Chapter 25
Working with Shame in Psychotherapy: An Eclectic Approach

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Abstract Shame as an emotion is a deep rooted one. Being a widely felt emotion, its presence in the context of psychopathology and psychotherapy with clients is of special importance. Shame as experienced by clients, often hides under the façade of secondary emotions of pain, embarrassment, grief or anger. Uncovering shame therefore requires great skill, patience and knowledge on the part of the therapist. At times, it is through the client's repetitive experiences and narratives that inklings of shame may be revealed. The repertoire of other emotions makes shame so distant for the client that it can take a long time accepting it as one's own. Working with shame in psychotherapy effectively has found to alleviate symptoms, decrease distress thus creating opportunities for accepting the self as it is. The current chapter aims at understanding shame from different theoretical perspectives, it's link with psychopathology and how it showcases in therapeutic settings. Selected cases of shame and working with it have been presented in the Indian context. Conclusions on effective possibilities for healing shame in psychotherapy in addition to suggestions for future research have been discussed.

Keywords Shame · Psychotherapy · Culture · India · Client

25.1 Introduction

The Oxford dictionary on-line defines shame as "a painful feeling of humiliation or distress caused by the consciousness of wrong or foolish behaviour". Researchers (Karlsson & Sjoberg, 2009) have found the root of the word "shame" to be traced to Indo-European word kam/kem meaning to "hide", "conceal" and "cover up". Amidst the realm of the positive and negative emotions, shame confines itself in the zone of self-conscious emotions which includes guilt, embarrassment and pride. These feelings consist of an inherent capacity of the self to evaluate itself thus making them

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'self-conscious' (Tracy & Robins, 2006). Even as guilt and shame continue to be used synonymously for the longest time, researchers have outlined clear distinctions between the two (Tangney, Stuewig, & Mashek, 2007). As theorized by Tomkins (1963) the response of hanging the head or lowering the eyes when one feels ashamed leads to an instant reduction of facial visibility. This is the reason why shame is often equated to 'loss of face' or to lose one's honour.

Shame has been primarily found to consist of two major components. The first is referred as an *external shame* which consists of thoughts and feelings on how one exists in the mind of others (Gilbert, 1997, 1998 Gilbert, in this book). It constitutes feelings of anger, contempt, rejection which others might have of one's self. The second component, *internal shame*, is experienced when one looks at one's self and criticizes and devalues it (Gilbert & Procter, 2006).

Additionally, shame has also been attributed to a person's current state or personality trait. When expressed as an emotion in specific situations, shame, becomes a state of the individual. However, when a person finds themselves ashamed more than often it is said to be rooted as their personality's trait. Repetitive childhood experiences of hearing oneself as "I'm bad and unattractive" or "Something is wrong with me" usually falls in this category (Claesson, Birgegard, & Sohlberg, 2007). This has also been described as "core shame" and shame proneness wherein a person experiences frequent episodes of shame states (Tangney et al. 2007; Cozolino & Santos, 2014).

As an emotion, researchers have often questioned the delay of the scientific field to be intrigued by the psychology of shame and a willingness to comprehend it (Kaufman, 1996; Zaslav, 1998).

25.2 Conceptual Framework: Understanding Shame Through Theories

Of the different theorists who've discussed about shame, some of the prominent theoretical perspectives have been offered by the evolutionary or functionalist, psychodynamic perspectives (Eriksonian, Attachment theorists, object-relationists), cognition and attributional approaches.

With respect to the evolutionary approach (Gilbert and Elison, in this book), humans have been found to be social beings carrying a social threat warning system. The behaviors associated with shame (such as averted gaze, slumped posture, lowered head) are submissive and strategies to disengage from a conflict (Dickerson, Gruenewald, & Kemeny, 2009). Theorists are of the view that shame, from an evolutionary perspective, can be both adaptive and maladaptive, facilitating relationships at one end and leading to defensive behaviors on the other, especially if frequently shamed as a child (Dickerson et al., 2009; Leeming & Boyle, 2013).

In the psychoanalytical tradition, Piers and Singer (1953) described shame as arising from the conflict between the ego and ego ideal in contrast to guilt emanating

from the tension between ego and superego. Erikson (1950) in his theory of lifespan development considers shame as a consequence of the child being unable to claim his autonomy as s/he learns toilet training in the second stage. Pioneers in the field of object relations emphasized on the internal mental representation the child has of his caregiver. As the child alternated between the experiences of union and autonomy with the other, it was in such moments that shame found its presence (Stadter, 2011). Attachment theorists (Bowlby, 1973, as cited in Mills, 2005) posited shame to be felt whenever the mother-infant bond faced disruption. According to Bowlby a child who feels unwanted by his/her parents also comes to believe that s/he is "essentially unwantable, namely unwanted by anyone."

Cognitive psychologists (Tangney & Fischer, 1995) have viewed shame as related to a global and 'pervasive sense of self as bad, defective or deficient'. This ability to self-evaluate oneself is believed to develop in children between the ages of two to three years. In contrast, theorists (Tomkins, 1962, 1963 as cited in Zaslav, 1998) of affect theory consider shame to be a negative emotion which impedes the occurrence of positive emotions such as interest-excitement or enjoyment-joy. According to Tomkins, this emotion allows individuals to both master and overcome obstacles that may prevent positive effects from occurring.

Thus, while different theorists have posited their understanding of shame and its expression, the common thread that is seen through all the perspectives is an understanding of shame as a social emotion capable of alerting an individual of their societal boundaries. Additionally, it is through an individual's internalisation of a behaviour that shame comes to be either adaptive or maladaptive.

25.3 Shame and Psychopathology

Research suggests that shame and shame proneness have been linked with psychological difficulties and mental illnesses. Shame has been found to be associated with depression, eating disorders, bipolar disorders, anxiety disorders, personality disorders (borderline and narcissistic and mood disorders) (Tangney et al. 2007; Candea & Szentagotai, 2013; Scheel et al., 2014). People suffering from borderline personality disorder have been found to report significantly higher levels of shame compared to those diagnosed with mood disorders. (Rüsch et al., 2007; Scheel et al., 2014). Shame has also been reported in people suffering from Post-Traumatic Stress Disorder, both, as a primary emotion seen at the time of trauma and a secondary emotion seen after the appraisal of the event. (Grey, Holmes, & Brewin, 2001; Ehlers & Clark, 2000). The role of shame has also been found in constant worrying present in Generalised Anxiety Disorder (Gosselin et al., 2003) and potential consequences of Panic Attacks which lead to catastrophic misinterpretations of body sensations in Panic Disorder (Austin & Richards, 2001).

Thus, shame as an emotion finds its place in a wide variety of mental illnesses which may or may not have been studied yet, leading to the need to understand its effect on both the client and the symptoms of the illness they are diagnosed with.

25.4 Shame and Culture

Emotions have been found to play a central role in social relationships (Oatley, Keltner, & Jenkins, 2006; Mesquita, 2010). Expression of an emotion allows one to express one's concerns, reveal strategies, goals, intentions to act, thereby allowing an individual to take a stance in the social world. (Solomon, 2004; Griffiths & Scarantino, 2009). Universally, emotion regulation seems to be motivated by a person's need to establish and maintain proper and good relationships (Thompson, 1991; Gross, Richards, & John, 2006). Different cultures have different standards, and great variation on what will illicit shame. Studies in the area of culture and emotions have found East Asian cultures (Bhawuk, Wang, & Sang, Sueda and Clarke & Takashiro, in this book) to be interconnected, interdependent and adjust to each other's expectations (Kim & Markus, 1999; Oishi & Diener, 2003).

Interestingly, while Western literature clearly contrasts shame and guilt as having an "external" (being oriented to others) versus an "internal" orientation (being oriented towards self), studies on collectivistic cultures give mixed findings on the differences and similarities between shame and guilt (Breugelmans and Poortinga, 2006; Wong & Tsai, 2007). It is purported that since collectivistic cultures do not view themselves as separate from their relationships with others, their contexts or actions, shame and guilt acquire less differentiations from each other. These two emotions are considered conducive, in building strong relationships as they highlight flaws and shortcomings, thus encouraging alignment with social rules and relational embeddedness (Leersnyder, Boiger, & Mesquita, 2013). The ability to focus on one's flaws allows one to experience self-criticism which pushes individuals to live up to other's expectations, especially observed in countries such as Japan (Lewis, 1995; Nisbett, 2003). Thus, less focus is put on "internal" orientation in collectivistic cultures as compared to western cultures (Morling, Kitayama, & Miyamoto, 2002).

Additionally, both Western and Collectivistic cultures differ in the value they attach to shame itself. It has primarily been found that cultures such as Indian, Chinese, Japanese view shame as one of the positive emotions as compared to Americans, who see it as a negative emotion. For instance, Rozin (2003) in a research found that Americans viewed shame and anger as similar as they are both negatively valenced in contrast to Hindu Indians who considered happiness and shame as similar as they are both socially constructive. It is owing to this reason, that shame in collectivistic contexts plays a salient role in everyday life. (Crystal, Parott, Okazaki, & Watanabe, 2001).

Since the emotion of shame is intricately woven in the fabric of Asian cultures, it's no wonder that both the client and the therapist may find it difficult to exterminate it from the narrative. In extreme cases, hypothetically speaking, a therapist may even talk of emotion regulation with complete negation of the emotion "shame". Thus, it may take a personal experience on the part of the therapist themselves to be capable of recognising shame and seeing its effects on the client's psyche, personality and their lived life.

25.5 Shame in Psychotherapy

Lewis (1971), a pioneer in recognising the importance of shame in psychotherapy, posits that shame represents a family of emotions such as humiliation, belittlement, feelings of low self-esteem and stigmatization. Additionally, it can represent itself as a core ingredient in experiences of feeling hurt, inadequate, rejected, exposed, defeated, intimidated, peculiar, powerless and helpless.

In other words, the emotion of shame can often mask itself in a variety of other feelings. It is because of this reason that it can elude both the client and the therapist for a long time, that even when identified, its' presence may bring a kind of a denial or confusion in the client as if the word "shame" had suddenly become foreign. Nonetheless as therapists, one needs a keen eye to detect the presence of shame, a skill which requires great clinical acumen, knowledge and experience.

25.5.1 Who Am I?

A client named Neetu, shared in our seventh session, her uncertainty on feeling ashamed about her personality during her teens. Neetu was a thirty-three years old married woman, who stayed with her husband and child, from a middle-income family, with a Masters degree in Education. Her spontaneous reaction to feeling ashamed was that of confusion. Neetu had brought concerns about her workplace into psychotherapy which would often manifest in forms of constant chatter and ruminations in her mind. She would spend hours worrying over her thoughts, perceiving them to be real at the pretext of household chores being left unattended to.

Thoughts such as "*What will they think of me*" or "*They will seclude me*" would disturb her to the extent of making her feel inferior, inadequate, worthless, small and useless. She was diagnosed to have Obsessive Compulsive Disorder and was seeking both pharmacological help as well as psychotherapy for the same. Neetu had given her colleagues at work all the power to decide her worth. In other words, a supervisor's praise would make her feel elated while a critical comment was taken at heart, making her lose her worth and confidence. With respect to social situations she found herself repeatedly getting "*hurt and betrayed*" as she would realise the motive of the colleague much later than the occurrence of an event. Over the course of initial sessions, it was found that Neetu was discouraged to make friends in her teen years, which took away the core knowledge and skills required to befriend people, recognise their intentions and protect oneself in accordance to different situations.

One particular session vividly brought to the front the aspect of shame. As she recalled her colleagues mocking at her in a meeting where she was presenting, tears filled her eyes and began streaming down her cheeks. In a few seconds a pain so deep unleashed itself through a generous cry wherein she averted her gaze, bit her lips and looked down and away. After a few moments of silence, I gently asked her "*What do you feel right now?*". She replied "*Inferior*" through her sobs. Tugging

along through her tears she said "*I felt like a demon in the story which I was talking about*". I calmly enquired "*What does being a demon means to you?*". She replied "*Not being sincere in my work*". I asked if she felt she was being insincere. To this she replied "*I feel like I'm not a correct person*". It is important to note here that this was not the first time Neetu felt like this. On other occasions in the past she had taken her superior's criticism at heart, personalising it to herself rather than the task which required re-working. Having read about shame and its' mechanisms in therapy I was particularly interested in exploring the emotion with Neetu. I recognised the *shame behind her repeated narrations of feeling "inadequate, small, inferior*" as put by her in prior sessions. Some enquiry about her childhood led her to share how her grandmother and aunt would constantly compare her with her sister. "*I wanted to be a correct person*" she uttered with emphasis on the word "correct". I asked what she meant by it. "*A person who is not very serious, jovial*". Further enquiry led her to share her elder's focus on wanting her to be "*studious, docile, quiet and polite*". Some of the principles offered by them to her included "*Find happiness in others' happiness*" and "*Don't allow others to point fingers at you*". It is here that the shame Neetu experienced in being herself became all the more evident.

The session saw great ambivalence from Neetu's end about her personality. While she had idealised the "*docile, polite*" person and aimed to be like that, she often felt ashamed about putting forth her perspectives to others or speaking her mind assertively. This also led her to feel '*inadequate and lacking*' every time she saw someone be confident and assertive in her approach. Lerner in her book (2004) The Dance of Fear, writes "Whatever is shamed, stigmatized or misunderstood in the larger culture gets absorbed as someone's personal shame". This is precisely how Neetu had internalised herself as an "*incorrect person*". In a culture like India, parents are often seen comparing their child either to their siblings, cousins or neighbours' children. While their intention is to encourage the child to hone their skills and capacities to be able to compete with the world at large, children sensitive to criticism often get emotionally affected by their elder's comments than motivated.

Some of the factors which were taken into account while formulating the role of shame in Neetu's narrative included the object relationistic perspective, wherein her urge to be the "only good person" in the eyes of a Supervisor or an elder was highlighted; the cognitive perspective, which accounted for her global attributions towards herself as "*bad, deficient and defective*" and the role of the Indian culture in shaming her for not possessing the necessary and favourable feminine qualities (of being "*quiet, docile and polite*") desired in an Indian girl.

Thus, the psyche quite literally internalizes words such as "*incompetent*", "*incorrect*" and "*lacking*" thinking them to be an inherent flaw in one's self. It was not long after the repetitive experiences of 'feeling inferior' that were brought in the sessions that I recalled something interesting. The therapist who had referred Neetu to me had emphasised her unending need for 'striving to be perfect' which further highlighted how flawed or incomplete she saw herself.

25.5.2 The Multiple Facets of Shame

What is essential to understand is that every time a client brings a particular emotion to therapy, that emotion itself has had its' share of trajectory-hiding, flowing, falling, rising, plundering, wrecking through the clients' many lived experiences. Like a river, shame brings along the many particles, debris, boulders of other emotions which have eventually submerged themselves so well in shame that shame loses its identity as an individual feeling. It took me seven sessions to comprehend the dynamics present in Neetu's case. Once shame came into the view, what was earlier seen as mere lack of confidence owing to depressogenic thoughts, that disturb client with OCD, changed.

25.5.3 Bringing Shame on the Table

The therapeutic approach I had envisioned for Neetu involved understanding her obsessions, compulsions and their content and psychoeducating her utilising the Cognitive Behavioral techniques. To address her feelings of inferiority and difficulty in handling anxiety a compassion focused and mindfulness approach was planned in addition to the primary humanistic stance I would adopt in therapy.

In the session described above when Neetu expressed her ambivalence on the parts of herself as being 'rebellious' versus wanting herself to be 'docile and soft spoken' I reflected back to her the continuous tug-of-war she felt within herself. I said "*It seems that a major part of you has been so driven to be docile and soft spoken that whenever the rebellious part of you comes forth there is shame associated with it. How do you connect with this*?" While Neetu understood about her conflicting parts of herself, she expressed surprise and confusion on my usage of the word "shame".

As I wrote my reflection post the session, going through previous session's notes I found something extremely captivating. Neetu in one of the earlier sessions had remarked "*I need to 'full' myself. Others are full vases, I have a lack, I'm empty, constantly running and not enjoying time with my family*". Her inability to process shame brought to mind Lerner's words and I quote "*Shame drives the fear of not being good enough. You may carry the shame around with you all the time but be aware of it for only brief moments*" (p. 118).

25.5.4 Unpeeling of Shame and Its Experience

At times the progress of therapy itself may become a problem wherein the therapist looks for quick-fixes or tools to work on the machine (a client) so as to be able to bring it back to its original working state. That said, psychotherapy is a process in itself, a space which allows the client to paint their life on a blank canvas which the therapist offers. Some of the essential aspects which I focused on working with Neetu

involved reflecting, mirroring, psychoeducating about her obsessive and compulsive phenomena and allowing a vast space for her to simply "be" sans any judgments, opinions, criticism or rebuke. Amidst these and other CBT techniques or tools of therapy, one of the most essential intervention used was borrowed from the therapist's basic humanistic stance and an eye on the therapeutic relationship (borrowed from Yalom's Gift of Therapy). My belief in Neetu's capacity to learn from her experiences, too see a world outside her "obsessional fantasy", to bring her back to the session than getting "lost" in her "obsessional narrative" played a key role in helping her understand the dynamics of her life viz a viz the OCD.

More details on the effectiveness of the interventions used were shared when Neetu was enquired for her feedback on her progress in the psychotherapy. She shared an increased capacity to filter her thoughts, to understand the difference between "real world versus an ideal world" and emphasised on the therapist's capacity to quickly catch her emotion and feeling state. Additionally, the homework tasks assigned and her writing brought immense clarity and perspective, for her, in work situations. Something which the therapist found very interesting, was revealed. Neetu also shared some of the metaphors which the therapist had used in various sessions to help her understand her state.

The cumulative effect of these interventions was seen in the tenth session wherein Neetu brought her confident, creative, ambitious, self-aware, socially-aware side of her, with traces of shame gradually processed. She shared her capacity to become indifferent towards her colleagues' comments and opinions, an ability to assert herself in dialogues wherein she earlier found herself speechless and a resolve to focus on her inner capacity and strengths.

Thus, in summary, the therapy process offers an amalgamation of skills, interventions and techniques used. With it is included the therapist's innate capacity to judge and customize techniques according to the needs of the client. In Neetu's case, the therapist-client fit felt just right.

25.5.5 Of Boundaries and Borders

Another client named Aastha, twenty-seven years old, single, with an educational background of Masters in Literature, came to psychotherapy with complaints of "*feeling disoriented, inefficient at work, difficulty in handling emotions and carrying an intense ball of pain inside her*". At the time of seeking therapy, she was working from home, accompanied by her parents, with her office based in another city. Initial sessions revealed history of a broken engagement wherein she found herself being cheated by her fiancé for another woman which left her feeling inadequate and perplexed about issues concerning loyalty. Aastha came from a family which was dysfunctional and had severely hampered her sense of 'self' in the early years. Sexually abused by a stranger at the age of eight (which was kept as a secret) and losing her grandmother, the only person who understood her, were losses too potent for her. It was no surprise then why Aastha would find herself repeatedly getting

caught in relationships which pulled her for love and affection even as a part of her would want to withdraw from the very person she admitted to being in love with. Despite her high intellect, florid vocabulary and deep potential to express herself she lacked on social skills and described herself as "*lacking a judgment over people's intentions*".

Very early in the sessions it was understood that Aastha had borderline personality traits. In sync with her diagnosis and goals for learning social skills and controlling her emotions, Linehan's (1993) Dialectical Behavior Therapy plan was followed.

25.5.6 "I'm Always Apologetic"

In one of the sessions Aastha shared how she found herself profusely apologising to people even as they were responsible for something wrong. As she expressed herself, I sensed a confusion within her which seemed to emanate from a place of ambivalence; a space where she believed herself to be inherently "wrong" ("*I must have done something wrong, even though I do not remember, because I'm wrong*") versus a space wherein she apologized to save the relationship ("*I have not done anything wrong but anything to save this relationship from going bad*"). With reference to this, Aastha shared an incident when she had to, literally, hold her heart as she apologized to her parents for something she did not agree with.

25.5.7 The Eternal Conflict

Time and again, in the sessions, Aastha would make references to a part of her which wanted to do something versus a part of her which was against it. Lost amidst the two voices she would either engage in actions that were impulsive, later to regret them, or completely shut herself and withdraw so as to avoid making any decision. On one such occasion she talked about the heated atmosphere at home in the midst of a fight. She exclaimed how fearful she was of fights and how nervous she felt about them. Further in the session she said "*I feel like a child at times, stubborn as a rock which says no to this and do something else instead. At the same time there is an adult which asks me to handle my situation well*".

On a later occasion, it was found that the contrary voices which would often entangle Aastha belonged to her father and mother. This expression of hers was utilised in therapy. Through reflection and psychoeducation, the Transactional Analysis model of the Adult, Parent and Child figures was explained; and the conflicting voices were attributed to her internalised scripts of her parents. Amidst the many aspects of an invalidating environment, as a child, she was often left confused about which parent to follow and to ignore. At this she remarked "*As kids we had the ability to forget, now we can't*".

Thus, shame at times becomes so imbued in one's behaviour that one forgets which part of the self it refers to. In Aastha's case shame got associated with not knowing which voice to hear. Even as she would choose a voice to which she believed in, it brought with it a shame so unbearable that was difficult to bear, a splitting which felt like a trap with no "grey's" in between. At this Brené Brown, in her book Daring Greatly (2012), writes "Sometimes shame is the result of us playing the old recordings that were programmed when we were children or simply absorbed from the culture".

25.5.8 Shame for What One Is not Guilty About

On one occasion Aastha forgot about the scheduled session. This led her to profusely apologise in the next session which was accepted by me non-judgmentally. The discussion about guilt led us towards understanding the role of shame in her life. Recognising the many traumatic experiences, she had faced as a child, leading to discordant voices within her, an effort was made to experience the child and the adult within her. Borrowing from the Gestalt therapy's empty chair technique, she was asked to imagine herself as a five-year-old Aastha and an Aastha of today. Through a guided visual imagery, she was asked to view the five-year-old as having done a mistake, hold her hand and say "*I'm there with you. I'll always be there with you*". Aastha began sobbing as she imagined her own compassionate self. Of all the situations she blamed herself for in the past, one of the biggest mistake she was reminded of by her family was of losing her virginity before marriage. Indian culture has for decades associated virginity and feminine integrity as being equivalent, wherein losing virginity is considered shameful for the entire family, for it brings bad name to the girl and her parents. On the other, nothing is asked of the man who may have had multiple sexual partners before he decides to marry.

As she composed herself after the imagery, Aastha shared the experience as feeling the warmth of an accepting hug, "*for the first time I felt completely accepted…it was amazing to be loved like that*". She continued "*That little girl was so scared, she felt bad that she was supposed to feel guilty*." She shared how she did not feel guilty about losing her virginity, which she considered an act of love, even as she was "made to feel ashamed" about it.

Of essential importance here is to highlight the usage of words "guilty" versus "ashamed". While many clients may use these words synonymously, Aastha clearly understood the difference between the two and was one of the high cognitive functioning clients in psychotherapy.

Her experience very delicately differentiated the boundaries between 'the self' and 'the other' juxtaposing itself to the definition of shame versus guilt. Her experience of connecting with her childhood self was one of the highlights of the therapy. It marked an ego integration which every therapist dreams for their client with borderline traits. The therapist in me was amazed at the wisdom that flowed from her. Her affirmative words brought a deep knowledge of how cultures alone can 'make' a woman feel

ashamed even as she isn't. The experience is akin to the image of a shame that is literally and metaphorically injected by others making one feel wronged even as one doesn't.

Aastha's case was primarily formulated from a psychoanalytical perspective wherein the role of shame found itself switching between the ego and the ego ideal on one hand and at other, displayed itself in the form of an inherently insecure attachment style. Her relationship with her primary caregivers left her feeling "essentially unwantable, namely unwanted by anyone", thus leading to high unacceptance of herself for the person she was. Keeping this in mind, a Gestalt approach along with the Dialectical Behavioral Therapy was envisioned for her to strengthen her ego functioning, be mindful of her emotional disturbances and coalesce her conflicting parts of the self.

25.5.9 The Space of Therapy

Shame as an emotion is not to be looked down upon. It will be a huge irony if we pity, belittle "shame" for existing in the first place. It's an emotion that needs to be pulled out of the closet of human heart and mind and be given a space worthy of compassion, care, love and vulnerability. It needs an atmosphere inherently warming and comforting that even as one feels like breaking into a thousand pieces, one knows that they'll join to make something beautiful out of them. A therapeutic environment, described by Winnicott as "holding" comes the closest to this. It is this compassion weaved with vulnerability, courage and a capacity to deconstruct shame that Brown (2006) emphatically focuses in her Shame Resilience Theory and Gilbert and Procter (2006) describes in Compassionate Mind Training (Gilbert, Oousthuizen, Merkin und Vanderheiden, in this book) approach.

25.5.10 Measuring One's Words

It is essential to note that certain processes demand a client to live them wholly, the same holds true for shame. While Neetu expressed her confusion at the word 'shame', Aastha came to process it at a much inherent level, differentiating it from being owned by self or being 'made to' felt. A greater learning from the beautiful individual differences of these two cases is the need to measure one's words as a therapist. In other words, as therapists we cannot impose our learning onto a client to make it 'their insight'. Every client carries within them a treasure trove of strengths, capacities and wisdom that nudges them to grow forward in life. Like a caterpillar waiting for the cocoon to break, this too is a process which needs immense patience, struggle and cracking open on a client's part, something, we as therapists can and in no way should take away from them. That said, it's essential to reflect, psychoeducate clients about shame, it's healthy and unhealthy components.

25.6 Conclusion

By sharing the two case vignettes an attempt was made to understand how shame often creeps in psychotherapy, plays hide and seek some times and masks beneath various other emotions on other occasions. From the view of psychotherapy, an effort was made to utilise shame sensitively with the material the client brings in the therapy, thus highlighting the existence of symptoms as well as the deep roots for their cause.

While research in the realm of shame is still nascent, it continues to be a domain of huge interest to both people and mental health professionals at large. It is essential for psychotherapists to correctly identify it and work through it with the client; for shame can be as powerful as a quicksand, sucking in people, their worth, their integrity; sometimes alone, other times with families and cultural baggage tangled with it.

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