).

2.10 Summary

Through a representative selection from the literature, this review illustrates the complexity of shame as an emotion that comes into the therapeutic relationship. The development of the literature on guilt and shame revealed how they came to be understood as two distinct emotions where guilt is associated with behaviour or actions and shame as the felt sense of badness about the self. While historically the adaptive function of shame may have related to hierarchical rank and dominance, a contemporary view of its adaptive function is characterised by Sanderson's (2015) spectrum of shame model. The review traced the connection between shame and the rupture in early attachment relationships and how that may be conceptualised in

relation to attachment theory, affect regulation, the neurophysiology of shame and the notion of dysregulation. The review explored the way in which shame is defended against as a means of repudiation, adding to the complexity of working with shame. The embodiment of shame was found in the literature to be a strong indicator of its presence. Significantly also, the literature pointed to the extent to which the female body and sexuality is more associated with shame in women than for men while the fear of emasculation was a strong theme in shame for men. Finally the review explored the enactment of shame in the transference and countertransferential relationship through which both the client and therapist's shame may be present in the room.

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter describes how the research study was constructed. It firstly explores the rationale for using a qualitative approach in the research design. The method of sample selection and the recruitment process will then be described. As outlined in the discussion below, data collection was through semi-structured interviews. The data was analysed using a thematic analysis approach and the suitability of this method to the subject matter will be explored. Finally, the discussion outlines the ethical issues involved in the research study and how these were addressed.

3.2 Rationale for using a Qualitative Approach

According to Harper and Thompson (2012, p.5), qualitative approaches allow experience and processes to be understood. Shame is a human emotion that is universally experienced but often remains unacknowledged, unnamed and concealed. It is a sensitive issue requiring patience and compassion to uncover in the therapeutic space. The research study set out to explore therapists' experience of identifying and working with clients who have shame experiences. Through qualitative research, the meaning of aspects of human experience can be mapped and explored (McLeod, 2011, p.ix). It is through meaning that the reality of life and social world is

constructed, for example through self-narratives, memories, experiences and rituals (McLeod, 2011, p.3). The emotion of shame may be deeply embedded in a client's sense of self and way of being in the world. The process of learning and understanding the therapists' personal experiences and insights in working with shame was supported by the use of a qualitative approach for which meaning is a central component.

3.3 Sample Selection and Recruitment

Shame can come into the therapy room at any time no matter how much or how limited experience a therapist may have so the decision was made to open up the sample selection to therapists with different levels of experience. A classified advertisement seeking participants with two years post accreditation experience together with a humanistic and integrative orientation was sent to the Irish Association for Humanistic and Integrative Psychotherapy (IAHIP) for inclusion in the weekly email circulated to all members. It was not possible to place a similar advertisement with the Irish Association for Counselling and Psychotherapy (IACP) without being a student member. The researcher also sought participants from her placement centre with the approval of the centre manager. The sample also included a suitable therapist identified early on in the process who had agreed to participate. Selection of the sample was made from suitable participants on a first come first served basis. The sample generated a cohort of therapists with considerable experience providing a deep, rich and diverse set of data. The sample size was

anticipated as being five to six participants but as the opportunity presented more recruits than expected, it was decided to increase the sample size to seven participants. A summary of the participants' details, all pseudonymised, is set out at Table 1 below:

Table 1 – Participants' Details

Name (Pseudonym)	**Gender**	**Experience (post-accreditation)**	**Professional Body ***	**Orientation**
Ronan	Male	4 Years	IACP	Humanistic Integrative
Clare	Female	8 Years	IACP IAHIP EAP	Humanistic Integrative
Maria	Female	6 Years	IAHIP	Humanistic Integrative
Teresa	Female	6 Years	IACP	Humanistic Integrative
Monica	Female	15 Years	IACP IAHIP	Humanistic Integrative
Joe	Male	10 Years	IAHIP	Humanistic Integrative
Sarah	Female	5.5 Years	IACP IAHIP	Humanistic Integrative

*

IACP: Irish Association for Counselling and Psychotherapy

IAHIP: Irish Association for Humanistic and Integrative Psychotherapy

EAP: European Association for Psychotherapy

3.4 Data Collection

The method of data collection was through semi-structured interviews. A series of fourteen questions was prepared in advance of the interviews (Appendix 3). The questions were reviewed by college peers and supervisors and tweaked in accordance with the feedback received to sharpen focus and expand the range of the discussion.

Five of the interviews were conducted face to face and two were conducted online via Zoom and Doxy.me. It was the intention of the researcher to carry out all of the interviews face to face but the Covid-19 restrictions were introduced during the period and it was necessary to make alternative arrangements. The researcher had concerns in advance of the online interviews that the discussions might be restricted or stilted by the technology but this did not turn out to be the case. Some nuances in relation to body language were missing from the online interviews but the quality of the data was similarly rich as the face-to-face interviews.

The participants were advised in advance that the interviews were being recorded. The recording was done with a voice recorder together with a transcription application, Otter, on a mobile phone. The questions were not all asked in the same order at every interview as the discussion in some cases led to elements of later questions being raised. The researcher did not find that this had any significant impact on the data set as a whole. After each interview notes were taken to record meaningful or significant aspects that had resonated with the researcher together with any responses that might require further investigation from the literature. The length of the interviews ranged from forty-five minutes to two hours with the majority taking

an hour to complete. The transcripts were all anonymised with no personal information or identifying features linking the interview back to the individual participant. The next section will describe the process through which the transcripts were analysed.

3.5 Data Analysis

According to Braun & Clarke (2006, p.79) thematic analysis is a method that enables patterns of meaning in a data set to be identified and analysed. A thematic approach allows the researcher the flexibility to extract the key themes from the data, which may not necessarily be from the prevalence of a data item but the extent to which it may capture an important element of the research study (Braun & Clarke, 2006, p. 82). A theme may include manifest content, that is, what is directly observable or explicitly spoken, and latent content, what is said implicitly (Joffe, 2012, p. 209). A thematic analysis is therefore eminently suitable as a way of understanding the meaning of shame experiences and how they may be identified and worked with in the therapy room.

All of the voice recordings and Otter transcriptions were transferred to a Microsoft Word document. Repeated listening to the voice recordings alongside the transcribed words helped the researcher to become very familiar with the data. Braun & Clarke (2018: 27.12) are critical of the notion of themes emerging from the data as it suggests a passive rather than active role for the researcher. Active engagement with

the data, listening to the nuances of what was said and not said, enabled the researcher to identify a number of themes, which were then coded. Similar themes were grouped together and distilled down to a small number of overarching themes, which reflected the core elements of the entire data set.

3.6 Ethical Considerations

A proposal was submitted to the Dublin Business School Ethics Committee in May 2019 and approval was received prior to starting the research study. Each participant was informed in writing of this approval. In addition, a copy of the Information Sheet (Appendix 1) and Consent Form (Appendix 2) was emailed to all of the participants in advance of the interviews. Each interview began with an explanation of the research study's aims, the risks of participating in the study, the participant's right to withdraw from the study at any time and the anonymity through which their participation would be protected. Each participant completed and signed the Information and Consent Forms before proceeding with the interview. For the interviews conducted online, the participants verbally agreed to the Information Sheet and Consent Form and this was followed up by signed versions.

All of the transcribed interviews were stored on a password protected hard-drive that only the researcher has access to and the original voice recordings and Otter transcriptions were deleted. Participants were advised that all of their personal details would be retained in accordance with the mandatory requirements for personal data

under the General Data Protection Rights (GDPR) Act 2018 and that only pseudonyms would be used in the data analysis/coding and final published study. All participants were invited to contact the researcher following the interview should any concerns or issues in relation to the research study arise.

3.7 Summary

In this section, the rationale for using a qualitative approach was explained together with the suitability of a thematic analysis for the research subject. Seven semi-structured interviews were conducted providing a wide range of experiences and approaches to working with shame. All of the ethical issues involved were considered and addressed.

CHAPTER 4: FINDINGS

4.1 Introduction

This research study set out to explore the manifestation of shame in the psychotherapeutic relationship. The findings from the seven semi-structured interviews are presented in this chapter. The participants had a wide range of post-accreditation experiencing ranging from 4 years to 15 years (See Table 1). While all interviewees are accredited with IAHIP and/or IACP with a humanistic integrative orientation, their approaches varied and included psychodynamic, person-centred, existentialist, integrative bodywork, biodynamic and Gestalt perspectives to inform their practices.

4.2 Themes Identified

The interviews generated a rich and varied data set, which were grouped together into three main themes. Within each of these themes related elements were identified and grouped into sub-themes as presented in Table 2 below:

Table 2 - Themes

SUPERORDINATE THEMES		
1. Shame in the Early Attachment Experience	**2. The Embodiment of Shame**	**3. The Therapeutic Relationship and Shame**
SUBORDINATE THEMES		
(i) Dysregulation	(i) Defences	(i) Transference and Countertransference
(ii) Implicit Shame	(ii) Gender	(ii) Therapist's Shame

Verbatim vignettes from the participants' interviews will support the discussion under each theme.

4.3 Theme 1: Shame in the Early Attachment Experience

The connection between attachment and shame was the most dominant theme in the research study across all of the interviews. All seven participants referred frequently to the origins of shame in early attachment experiences. Two of the therapists spoke about how quickly shame is learned. For example, Ronan illustrated how this typically happens:

> *'You shouldn't be doing that', so what's getting laid down in there, and the child in response to that bit of play, you know, that shameful behaviour, we don't do that*

Clare attributed shame to the impact of repeated ruptures in the relationship:

> *Yeah, it's like there was a rupture in the dynamic with shame in the attachment experience. And that now becomes embedded and there was no repair. And when that happens again and again and again that becomes chronic, and then the impact is like trauma.*

Monica echoed this as she talked about the reaction of the infant to rejection and what the child is left with:

> *That's a big piece, very, very big piece, you know, an avoidant attachment will never acknowledge a need. You know, because shame has been in that very first place, the natural biologic, reaching out, and to be failed, you know, dismissed, and then having to withdraw, just leaves a very big wound of shame.*

Other participants reflected Monica's visceral description of shame as a "wound" that is carried from early childhood into adulthood. Maria captured this when she spoke about the sense of self that clients experience in shame:

> *One of the things that I am always surprised at is the depth and intensity of self-loathing in clients…. the self-loathing and self-criticism, that harshness that I would probably have associated with more childhood adversity than what I'm experiencing. So that's why I'm really, really interested in these early attachment relationships, and the opportunities, for shame in them*

Ronan referred to the double bind of shame, not only was the client experiencing the emotion of shame but was also fearful of being judged:

> *Don't judge me Please don't judge me this, this is what I want to tell you, I'm struggling to tell you, don't know whether I should tell you. And whatever you do… please don't judge me because I'm…. feeling shameful enough as it is.*

Shame was identified by some of the participants as feeling bad at core compared to guilt, which was related to a transgression. As Joe put it:

> *Shame is a feeling when something bad happens in relationship I attribute the badness to me. I am bad, rather than something bad happened to me.*

In fact, all of the participants distinguished between the way that guilt and shame present in the therapy room. Maria said:

> *And yet, people will offer their guilt easily…. One of the first things will be in the room with people, 'I feel so guilty about that', 'I have a lot of guilt about that'…so, guilt is something that is actually easy to talk about….. whereas, shame is not.*

The notion of shame having an adaptive function was not mentioned by any of the therapists, though one therapist, Ronan, referred to such a function in guilt:

> *Sometimes we need to be guilty around some things we've done.*

4.3.1 Dysregulation

Exploring the link between attachment and shame further with the participants, the researcher sought to understand what it was about early attachment experiences that engendered feelings in clients of being intrinsically bad. Three of the participants referred to the sources of chronic shame in attachment as dysregulation or the "dysregulating other". Sarah described it as follows:

> *I think it's very much in terms of that dysregulating other. So how we develop shame I believe in our very early childhood, our experience of being with a dysregulated other and becoming dysregulated.*

Maria coupled the annihilating impact of shame with the dysregulating other:

> *Shame is a, it's the feeling of, you know, fragmenting, falling apart, crumbling in relation to a dysregulating other, so it has a physical experience of disintegration and collapsing.*

Clare developed the notion of dysregulation further and how it might present in the therapy room:

When the child is left in this perpetual state of dysregulation and that's been their experience again and again, they're going to find it difficult to regulate themselves, so they might find themselves always in this very depressed state, and then suddenly swing up into this, maybe attack, attack the therapist, you know because something has been activated.

Sarah spoke about the challenge of watching her own dysregulation as well as that of the client and knowing when to name it:

I have to monitor my own dysregulationness……. if you wish, but also just watching how clients get dysregulated in terms of embodied dysregulation….. so, you know, sometimes I name it sometimes I don't.

4.3.2 Implicit Shame

One of the characteristics most closely associated with shame is that it is very often hidden. Nonetheless, four of the participants recognised shame, though implicit, as being in the therapy room all of the time. However, one of the therapists, Ronan, acknowledged that shame is not always something that he would have been aware of:

I've had to start thinking about shame, and how it might manifest in the relationship more. And, so I suppose that maybe indicates how aware was I? I'm over seven years seeing clients at this stage so how aware have I been of it from the off, I would say for a long time, maybe quite unaware of it.

Meanwhile, Maria spoke about the need to hide away in shame, the need to make oneself really small and unseen:

I need to hide, just need to go away and hide, it's like I disappear into this little cube, I go into this little cube in there.

Clare spoke about the way in which shame attacks the core of the self:

Shame is an implicit feeling that there's something wrong about the self so you develop like a belief system that there's something wrong inherently wrong with me as a human being. And therefore, my existence

For Monica one of the first elements in uncovering shame was in acknowledging its power and she spoke about its dominance over other emotions:

> *I will always say to my clients it's the only emotion I know that can suppress all other emotions. You know, shame, it's like people will talk about anger suppressing a lot but anger even completely dissipates under shame. So for me it is, you know, the king.*

Clare acknowledged that with most of her clients shame will eventually come in but it can be very subtle:

> *I suppose, … nearly all my clients will come to some piece around shame. And it might not be explicitly the word shame that is used; shame can come in very implicitly.*

For Teresa there was often a reluctance to name shame, the notion of shame about shame and the fear of re-traumatising the client:

> *So pacing and timing when it comes to naming has to be a very subtle game, maybe, very very subtle and how, allowing the implicit to come into the room, allowing it to emerge into the relationship.*

There was a unifying experience amongst all the therapists about the silence of shame. Monica referred to her experience about shame being manifested in its absence:

> *So in a lot of ways if I sense, you know, that there's an implicit manifestation in some way so it's a really about an absence of something in the relationship more than something there.*

One of the difficulties in working with implicit shame is the fear of re-shaming a client and this can give rise to shame being avoided by the therapist. Joe spoke about one such situation where this was his experience:

> *When she presented that to me, I changed the subject, which replicated her environment, her experience and her shame for her core experience, which she was taking the risk to present. And so I really shamed her, shamed her in*

the therapy, just in parallel with how she has been shamed outside of the therapy. I didn't, wasn't aware of at the time but I can tell you now, because I've processed this so much process in supervision.

4.4 Theme 2: The Embodiment of Shame

In order to work with an emotion that is so hidden or implicit, the researcher was keen to explore with the participants how shame is manifested and identified in the relationship. For all of the therapists, the embodiment of shame was key to its presence. For example, Clare said *there are lots and lots of cues, lots of physical cues for sure.*

While shame may not be stated explicitly or named as such, the way in which clients hold shame in the body was a common experience amongst the participants. The following vignettes illustrate this embodiment:

> *I'm gonna hold it in the body. Even though the body won't hold it because the body will be speaking in its own way too its but I daren't name it now – Ronan*
>
> *But how I would and I presume most therapists do pick up shame, would be in the body response. So for some, it is a very obvious**,** in that this hiding behind hands, this hiding behind hands is something that puts the shame in the room straight away - Maria*
>
> *I think, you know, you can simply see it. You know, it's very, very embodied at times for people. But, but often it's the down head, it's, it's the collapsed body. It's like you kind of see that in depression as well but often is in shame – Sarah*.

There are many words for shame including embarrassment, humiliation, scarlet, to name just a few. Joe dismantled the term 'mortification' to convey his very powerful understanding of embodied shame:

> *Now, mortification, the first four letters of the word mortification M O R T is the French for dead. And that's the actual embodied experience, that's how painful, and, of course can even be beyond pain because a dead person doesn't feel, dead body doesn't feel pain, and numb, the embodiment of it is numbness. And it can be numbness; it can be in response to the threat of mortification.*

Six of the seven participants drew parallels with the embodiment of shame and trauma in terms of the body's neurophysiological response. For example, Monica explained:

> *I think because it's because it's very embodied, it's very connected with your autonomic nervous system….. I touched on polyvagal a little bit but that will be very much around the shaming…the physicality of that, even when you think about it the, the red face, the whole flushing of the face.*

Clare's experience of working with shame and trauma were very similar:

> *You have to use a trauma informed model. We use a trauma informed model because when someone experiences chronic shame their reactions are based on the same. The nervous system is going to get fired up.*

4.4.1 Defences

Perhaps, unsurprisingly for an emotion as indefatigable as the participants describe above, clients defend strongly against shame being brought into the therapeutic space. The use of different defence mechanisms by clients was referred to by the participants including avoidance, attacking, humour, anger, blaming and withdrawal. All of the interviewees spoke about how the different defences are expressed and played out in the therapy room. For example, Clare first spoke about avoidance:

> *Avoidance…… I'm not gonna show up in the room or I just won't come back.*

She then went to describe how clients use withdrawal as a defence:

> *Then you have the withdrawal, pulling back from contact, pulling back from the world even at times. You know I don't really have a place in the world. I don't really feel like I have the right to exist.*

Ronan described what he felt was a very commonly used defence that is often not seen as such:

> *One of the ways we defend too - we dress it up in other tropes or vocabulary, or we make a joke about it because it's maybe more palatable that way, 'I haven't exactly bared me soul now'.*

Similarly, Monica identified blaming, including blaming the therapist, as one that she has increasingly become alert to:

> *And so, I am now paying a keen ear, keen attention to clients who do a lot of complaining and blaming. And I'm starting to listen and watch for the shame in that shaming. I think blame is a defence.*

Maria reflected on the use of defence mechanisms generally in the experience of shame:

> *Shame is one of those, kind of the last feeling we want to experience, and we defend a lot around shame. And so, some of our most long-standing defences and our most, our toughest defences can be around shame.*

4.4.2 Gender Differences in Shame

Within the embodiment of shame the researcher was curious to investigate if male and female expression of shame differed. Both Ronan and Joe believed that gender was an important factor in what a client brings to therapy. Joe stated:

> *Yeah. Gender does influence the way shame has manifested, we are talking in the psychotherapeutic relationship, are they feeling that, oh I can't say that here now, because I'm working with a man?*

Clare was less definitive about a male and female distinction in shame expression but acknowledged that some traditional stereotypical male behaviour patterns can be manifested:

> *We all have the capacity for shame. So when it comes to male and female, it depends on what the client perceives to be shameful, or what's evoking the shame so it may for a male it might be difficult to cry*

Meanwhile, Ronan spoke about the handed down shame, which he believes contributes the way which shame becomes embodied:

> *It's drummed into us since we're about four years of age when we start going to school and going to religious class, religion, that's the whole story of the fall. And Eve stepping out of line and the Garden and mankind condemned to bloody hell for a long time since and, I mean, what's getting laid down on us there as, as innocent naïve, vulnerable, small, human beings?*

Sarah's experience was that there was more shame about shame for men:

> *I think there might be differences in men and women in that I think some men don't like the label shame. You know they wouldn't like that, that's maybe one difference of men I would say. Women would be much more familiar with being shamed in society. And more easily shamed, for men, it's not very masculine thing. They might experience it but I think they might find it a little bit harder to verbalise it or be more defended against the experience.*

Monica, Maria and Teresa had all worked with clients who had pervasive shame from sexual abuse. Maria also referred to the stigma and shame, irrespective of gender, that came from being poor or from a marginalised sector, such as being a member of the Traveller or immigrant communities. She also identified more frequently now male clients having feelings of shame about their bodies that might in the past have been more associated with women. However, in Maria's experience women were more likely to physically hide their shame in the therapy room:

> *So a lot of it will be in gesture, women, not men will use the cushions; there will often be cushions around here, cushions as a way to protect themselves, perhaps, eh, hide a part of the body that they may be shameful about.*

4.5 Theme Three: The Therapeutic Relationship and Shame

The importance of the therapeutic relationship came up frequently during the interviews. Some therapists had been working with clients for long periods of time before shame work began. In these cases, a long established relationship where a strong degree of trust had been built up was central in working with shame issues. Sarah described it as follows:

> *Psychotherapy - it is extremely helpful because it is about the relational. If you work relationally, if you think the relationship, the embodied present relationship, being there for that person.*

Sarah's experience resonated with Maria who similarly spoke about being present to what is happening in the relationship:

> *So a lot of that is in trusting the relationship, and in tone, and in describing and mirroring without…staying really, really curious.*

Clare also stressed how closely she monitors the relationship with clients:

> *So it's kind of being aware of, like, what's palpable in the room you know what's happening with my interacting with this client, because my interaction or my relationship with this client is going to determine, well it's going to determine the outcome of the therapeutic process or even the outcome of even that session.*

Joe outlined how he tries to provide the support that the client was missing:

> *And….solidarity is the essence of what I offer, sensitivity of what solidarity was missing for the client and what solidarity is in the now, in this therapeutic relationship bringing to life as a felt experience for the client, a support in the room.*

Monica recognised what is left for a client if shame is not made explicit and her approach is to take the stigma out of shame:

And if you don't step into it now you know that it can leave an awful lot out of the work. But you have to really open that space. Make shame welcome. You know, and normalise it.

4.5.1 Transference and Countertransference

Most of the participants referred to the transference and countertransference as the mediums through which shame is played out. Teresa explained:

I think we have all been shamed by somebody at some stage so I think it's possibly if somebody in authority, be it a parent or school, whatever has shamed the person in therapy. The client, well then chances are that some of that is going to be, you know, if there's a transference around authority to the therapist, then there will be a transference of past history in relation to authority.

Monica spoke about her experience of transference inhibiting a client's ability to bring in shame:

I have no doubt, with my clients that it is all about the transference, and that's why I now as a therapist don't hesitate, very much to bring shame in, you know because I reckon transference could be a big part for them, in stopping it of course, because most of the shame will be parental. You know, so if I'm somebody's mother or father sitting here.

Similar to other emotions, shame that cannot be expressed in the therapeutic relationship is unconsciously acted out. Maria characterised her experience of a shame enactment:

And the rage that builds up, even though they've never had this relationship, now in adulthood there is still this longing, maybe still I can have this relationship. And the, the, the vulnerability in that, that part of them is still longing for relationship with the parent who is long dead or for whom there was only ever troubled relationship.

Maria also spoke about having the disavowal of shame:

We are not even going to speak about this; it is not even in the room. Yea, complete dissociation.

For Sarah, the enactment of the attachment experience and the means through which change could be effected were only possible through the therapeutic relationship:

It's slow work because they have to come to really trust that they can trust an enactment, you can stay with that but if you have that relationship that's developed, a real sense of you matter to the client. I think you have to matter to the client to effect a change.

In relation to countertransference, Sarah and Teresa spoke about what the client's shame evokes in them:

I'm starting to feel that I'm bad that I've done this, but I haven't done anything except given the client an experience but I can get caught into that – Sarah

In relation to countertransference,……there can be from clients, you know you're useless,…there can be a countertransference then around shame that you're not good enough - Teresa

Monica described how previously her own countertransference prevented her from talking about shame:

I suppose, more in the past, than recent, of course I think my own countertransference around shame would have blocked me from bringing it in.

4.5.2 The Therapist's Shame

While countertransference can be generated in response to the client's transference, all of the therapists recognised that their countertransference was also about their own shame. Maria spoke about her first realisation that the shame in the room could belong to the therapist as well as the client:

> *It is interesting to learn that shame could be in the room, not just something that the client brought with them, but shame could be in the room, it could be between us, and it could be even the therapist's shame so that was really interesting.*

Each of the therapists spoke about their awareness of their own shame as demonstrated in the following two vignettes:

> *Yeah, I don't need to look too much further than my own family narrative or handed down family narrative eh, to see the effects of shame. But I'm probably recognising it more in clients than I realised, because there is so much of it in me own DNA – Ronan*

> *And I have to be aware of my own shame as well. So I have to think oh gosh now have I heard this other person, start to be, feel the bad therapist, because I know shame is a big thing with me back into intergeneration in my father's family. Very clear thread running through – Sarah*

In addition to talking about her own shame, Sarah spoke about the impact of being shamed by the client:

> *I mean it was a really very strong shaming attack on me. And that was, that was interesting because then it's you that starts to feel it but then you have to put your feet on the floor, you have to breathe, you have to ground, you have to think of the client and stay with the client but it really threw me. These people pick up if you have shame. And they will go for you and she did, and it was an interesting experience from the other side of being the one that felt ashamed, and was deliberately being made to feel shame.*

Ultimately, there was a consensus amongst the participants that to work with shame, therapists need to continually monitor their own shame. As Clare stated:

> *I think over the years, lots of supervision… has helped me to really look at, well, my own shame. And if I can recognise my own experience of shame or what it evokes internally for me.*

4.6 Summary

This chapter set out the findings from the research study on shame under three main themes relating to attachment, embodiment and the therapeutic relationship. The findings revealed very powerfully the extent to which shame is present in the therapy room and its impact on both therapist and client. The researcher was struck by how alert the participants were to its presence: how shame could be found in the dysregulation from early relationships; the defences employed by clients to keep shame out of reach and how such defences revealed rather than hid shame in the body; gender differences in the manifestation of shame; and the strength of the enactment of shame in the therapeutic relationship. The participants' experiences reflected a deep understanding of clients' aversion to shame and fear of it being exposed. The researcher was very moved by the participants' own shame narratives and it was evident that their personal experiences of shame contributed to their insights in working with shame issues. Chapter 5 will explore the emergent themes in the light of the literature reviewed.

CHAPTER 5: DISCUSSION

5.1 Introduction

The aim of this thesis was to explore the manifestation of shame in the therapeutic relationship. The three themes identified in the Findings chapter will be discussed in this chapter: shame and the early attachment experience, the embodiment of shame, and shame and the therapeutic relationship. The main focus of the discussion will be on the relationship between these themes and the theory and literature reviewed in chapter 2. The strengths and limitations of the study together with recommendations and conclusion on this subject matter will form the final part of the discussion.

5.2 Shame and the Early Attachment Experience

The early attachment theory of Bowlby and Ainsworth established the importance of the primary relationships in shaping emotional development, regulation, and patterns of relating to others. DeYoung (2015, p.xiv) maintained that chronic shame in adults can be traced back to the young infant's early repeated experiences of affective dysregulation. While some of the participants of this present study had worked with shame that came from other sources such as abuse, all confirmed their intuitive sense was, that for most clients, shame originated from ruptures in early development. The crippling and debilitating pain of shame, of being let down, of being "less than",

being diminished, marginalised, not being acceptable, weaved throughout all of the interviews. The findings revealed that there was no ambiguity between shame and guilt as far as the interviewees were concerned; they are very different experiences both in presentation and affect, notwithstanding their often-interchangeable use in the lexicon of emotions. Maria characterised this difference as the ease with which guilt is brought into the room but not shame.

The capacity for shame to instil feelings of being intrinsically bad was another motif in the findings. DeYoung (2015, p.18) talked about the power of the 'dysregulating other' in the felt sense of shame. Sarah spoke about how the experience of the 'dysregulating other' inhibited clients' ability to regulate themselves. Consequently, in her experience, the lens through which the clients view themselves and the world is from a position of dysregulation. This is line with DeYoung's (2015, p.xiii) view that an integrated self is developed from the regulation and emotional attunement of an attachment figure; when that person is emotionally absent, 'the dysregulating other', self regulation is not learned and in its place is fragmentation. Two of the participants spoke of the very visceral impact of shame in the therapy room; Monica referred to the fragmentation and disintegration that DeYoung (2015) identified, while Clare described the volatility that dysregulation can provoke for a client if something is activated and how that might translate into a strong defensive reaction against the therapist. Within the chaos of such dysreglation and disintegration, the role of the therapist may first and foremost be about helping the client to learn how to regulate before any shame work can begin.

The literature review identified different types of shame, external and internal, explicit and implicit shame (Gilbert, 2007, Schore, 2003). For most of the interviewees implicit shame corresponded with their perception of shame, of being hidden, inaccessible, and at times, unconscious. Four of the participants stated that shame though often unnamed or unacknowledged was in the room all of the time. The participants all agreed that the implicitness of shame meant that it very often manifested in silence and indeed was sometimes conspicuous by its absence. Some of the difficulties of working with implicit shame are that it can be named or brought in too quickly or avoided altogether, thus there is the danger of re-shaming the client. One participant recounted an experience of avoiding an important issue with a client and later came to understand that in so doing he had fallen into the trap of re-shaming. In the early literature on shame, Helen Block Lewis (1971) captured the meaning of such an experience when she identified this avoidance as 'by-passed' shame (Scheff, 1987, p.110). For Lewis, shame that is left untouched has the power to re-shame over and over again. Joe's retrospective understanding of this experience highlights the need for strong supervision in working with shame issues.

Schore's work identified the way in which early experiences create internal working models that become the templates for interpreting later experiences (2003, p.257). Thus, the link between implicit shame and attachment; early shame episodes become imprinted and prime the individual for further shame experiences (Cozolino, 2016, p. 95). Two participants spoke about the speed with which shame is learned from the early experiences of seeing or hearing disapproval from the primary caregiver. The desire to protect against such experiences as an adult was described by one

interviewee in her depiction of keeping oneself small, hidden and out of sight. Two other participants spoke about how slowly implicit shame emerges in the room and the sensitivity involved in naming shame as such. Given how implicit shame can be, it was interesting that Monica described its power as an emotion that "can suppress all other emotions". She talked about clients who may be justifiably angry about early childhood experiences but the anger is dissipated under shame, which is the predominant emotion. The idea of emotions being stacked on top of each other under the overarching edifice of shame was not apparent in the literature reviewed and provided the researcher with a thought-provoking construct with which to interpret what is happening in the room.

5.3 The Embodiment of Shame

The participants characterised external shame as primarily the outward manifestation of shame or its embodiment. DeYoung (2015, p.63) drew attention to the physical cues for shame that are held in the body. Typically, these will include little or no eye contact, covering the eyes or other parts of the body, blushing, sweating, and wrapping the body around itself. The literature supports the embodiment of shame experiences described by the participants. Different participants described experiences where shame was revealed in the body rather than what was being said or not said. For example, Maria spoke about the gesture of covering the face with the hands, which in her experience immediately brings shame into the room. Ronan spoke about the non-verbal actions of the body that expose shame. The language of shame

also powerfully revealed the extent of the feeling that shame engenders, for example, Joe linked the word 'mortification' to the numbness of shame. The researcher was struck by the participants' curiosity and empathy for their clients' embodied states but also by their willingness and openness not to rush to judgment or to pathologise their clients' shame experiences. This reflected the spectrum of shame model referred to by Sanderson (2015, p.22-23) who posits that not all shame is chronic.

The embodied response to shame can be similar to trauma in hyperarousal and fight flight freeze responses. Matos and Pinto-Gouveia (2010, p.307) infer from their studies that the encoding of early shame experiences has similar characteristics to traumatic memory. The findings were supported by this research; a number of the participants referred to the physical link that they saw between trauma and shame in the therapy room; some spoke about the stillness in the body, irregular breathing, while others picked up on the client's inability to speak, dissociation, and flushing of the face, all reflective of an activated autonomic nervous system. The participants who connected shame with trauma had an innate sense of early shame experiences being triggered and, as one therapist described it, the meaning of working with such embodied memories and their physiological impact was the same as working with trauma in reframing a client's experience.

The use of defences is another way in which shame is embodied. The literature and findings reveal the extent to which shame can elicit excruciating pain for clients and unsurprisingly strong defence mechanisms are employed to keep the unbearable emotion of shame under the surface or indeed out of consciousness at all. Across all

of the interviews the defences proposed in Nathanson's (1992) Compass of Shame: avoidance, withdrawal, attack other and attack self were referred to by the participants who frequently witnessed their use in the therapy room. Two participants referred to their experiences of humour and blaming as defences, both reflected in the literature (attack self and attack other respectively). The researcher wondered if their function as defences against shame have become somewhat obscured because both of these defences are seen outside the therapy room more than some of the others.

Essentially, what came across most strongly to the researcher was the sensitivity with which clients' defence mechanisms were managed by the participants. The meaning of defences for clients was acknowledged, amidst their need to hide and avoid exposure or to express anger and rage; there was an unspoken but ostensible belief amongst the group of participants of the necessity of working with shame defences rather than trying to dismantle them.

In this last part of the embodiment of shame theme the discussion will explore gender differences in the expression of shame. The gender split in the group was five women and two men and it was interesting to see how their perspectives on shame differed. For the male participants, shame was about what was handed down through the generations, for example, the story of 'the fall' in the Garden of Eden, the impact that their gender had on what female clients could bring to therapy, and their own avoidance around shame particularly related to intimacy. The female participants were mostly more at ease in talking about shame with either male or female clients including shame about intimacy. While most of the female participants initially felt

that there was no significant difference in gender expression of shame the subsequent discussions revealed their experiences that male and female shame was not always the same. Clare spoke about the shame men felt about crying while Sarah spoke of men's perception of shame as emasculating, and how strongly defended men were against shame. Neither of the male therapists spoke about having experiences of shame with male clients and when reflecting on the data, the researcher wondered if this was significant; that perhaps male therapists might feel emasculated in talking about shame to male clients. The notion of emasculation was representative of the research carried out by Stepien (2014, p.7) and the idea of shame undermining male identity. In relation to the expression of shame in women, Maria spoke about the use of props in the room such as cushions to hide what are considered to be shameful body parts. While not stated explicitly, the clear implication was that shame referred to female sexuality. This corroborates much of the literature on shame where sexual activity is closely aligned with female but not male shame (for example, Nurka 2012, Stepien, 2014). The researcher found the connection of shame with female sexuality in the literature and findings particularly apposite in the light of the narratives that emerged from the #MeToo Movement.

The embodiment of shame refers to the way in which shame is contained in the body but it also refers to the body itself as a powerful source of shame for both men and women (Sanderson 2015, p.84). While shame in relation to body issues such as weight and feelings of attractiveness might previously have been more associated with women, the study found some female participants were increasingly seeing male clients presenting with body shame. For men there was the further complexity of such

shame being layered with feelings of emasculation or shame about shame. The researcher wondered if this phenomenon represented the impact of the public shaming on social media platforms infiltrating the therapy room.

Finally, Sarah spoke about how women are used to being shamed in society. Certainly, the literature evidenced women being more shame-prone than men and the different ways in which boys and girls are socialised to fulfill their respective role expectations (Tangney, 1994, Ferguson, Eyre and Ashbaker, 2000). While traditional gender roles continue to evolve and change, the Ludwig and Thoma (2013) workplace study suggests the negative self-evaluation that shame proneness generates is not easily quashed.

5.4 The Therapeutic Relationship and Shame

The therapeutic relationship has been hailed across the literature on psychotherapy as the most important factor in effecting change (Clarkson, 2004, Cooper, 2008). The findings reflected the participants' certainty that the strength of the relationship and working relationally was the cornerstone through which shame issues could start to emerge. Some participants had worked with clients for long periods of time, three to four years in one case, before the client was ready to allow shame to come into the room. One therapist spoke about the need to continually stay open and curious about what was happening for a client, and sometimes having to anticipate the shame in the room. The findings illustrated that in addition to giving the client an empathic and

deeply supportive experience, it was about creating an environment where shame could come in and be normalised.

The literature refers to how shame is enacted both in the transferential and countertransferential relationship and it is in the intersubjective space between client and therapist where this is played out (Hahn, 2000, DeYoung, 2015). Most of the participants recognised that who they represented for the client in the transference from early shaming experiences often made it more difficult for shame to be made explicit in the room. In fact, one participant believed that inhibitions posed by the transference necessitated her being proactive about bringing shame into the therapeutic space. The transference enactments detailed in the findings were manifested in either furious outbursts or complete dissociation, both representing the early pre-verbal relational experience of shame that DeYoung (2015) identified. Clarkson's (2004) theory that the anger in the enactment relates to what is present now in the therapeutic relationship but missing from early experiences resonated with Maria's experience of the rage and vulnerability about longed for but never realised relationships. Working through, without getting caught in the enactment process, was as Sarah pointed out dependent on the value of a strong relationship, the therapist's ability to withstand the enactment process and the importance of mattering to the client.

There was a general consensus amongst the group about how easily their countertransference triggered feelings of inadequacy and failure as a therapist. It is therefore easy to see how the notion of collusion that Morrison (2008) referred to,

could be unconsciously engaged with in the intersubjective relationship to avoid the toxicity of shame. The therapist's countertransference may be activated as a response to what is happening for the client and/or when his or her own feelings of shame come to the fore (Hahn, 2000, Hahn, 2004). For the researcher, the willingness and openness of the participants to discuss their own shame was one of the unexpected and important elements of the study. The earlier discussion referred to one participant, Joe who considered that his gender determined what female clients might talk about in therapy. In the interview he readily acknowledged this also related to his own feelings of shame. The other vignettes in the findings also illustrate the level of awareness that all the participants had about their own shame. Their powerful narratives revealed the capacity for the participants' shame to be present in the room in equal measure to the clients' shame. Unconscious processes in the relationship mean that sometimes a client may detect a therapist's shame and in the negative transference it can be acted out in the form of shaming the therapist, as was Sarah's experience. Similarly, countertransference arising from the relationship or therapy work may ignite the therapist's defences and the client may be shamed or re-shamed as Joe described. In working with shame, Sanderson (2015) emphasised the need for therapists to have done their own work on shame and this was borne out by most of the participants. The findings outlined in the discussion above correspond closely to Wallin's statement about the evocation, enactment and embodiment of what cannot be spoken (2007, p.261). In the final analysis, shame is mediated in and by the therapeutic relationship; in the intersubjective space between therapist and client rests the possibility for shame to come in and be made manifest.

5.5 Limitations of the Study

The topic of shame is very broad and in a dissertation this size it was only possible to focus on some elements of it. Due to the permitted word count of the study, it was not possible to expand the discussion on a number of aspects about shame, for example, the shame associated with female sexuality or the shame that comes from being a member of a marginalised group. In addition, the discussion was written from the perspective of a Western ideology where shame belongs to the individual and this does not take account of how shame impacts on collectivist cultures.

The researcher deliberately chose an experienced cohort of therapists for the study as they were more likely have some experience of working with shame. It would be interesting to do a similar research study with recently qualified therapists or pre-accreditation students to see if a shame focus forms part of their work.

Five of the interviews were conducted face to face and two were done online due to the Covid-19 restrictions. The researcher did not find the quality of the online interviews to be any less than the face-to-face interviews but what was missing was the opportunity to see the nuances of body language for the online participants, particularly when talking about a subject such as shame.

5.6 Strengths of the study

The strength of the study was firstly being able to recruit seven experienced therapists with a wide range of modalities within a humanistic and integrative orientation. This provided very rich data for the study and much insightful learning about the manifestation of shame in the therapeutic relationship. Secondly, the participants' willingness to talk openly about their experiences including their personal experiences of shame added clarity and a depth of understanding to what is a complex emotion. The characteristic most associated with shame is its tendency to be hidden and the study sought to uncover the nature of shame. By continuing to identify and name shame it is hoped that the study will contribute to the monumental task of normalising shame.

5.7 Recommendations

It was clear from the interviews with all of the participants that shame is a difficult emotion to manage in the therapeutic relationship. Working with shame requires therapists to have explored their own shame, its origins, and impact and how it may get triggered in the therapist client dyad. Most of the participants had done some additional training around shame through which they had explored the personal meaning of shame for them. The researcher considers, and this was supported in the literature (Sanderson, 2015) that training courses for psychotherapy students could

usefully include a theoretical and experiential component on shame that would increase awareness and understanding of its manifestation in the therapy room.

5.8 Conclusion

The focus of this study was an exploration of the manifestation of shame in the therapeutic relationship. The findings revealed that shame comes from many sources but the study focused predominantly on shame from the rupture in early attachment experiences. The notion of shame as relational in the context of a 'dysregulating other' was identified as the basis of shame for many clients. The toxicity of shame means that it is heavily defended against to the extent that it is often completely disavowed. Interestingly, one participant, pointed to the dominance of shame and its power to dissipate all other emotions. The results showed that the expression of shame is not always the same for men and women. According to the findings, men tended to be more defended against shame and to experience shame about shame, whereas women, while being more shame-prone, were more likely to physically hide their shame particularly shame about sexuality. The body was identified as both a significant container for shame and a source of shame in itself. In addition, the value of the therapeutic relationship was highlighted as the most significant element in working with shame. Given the implicitness of shame, the findings showed that clients act out early shaming experiences through the transference enactment. Similarly, therapists' own shame can get caught in the countertransferential response. The findings conveyed a strong message for therapists to have done their own shame

work in order to inform shame work with clients. Overall the study was supported by the literature on shame, it illustrated how present shame is in the therapeutic relationship, its capacity to undermine and diminish the self, and the importance of making shame manifest in order to lessen its power.

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APPENDICES

APPENDIX 1: Information Sheet

My name is Celia Daly and I am currently undertaking an MA in Psychotherapy at Dublin Business School. I am inviting you to take part in my research project, which is concerned with shame, how shame comes into and impacts the psychotherapeutic relationship, how it may be identified, and subsequently worked with. I will be exploring the views of people like yourself who are experienced practitioners working with a humanistic and integrative approach to psychotherapy.

What is Involved?

You are invited to participate in this research along with a number of other people because you have been identified as being suitable, being an experienced therapist working with shame issues. If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience, which should take no longer than an hour to complete. During this I will ask you a series of questions relating to the research question and your own work. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

Confidentiality

All information obtained from you during the research will be kept confidential. Notes about the research and any form you may fill in will be coded and stored in a locked file. The key to the code numbers will be kept in a separate locked file. This means that all data kept on you will be de-identified. All data that has been collected will be kept in this confidential manner and in the event that it is used for future research, will be handled in the same way. Audio recordings and transcripts will be made of the interview but again these will be coded by number and kept in a secure location. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

DECLARATION

I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research.

I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant (in block letters) _____

Signature_____

Date / /

APPENDIX 2: Consent Form

Title:

An exploration of Shame, the way in which it presents and is worked with in the psychotherapeutic relationship

Please tick the appropriate answer.

I confirm that I have read and understood the Information Leaflet attached, and that I have had ample opportunity to ask questions all of which have been satisfactorily answered.

Yes No

I understand that my participation in this study is entirely **voluntary** and that I may withdraw at any time, without giving reason.

Yes No

I understand that my identity will remain confidential at all times.

Yes No

I am aware of the potential risks of this research study.

Yes No

I am aware that audio recordings will be made of sessions

Yes No

I have been given a copy of the Information Leaflet and this Consent form for my records.

☐Yes ☐No

Participant _____ Name in block capitals

_____

Signature and dated

To be completed by the Principal Investigator or his nominee.

I the undersigned, have taken the time to fully explained to the above participant the nature and purpose of this study in a manner that he/she could understand. We have discussed the risks involved, and have invited him/here to ask questions on any aspect of the study that concerned them. In line with GDPR regulations, data will be retained for no longer than is necessary. All records where you can be identified (e.g. recordings, etc) will be destroyed after all phases of data collection are complete and the data have been fully anonymised. At this point, your data can no longer be withdrawn from the study as it is no longer identifiable.

_____ _____

Signature **Name in Block Capitals**

_____

Date

APPENDIX 3: List of Interview Questions

1. From the work with your clients, how do understand the meaning of shame and has this changed in the time that you have been practicing?
2. How does shame manifest in the therapeutic relationship?
3. Does gender influence the way shame is manifested?
4. From your experience, have you found that shame affects the therapeutic relationship and in what ways?
5. What do you see as the difference between shame and guilt?
6. In your experience with clients, have you found a link between shame and early attachment experiences?
7. Can you think of an example of a client where shame was held in the body and how this impacted the client therapist relationship?
8. Can you describe the way in which clients defend against shame?
9. How do you work with a client who has shame?
10. Can you tell me of a case from your experience where psychotherapy was helpful for a client with shame issues?
11. Are you finding in your practice that social media platforms are now coming into the therapeutic space and contributing to shame for clients?
12. Can you explain, from your experience, the way in which transference/countertransference issues in relation to shame might arise in the therapeutic relationship?
13. In your professional opinion do therapists need specialist training and skills for working with shame?
14. Is there anything else you would like to add, that has not already been discussed?