Chapter 11
Shame and Psychotherapy: Theory, Method and Practice

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Abstract Shame along with guilt and embarrassment, belongs to a family of emotions that have been called the self-conscious emotions. These emotions are known to make us inward focused, however, shame almost always occurs in the presence of the other or imagined other making us relationally focused. When appropriately experienced, shame can be a modulator of interpersonal relatedness, however, if it is denied in oneself or not accessed meaningfully, it can lead to disconnect in the emotional and relational realm. In psychotherapeutic literature, there has been a surge in clinical interest in shame and many of the problems of anxiety have now been reconceptualized as problems of shame. It has been found correlated with a host of psychiatric disorders like depression, suicidal ideation, anxiety, eating disorders, PTSD, and substance abuse. An appreciation of manifestations of shame in psychotherapy may greatly deepen our ability to connect with and understand our patients' experience. This chapter will discuss the relevance of shame in therapeutic practice, the importance of assessing shame, identification of verbal and non-verbal markers of shame, role of shame in therapeutic alliance, and some principles a therapist should follow when treating shame.

11.1 Introduction on Shame: Construct and Relevance to Psychotherapy

Shame is one of the more complex self-conscious emotions which has recently achieved a point of great significance within the domains of psychopathology and psychotherapy (Gilbert and Miles 2000; Lester 1998; Quigley and Tedeschi 1996; Tangney et al. 1992). Psychotherapy practitioners and researchers now agree that an appreciation of manifestations of shame in psychotherapeutic practices is imperative to correct understanding and management of many psychological disorders. The recent emergence of shame in formulations of pathology has generated new

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possibilities for interventions in disorders which up to now were viewed as difficult to treat (MacBeth and Gumley 2012; Orsillo 2005).

This chapter will provide a glimpse of different dimensions of shame-proneness, it's relevance in some common psychological disorders and the new-wave therapies which have found significance in treating problematic shame. While the most emergent theoretical models of shame are from Western psychology, it is recognized that this may not be the only model nor the only mode of intervention with shame. The last section in the chapter will briefly speak about the implications alternate ways of approaching shame and its relevance to psychotherapy.

11.2 Dimensions of Shame

Shame and guilt were used almost synonymously till their cognitive, affective and motivational dimensions were teased apart (Lewis 1971; Tangney et al. 1996). Lewis (1971) whose work was pivotal in distinguishing guilt and shame posited that guilt occurs when a person attributes a negative outcome to a specific behavior or transgression whereas shame occurs when the negative outcomes are attributed to the entire self. If the voice of guilt uttered, "I did wrong", the voice of shame shouted, "I am wrong". The cognitive-attribution model considers shame to be a consequence of global, stable and internal attribution to negative events (Abramson et al. 1978). In other words those experiencing shame make more internal, global and stable attributions to negative situations and this attributional conceptualization of shame is the predominant view held in clinical research and practice of psychology (Lewis 1971; Tangney and Dearing 2002).

Shame is a normal social emotion occurring in the interpersonal matrix and it directly affects how one connects with the outside world. The developmental and evolutionary perspective of shame views it as a marker of one's social desirability and an alarm to possible loss of social attractiveness (Gilbert et al. 1994). The perceived loss of social status generates responses like submissiveness in order to appease the other or induces withdrawal and hiding in an attempt to avoid scrutiny from others. Therefore, the self can be a reference point both from the inside and outside while undergoing shame. This assessment of oneself from inside and outside has led to the distinction between internal and external shame (Gilbert et al. 1994). In external shame there is anxiety about one's likability and acceptability resulting in heightened preoccupation with evaluation from others. The experience of criticism and rejection from others in external shame has shown significant correlation with depression and anxiety (Gilbert 2000; Kim et al. 2011). The Other as Shamer Scale (OAS) is a measure of external shame assessing different aspects of what people are actually concerned with in being judged (Goss et al. 1994). The OAS has shown significantly high correlations with depression and other mental disorders. In internal shame the struggle is about living up to one's own ideals and experiencing a sense of dejection at having failed to do so (Gilbert et al. 1994; Gilbert 2000). As it is apparent, both, internal and external shame, are not completely separate entities

with one affecting the valence of the other, however, they can provide two separate points for assessment and intervention (Gilbert 2000).

Another approach to the study of shame is from the perspective of state and trait. De Hooge et al. (2010) uses the term “acute shame” to describe state shame which is a discrete and circumscribed emotional state. Similar to guilt, it is more focused on behavior and promotes approach tendencies. In contrast, chronic shame or shame proneness is akin to a trait where the experience of shame is frequent and painful and motivates self-protection through hiding and withdrawal. The chronic or trait approach to shame has led to terms like shame proneness, characterological or dispositional shame. Kaufman (1989) developed the idea of internalized shame which described a “shame-bound” personality or “shame-based identity”. Unlike it’s healthy form, internalized shame is a developmental deficit where repeated experiences of shaming in childhood leads to a generalized sense of being unworthy and inferior. These childhood experiences of shaming are believed to induce fears of evaluation, extreme shyness and lack of trust and hostility in relationships which then persist into adulthood (Gilbert and Miles 2000). Much of the research literature on shame and psychopathology takes a trait or deficit approach to shame. There is research evidence from undergraduate samples and clinical population to suggest that the self-denigration and withdrawal of shame-proneness is associated with interpersonal consequences like fear of intimacy and poorer quality of interpersonal relationship (Black et al. 2013; Lutwak and Ferrari 1997). The Test of Self Conscious Affect (TOSCA) measures chronic shame (Tangney and Dearing 2002) by presenting a range of scenarios and asking respondents to rate their anticipated distress in these situations. Cook’s (1988) Internalized Shame Scale (ISS), additionally helps to rate the frequency with which particular thoughts or feelings of shame are experienced. Both these measures of trait shame or shame-proneness give crucial clinical information about shame and possible points of intervention.

Nathanson (1992) speaks about the “compass of shame”, which outlines the specific ways in which people deal with shameful experiences. There are four basic modes which branch into different behaviors and generate various forms of psychopathology. These are withdrawal, isolation, attack on others and attack on self. Engaging in addictions can be a manifestation of withdrawal from the pain of shame as is narcissistic pathology with its excessive avoidance of truth about oneself. Attack on others out of shame can explain rage reactions which is an attempt to balance power in a relationship. Attack on self due to shame can manifest in eating disorders where food becomes a way of punishing oneself and in worst case scenario it may result in suicide (Baumeister 1990).

11.3 Shame and Psychological Disorders

With increased clarity on different dimensions of shame-proneness and the development of rating scales for its measure, a significant number of studies have emerged correlating shame with different psychological disorders. In many ways,

from being an invisible emotion, shame-proneness has emerged as the single, most important explanation for multiple psychopathology. The negative, global and stable attribution of shame makes it a key self conscious emotion in disorders like depression (Gilbert 2000; Gotlib 1984), social anxiety (Lutwak and Ferrari 1997; Li et al. 2005; Gilbert 2000), post traumatic stress disorder (Sippel and Marshall 2011; Twohig 2008), addictions (Treeby and Bruno 2012; Wiechelt 2007) and eating disorders (Frank 1991; Gee and Troop 2003). This section will review some of the psychological disorders in which shame proneness has shown significant correlation with origin and maintenance of psychopathology. It is not a comprehensive review but a summation of significant findings from the perspective of psychotherapy.

11.3.1 Anxiety Disorders

There are several overlapping features between shame and social anxiety. The fear of social evaluation and avoidance of social situations which is a hallmark of social anxiety is also the core experience in shame-proneness. External shame which is an aspect of shame related to concerns about other's evaluation of oneself is found to resonate closely with social anxiety (Gilbert and Miles 2000). When individuals with social anxiety and extreme shyness have been compared with non anxious adults, they have shown significantly higher scores on shame measures (Gilbert 2000). In a study examining shame and guilt in anxiety disorders in a clinical population, symptoms of both social anxiety disorder (SAD) and generalized anxiety disorder (GAD) shared significant relations with shame-proneness after controlling for other types of anxiety disorder symptoms, depression symptoms, and guilt-proneness (Fergus et al. 2010). The relationship of shame proneness with GAD implies a larger link between shame and worry which is the fundamental problem in anxiety. In another study, when different aspects of shame like cognitive, bodily and existential shame were examined in various psychiatric disorders, it was those with SAD who reported significantly higher levels of both cognitive and bodily shame (Scheel et al. 2014). The heightened bodily shame was a finding of significance as self-conscious focus on physical appearance can be as consequential in SAD as the cognitive aspects of shame. In an unpublished doctoral study, Sinha and Raguram (2011) found self-identified shy young adults to have a significant and high correlation with shame which was thought to increase their vulnerability to social anxiety disorder. The indiscriminate use of shaming, comparison and criticality within the family predisposes individuals to chronic shyness, SAD and avoidant personality (Erwin et al. 2003; Bruch and Heimberg 1994). These parenting styles might socialize individuals to unhealthy shame and predispose them to worries about social evaluation.

11.3.2 Anger

The pathway from shame to anger is more complex and less intuitive than it's relationship with anxiety or depression. Multiple research evidence suggests that while on one side shame generates an appeasement and withdrawal response, irrational rage and hostility are the occupants of the other side of shame (Harper and Arias 2004; Nathanson 1992). Some authors have gone as far as to suggest that all acts of violence have some form of unattended shame at it's core and Lewis (1971) termed shame induced anger as "humiliated fury" (Scheff 2012; Tangney et al. 1992). The shame-anger theory propounds that criticism from others and the resulting sense of rejection is experienced as painfully shameful, especially for those with early experience of repeated shaming. The experience of shaming develops an internal model of self as inferior and inadequate and a belief that they exist negatively in the minds of others. These early experiences also increase the propensity to self blame and general psychopathology (Gilbert and Miles 2000). Moreover, the experience of constant shaming results in the internalization of parent's blaming behavior (Bruch and Heimberg 1994). When facing rejection and shame, the mind instantly seeks whom to blame to overcome the pain of rejection. There is research evidence to suggest that it is the provocation experienced in response to felt criticism which results in the anger and not the presence of an angry temperament (Hejdenberg and Andrews 2011). In a couple of longitudinal studies, shame proneness was found a risk factor for later deviant behavior (Stuewig et al. 2014) and higher rates of recidivism in contrast to feelings of guilt (Hosser et al. 2007). Scheff (2012) described the phenomenon of the recursive "feeling trap" which helps to explain the cycles of emotions with relation to anger. He proposed that emotions can multiply and gather force over time; one can become ashamed because one is ashamed, or angry because one is ashamed, then ashamed because one is angry, and so on, gathering increasing force with time, till it results in anger, depression or self harm.

11.3.3 Depression

The conceptualization of shame has many parallels with the attributional theory of depression. It is proposed that depressed individuals become shame prone due to their tendency to make internal, global and stable attributions to negative events (Abramson et al. 1978). Shame has been found in severe depression through several other pathways like "moving away" and withdrawal which decreases reinforcing environmental contingencies, poor social support and self focused ruminations (Cheung et al. 2004). Depression can also result from the shame experienced with the perceived discrepancy between the idea and the real self. In a meta-analysis examining the different facets of shame, external shame was associated with depressive symptoms and had larger effect sizes when compared to internal shame (Kim et al. 2011). External shame which relates to preoccupation with the

evaluation of a critical other may be specially active in depression and mark a break in social bonds. The Other as Shamer Scale (Goss et al. 1994) which is considered a good measure of external shame has been found strongly associated with different measures of depression (Allan and Gilbert 1997; Cheung et al. 2004; Cook 1988). The emptiness factor has predicted depression most robustly out of the other factors highlighting the sense of isolation while experiencing external shame. In worse cases, external shame increases the vulnerability to suicidal thoughts and ideations through its concerns with public condemnation and ridicule.

11.3.4 Alcohol Dependence

Shame contributes to both the origin and maintenance of alcohol dependence (Dearing et al. 2005; Meehan et al. 1996; O'Connor et al. 1994). Shame has shown significant correlations with various aspects and stages of alcohol dependence like continued use, propensity to relapse, stigma related to help seeking and adherence to treatment. There is a high positive correlation between shame and alcohol use and dependence in varied populations like students, jail inmates and those seeking de-addiction treatment (Dearing et al. 2005; Meehan et al. 1996; O'Connor et al. 1994). Shame-proneness can increase alcohol use through its avoidance of painful emotions (Treeby and Bruno 2012) and self devaluation resulting in self destructive behavior. In a study with 281 university students, Treeby and Bruno (2012) found that alcohol was primarily being used to cope with underlying feelings of anxiety and depression. The stress coping hypothesis has propounded the notion that drinking is one of the maladaptive ways of coping with stress (Cooper et al. 1995; Holahan et al. 2001). It is highly likely that those who are shame prone and who have low self-esteem, anxiety and depression chose to use alcohol to treat these. For example, a person who feels ashamed because of inadequate sexual functioning might resort to drinking to cope with his/her feelings of inadequacy. Shame-prone people have also been associated with a tendency to drink for mood enhancement (Treeby and Bruno 2012). Those who rely on drinking to enhance mood are probably poor at mood regulating strategies and more susceptible to getting dependent on alcohol. The Treeny and Bruno (2012) study also found that shame-prone people might be drinking for reasons of conformity to avoid peer-based rejection. Drinking then becomes a way of meeting approval and acceptance and creating a sense of belonging in those who feel that they are otherwise not likeable or acceptable.

11.3.5 Trauma

Shame has been linked with early trauma and adult psychopathology in a range of disorders, from bodily shame, eating disorder to post traumatic stress disorder

(PTSD) and borderline personality disorder (BPD) (Andrews 1995; Robinaugh and McNally 2010). The DSM-V has included emotional states of anger, horror, guilt and shame along with fear in the repertoire of negative emotions which are predominantly aversive emotion of PTSD. Within PTSD sample, when those with higher levels of shame have been compared to the low shame group, those with higher shame exhibited a proneness to engage in self-critical thinking and a lesser tendency to engage in self reassuring thinking (Olatunji et al. 2009; Resick and Schnicke 1992; Robinaugh and McNally 2010; Shin et al. 1999; Sippel and Marshall 2011).

Shame may be a primary emotion which is experienced at the time of abuse and can also be the ongoing emotion as a result of the reliving and assessment of the trauma incident. The feelings of powerlessness and humiliation experienced during the trauma and the feelings of helplessness created by the inability to take action to defend oneself lay down the grounds for shame-proneness (Andrews et al. 2000). The interpretations of the traumatic event and the experience of negative affect like shame during the trauma has been described as the critical link between the experience of a potentially traumatic event and the development and maintenance of PTSD (Ehlers and Clark 2000; Andrews and Hunter 1997). The occurrence of a highly traumatic event in the presence of an intense emotion like shame makes trauma memory more accessible and vivid (Berntsen and Rubin 2002). Researchers have found that the more central a traumatic event is to one's life, the more one suffers from symptoms of PTSD and depression (Berntsen and Rubin 2002). Early trauma experiences like abuse create problems of attachment and emotional dysregulation especially as they become a part of one's identity (Pulakos 1996).

11.3.6 Borderline Personality Disorder (BPD) and Suicide

BPD is one of the more difficult disorders to treat with the high rates of abuse, anger, aggression and self-harm. There are many indications that an inability to cope with the emotions of shame is closely related to the origin and maintenance of symptoms of BPD (Rizvi and Linehan 2005; Schoenleber and Berenbaum 2012). BPD patients score higher on shame as compared to control groups and even other clinical groups on both explicit and implicit shame measures. Arousal of shame in laboratory conditions has revealed a specific pattern when shame is aroused. Once aroused it takes longer for the shame to dissipate and the experience of shame is particularly aversive to the individual. This phenomenon has been labeled as "shame aversion" and it appears that those with BPD are particularly intolerant to the experience of shame. Due to shame aversion, anger becomes one of the maladaptive strategies to deflect from the pains of shame (Gratz et al. 2010; Nathanson 1992; Schoenleber and Berenbaum 2012).

Over the years, a clear relationship has emerged between shame-proneness, suicide attempts, and self-injurious behavior in adult BPD patients (Brodsky et al. 2006; Brown et al. 2009; Rizvi and Linehan 2005; Schoenleber and Berenbaum

2012; Shearer et al. 1988). Research on motivations for non-suicidal self-injury indicates that the majority of individuals who self-harm do so as a means of emotion regulation and for borderline clients shame is a hard to cope with emotion (Klonsky 2007). The second most commonly endorsed motivation is self-punishment (Klonsky 2007). It has been suggested that individuals with BPD have learned that they deserve punishment and thus seek to express anger toward themselves by self-harming (Gratz and Tull 2011; Welch and Linehan 2002).

In a study investigating the factors in a drug overdose, results indicated that the majority of overdoses occurred in the presence of shame related thoughts and emotions. The predominant feeling while the overdose occurred was loneliness and a sense of shame and failure (Bancroft et al. 1976). Baumeister (1990) suggested that suicide may be a way to escape from harsh realities about oneself, a feeling that they have certain qualities which they cannot change (Rizvi and Linehan 2005). Tangney and Dearing's (2002), longitudinal study on shame in American children in the 5th standard predicted suicide attempts as late as in young adulthood. Thus, unresolved shame can be a significant predictor for later suicide attempts.

11.3.7 Eating Disorders (ED)

In Eating Disorders (ED) both shame and guilt are intertwined with different aspects of the disorder and as well as one's identity (Frank 1991; Masheb et al. 1999). State and trait shame is considered high in women who have a history of ED or who currently have symptoms even after controlling for symptoms of depression (Gee and Troop 2003; Troop et al. 2008). There have been some findings common across different diagnoses of eating disorders. They experience high levels of self-directed hostility, significantly lower levels of self-compassion and self-criticism is a strong predictor of eating disorder symptoms (Andrews 1995; Cooper et al. 1998; Doran and Lewis 2012). These women may also strive for a higher level of perfectionism and in some way restricting food becomes a way of striving for a better self. A general sense of worthlessness and inferiority and fear of being abandoned is a common emotion expressed by women with ED (Murray and Waller 2002; Cooper et al. 1998). When different aspects of shame and eating disorder were studied, there emerged a clear association between external shame and anorexia nervosa and internal shame was predictive of bulimia nervosa (Troop et al. 2008). The specific associations may become significant from the therapeutic perspective, providing different ways of intervening with this population.

Shame in ED has been studied especially for bodily shame as compared to general shame. In a retrospective interview study, bodily shame mediated the link between childhood abuse and adult bulimia (Andrews 1995). Both in clinical and non-clinical samples, bodily shame appears to be a stronger predictor of ED than general shame (Burney and Irwin 2000; Doran and Lewis 2012) even though aspects of shame including bodily characteristics, non-physical characteristics,

general behavior and behavior around eating are all significantly correlated with shame. Women with an eating disorder are reported to hide their bodies in various ways, even in the most intimate relationships. Shame generates a fear of creating disgust in others and in ED higher levels of shame have also shown an association with lack of disclosure in therapy (Swan and Andrews 2003).

In all the disorders mentioned above, it is apparent that shame causes a break in the social matrix and results in disconnection, both within one's own self and in relationships. Shame can hide behind different pathological presentations like alcohol abuse, eating disorder or depression. The quality of the early rearing environment and abuse significantly affects how shame gets represented internally as well as whether one learns to cope with shame adaptively. When emotions of shame are met with criticality and rejection, it becomes a toxic part of one's emotional life.

11.4 Shame in Therapeutic Practice

11.4.1 Starting Points in Shame Work

It would be difficult to imagine any client narrative where shame and the pains of shame experience were not being expressed. Empirical evidence from various disorders highlights that shame-proneness increases vulnerability to psychological disorders and makes existing ones more difficult to treat (Parker and Thomas 2009; Wiechelt 2007). Targeting shame directly is believed to increase effectiveness of therapy and improve well-being, however, the literature on treatment of shame is presently evolving and the detection of shame is itself considered challenging. It would not be wrong to say that shame works in mysterious ways, as it is the natural tendency of shame to not express itself by its true name. In societies where the value of shame experience is not explicitly recognized it emerges largely in the context of depression, addiction or other psychological disorders for which the client seeks help. The narcissistic grandiose defense against shame is a classic example of how deeply entrenched shame can become. Recounting stories of shame makes people re-experience the unpleasantness and pain associated with it and threaten to overwhelm them (Scheff 2012). Discussing shame is further taken to imply having done something shameful or committing a moral faux pas and this creates a fear of being judged and inviting further rejection. Therefore, clients may constantly anticipate emergence of shame sensitive topics and side step them to avoid pain and rejection. Parker and Thomas (2009) list a series of helpful differences between shame and guilt that counselors and therapists need to be cognizant of when evaluating or treating patients in view of self-conscious emotions. If the presentation of a problem is focused on a global sense of one's badness rather than feeling bad about a specific action, then shame is likely to be the central emotion. They postulate that this distinction is important diagnostically because a client who makes a global, shame based judgment of self is developmentally at a different place as compared to feelings of guilt. Parker and Thomas (2009) also state that the

hyperfocus on one's own self creates a cognitive and emotional rigidity which lowers ability to empathize and detracts from problem solving. It creates a short sightedness towards the possibilities of multiple causalities for a negative outcome. In contrast, a guilt dominated person will describe the negative event as a matter of bad choice and stay focused on the behavior attempting to change those actions and choices.

11.4.2 Withdrawal and Concealment

Withdrawal is a natural response to shame and which can alert a therapist to it's presence. Therapy relies heavily on emotional expression and disclosure and assumes them as necessary for therapeutic success. The therapy process requires a person in need to bare their deepest secrets to a stranger and clients may struggle to understand what can be revealed and what will bring forth more shame. A client may keep an unwanted pregnancy and an abortion hidden from both her partner and therapist to avoid shame, only to feel worse for not being an honest person. Another client who begins to experience sleep disturbances and strange dreams following the loss of a friend may be unwilling to talk about the death as it brings up shame for having romantic feelings towards a best friend. Clients with eating issues may hide their difficult relationship with food as it brings up shame associated with their body image. An insistence from the therapist to delve into it could generate resistance, withdrawal and anger and potentially more shame. In a study directly exploring shame proneness and it's relation to disclosure in therapy, college students in the United States thought of a shameful secret of theirs and rated the degree of shame they felt about the secret, their willingness to disclose the secret to a potential counselor, and their expected support from a potential counselor. Participants who experienced shame regarding their secrets predicted lower anticipated support from the counselor which predicted lower willingness to disclose the secret (Dorahy et al. 2015). These findings indicate that a crucial aspect of concealment lies in the anticipated risk of disclosure, and that shame was aroused even in disclosing symptoms of a disorder which is perceived as stigmatizing. Since therapists are a part of the culture which shapes reactions to certain issues like sexuality, trauma, abuse and addictions, clients may have assumptions about therapist response to disclosure. It would then be beneficial to discuss what the client perceives as the cost of revelation and how to create an environment of safety and support in which disclosure can occur.

11.4.3 To Be Direct or Not

While it has been suggested that shame be directly addressed there is some evidence that a direct attack on shame may unintentionally generate automatic withdrawal

both from the therapist and the difficult emotions (Dorahy et al. 2015). When participants in a study were assessed on how they would like therapists to respond if their client disclosed a shame-inducing incident, interesting insights were received (Dorahy et al. 2015). Participants overall, and those with high shame proneness, did not feel withdrawal was helpful nor did they believe that staying focused on the shame feeling was particularly helpful when it was disclosed in therapy. It was an intermediate approach which was deemed most effective. An approach which allowed clients some contact with shame affect when disclosing and also providing skills in managing these emotions is deemed most helpful. It was also clear that the habitual withdrawal response in everyday interaction was not seen as beneficial while doing therapeutic work. This was interpreted as a sign of hope in clients that shame could be overcome and that the support received in therapy may provide necessary courage to face the threat from shame activation. Thus, it is prudent that probing is used sparingly at the initial phase and focus should be maintained on creating a safe environment for emotional expression. The overzealous attempts to enter into the client's world and set it right may fracture the tenuous relationship which can instead be strengthened over time with creating a safe and nurturing therapeutic environment.

11.4.4 Therapeutic Alliance

Both implicit and explicit aspects of shame make therapeutic alliance a difficult process. Therapeutic alliance has been a long established predictor of successful therapeutic work. Therapeutic alliance has three important elements which are imperative to therapy effectiveness; agreement on goals, agreement on therapy tasks and development of an affective bond (Bordin 1979). It is believed that the two components of tasks and goals of the alliance can only develop if there is a personal relationship of confidence and regard. Like all relationships that aim to heal, faith and trust become a necessary component before goals can be achieved and healing can occur. Engaging in behaviors aimed to circumvent potentially shameful interactions with others presents significant problems with therapeutic alliance. Those with high external shame are more watchful for other's reactions and sensitive to being judged. They might conceal undesirable information and reveal only what is considered acceptable. Interpersonal avoidance can present in many ways, from avoiding eye contact to omitting significant clinical material. Client's may completely avoid a question or skip certain chapters of their lives. They may laugh nervously, or clear their throat while talking of something shameful as if the words were stuck in their throat. The therapist may note an unexplainable forgetfulness or difficulty in doing emotion focused work. The client may even lash out at the therapist for asking certain questions. The presentations of shame are as varied as the representations of psychopathology itself and when shame moments occur in therapy they may be totally unanticipated. The labelling of these presentations as resistance can create blocks in developing a free flowing interaction. It may

generate feelings of frustrations and inadequacy in the therapist as well as further jeopardizing therapeutic alliance. Nathanson's (1992) models of shame talks of typical shame avoidance strategies including preemptive avoidance of and escape from perceived shame triggers. There may be an attempt to completely circumvent situations that could potentially elicit shame or focus energy on disengaging from situations where shame has already been elicited. The use of attack and aggression are probably attempts to cope with shame that has been already aroused. Some clients may report a sudden flight into health.

Shame experiences have very often taught clients that safety lies in disconnection and withdrawal. In the initial stages of forming an alliance, acknowledging and respecting the role that withdrawal has played in maintaining the integrity of self is more imperative than challenging and pointing out its maladaptive nature. In some ways the work is akin to motivational enhancement for a person dependent on a substance. It might require the therapist to align with the client's worldview and roll with the resistance. Attempting to develop a genuine understanding of what role withdrawal played in the person's life improves motivation to discuss its pros and cons and eventually work at overcoming it. Therapists are advised to remain open to their own experiences of shame and withdrawal which can stop them from being fully present and engaged in the therapy session.

11.5 Some Goals in Shame Work

The process of working with shame begins with acknowledging it, facilitating its expression, understanding the various internal and external factors in its existence, making connections and finally learning to separate the self from it.

11.5.1 Facilitating Expression of Shame

For those who have never verbalized their shame experience to another for fear of being judged, expression and verbalization of it in front of an audience is a big starting point. Encouraging expression of emotions which have been held secretly can provide a sense validation to parts of oneself which were considered too "bad" to be unmasked. Therapists need to facilitate this expression by attending closely to both the verbal and non-verbal signs of shame coping styles like avoidance or attack. The therapist would be wise to listen carefully for issues that might court shame and ask questions around their presentations. A simple inquiry like, "you looked down for a moment there, could you share what was going through your mind?", can be made. This can allow for more conscious processing of emotions rather than denying them. For a subset of clients, identifying and labeling the emotion of shame can give them valuable insights into their usual attributional styles. If the client experiences and expresses distress in discussing the shame

experience, more direct statement like "sometimes we feel angry or ashamed if we are asked about certain topics and we wish to avoid them", can allow the client to express their distress. These moments of shame can also be noted and revisited at a later juncture when the client is more distanced from the emotion and in a better state to discuss it. Topics related to body image, sexuality, abuse, suicide attempts and even symptoms of mental health may all elicit different levels of difficulty depending on the person's background and experience.

Initial discussions are mostly overwhelming and draining for the client and withdrawal is an immediate respite they may seek. The therapist has to acknowledge and even allow for some withdrawal but eventually drawing the client back into the discussion is imperative to create movement in therapy. It is essential to provide the holding environment in which client can talk about their deepest fears without feeling like they wink be overwhelmed. Giving voice to one's experience of abuse, deprivation, humiliation in the presence of an unconditional other can be of no small significance. It can create a cognitive and emotional shift and a sense of freedom from letting go of what was so tightly held to one's core.

11.5.2 Making Connections

Clients in therapy understand that the way to defeat withdrawal and isolation lies in making better connection with their support systems (Vliet 2008) and efforts towards this end cannot be initiated too early in therapy. In some ways making connections require becoming more deeply connected with one's own values and desires for one's life. Clients may recognize that withdrawing because of shame takes than farther away from their goal of establishing genuine and compassionate relationships. Therapeutic alliance serves an invaluable function enhancing the individual's sense of being a worthwhile and worthy person. Knowing that there is one person who provides unconditional regard leads to a sense of being valued and needed which can counteract a negative self-image. The person's growing confidence in social context should be encouraged and reinforced and an attempt can be made to reconnect with various social networks. Overcoming interpersonal distance would also mean examining a person's role in disconnected relationships, and taking real responsibility for repairing the damages in the relationship. Often clients are required to work with forgiveness, overcoming anger and making peace with extremely conflicted aspects of themselves. This is hard, honest work, which needs the therapist's encouragement all the way. The therapist may engage the client in rehearsals and role plays for maximizing opportunities for successful interactions. The person may also be encouraged to talk about their shame with empathic others, even join groups or religious communes where these stories can be shared. Letting go of the secrecy of shame can forge new and meaningful connections for many of the disfranchised clients.

11.5.3 Understanding Shame

Understanding one's shame process requires assessing multiple aspects of life. This process is incomplete without visiting early family relationships and attachments. The first experience of shame probably occurs in interactions with one's early attachment figures as a part of early socialization. Some parents block the natural function of shame by using love withdrawal as a kind of punishment and get in power struggles with the child. Other parents are prone to anger and these styles probably result in a need to safeguard the self from shame and avoid further hurt. Exploring and identifying how these interactions affected early attachment and later interpersonal interactions is beneficial towards the goal of understanding shame. Clients may also develop an understanding of how their shame and particular shame coping style evolved. For example, a person who was shamed by parents for failures may resort to procrastination and avoidance of responsibility to fight the shame of failure. This person may underperform at work, avoid taking risks and fear intimacy. Shame driven perfectionism is not an uncommon finding within therapy clients. Those who constantly seek accolades and recognition may understand their deep sense of shame related to failure. Narcissistic rage and contempt is one the extreme ways of coping with internal shame. The only way to feel acceptable from the inside becomes a constant need for external accolade. Over a period of time, the client can develop awareness of when the particular shame coping strategy kicks in and it can be helpful to frame effective strategies to deal with the shame. The aim is to help the client take value driven decisions for life rather than be a hostage to their own emotions.

11.5.4 Enhancing Emotional Coping

Emotional regulation is never far in the work with shame. Substance abuse, eating disorders, and self-harm represent multiple ways in which individuals try to evade the internal unpleasant reactions to shame (Frank 1991; Treeby and Bruno 2012). For many people shame attacks at the core of the self and activates the primitive flight or fight response. Signs of weakness, lack of knowledge or control can all generate shame and therefore be covered or controlled with behaviors made to appease or attract or attack. Shame proneness has also been related to engaging in excessive wishful thinking about possessing desirable qualities as a way of regulating negative emotions. All of these create a diversion from concern about one's self-image. Becoming more tuned to one's internal self-talk is invaluable to understanding why one feels the way they do. Negative self-labels and calling oneself a bad person for negative events generates painful emotions which can accumulate over a period of time and result in harmful emotional spillovers. The use of empty chair to elicit and address the self-critical voices which have become internalized as one's identity has been particularly useful to accessing and

addressing emotions of shame. Asking the person to step out of their shoes and imagine how they would help a friend or child respond in similar situations generates helpful voices which can then counter the critical self-talk. The work with emotional regulation also lies in helping the person take real stock of one strengths and weaknesses without falling into habitual shame reactions and avoidance. The client can recognize the very high moral standards they hold for themselves both personally and interpersonally. Anger in circumstances where personal standards are not met can be examined from perspectives of self discrepancy where less than an idealized self is not valued. Specific strategies like anger management and assertiveness techniques become helpful skills in more effective management of negative emotions. Many a times leaving behind negative influences and making a new start is seen as a good way of emotional regulation and it doesn't allow shame to fester and grow. Focusing on positive activities and actions which generate positive emotions greatly benefit emotional coping and well being. Taking up new skills and activities to buildup one's strengths reinforces the positive aspects of oneself instead of staying focused on deficits.

11.5.5 Externalization and Acceptance of Shame

A big part of externalizing shame is to learn to accept situations and one's own feelings in a realistic manner. Clients may blame themselves for abuse or trauma and see it as a result of their own unlikeability. Shame, which resulted from early abuse or traumatic upbringing, requires reaching an understanding that most of the contributors to abuse had nothing to do with the individual himself/herself. The development of this understanding helps to put the blame where it belongs. Writing letters to the hurtful party and expressing how the abuse shattered and took control of their lives validates the experience and simultaneously externalizes the experience. The client might also be encouraged to write a letter expressing compassion and support to an imaginary person who experienced similar trauma. Creating emotional distance facilitates the flow of compassion and actually helps the client to experience this more easily than if he/she was focused on her/his owns self.

Accepting different aspects of oneself, both the desirable and the undesirable, is a big learning step towards making shame adaptive. An inability to express genuine feelings of hurt or anger keeps the shame as an internal experience to be repeatedly churned and experienced. It is also as important to learn to reject what is another person's projection of shame. The focus on one's own strengths, divorcing from labels or limitations caused by others, experience pride in overcoming adversaries and celebrating achievements go a long way in developing positive coping with shame.

11.6 Specific Therapies that Target Shame

There are certain approaches which broadly target the goals mentioned in working with the shame prone person. These have mostly grown out of the mindfulness and acceptance based approaches. Dialectic Behavior Therapy (DBT) with its underpinnings in mindfulness found early success in the treatment of shame in BPD patients. A treatment derived from DBT called "opposite actions" has been particularly applied to treating shame in BPD (Rizvi and Linehan 2005). This strategy requires identification of the current unwanted emotion, then identifying what are the usual urges and actions generated by these emotions and then finally determine and engage in actions which are completely opposite to the usual actions (Rizvi and Linehan 2005). For example, if the action tendency is to shrink and hide, the client will be encouraged to approach and hold oneself high. The client is oriented to the rationale of treatment and the nature of shame as psychoeducation is found helpful to client co-operation with the technique. Results with opposite action in one study have given promise and hope that it can be used as a standalone treatment specifically for shame (Rizvi and Linehan 2005).

Acceptance and Commitment based therapies (ACTs) and Compassion focused therapy (CFT) have shown favorable outcomes in targeting lack of compassion and self-criticality, the chief deficits in shame proneness. Cognitive behavioral interventions have been the mainstay of treatment for negative beliefs about self. However, more recently mindfulness and acceptance based approaches have been tested in groups of clients with PTSD, ED and substance abuse who were resistant to traditional CBT and found to be effective (Gilbert and Procter 2006; Hernandez and Mendoza 2011; Luoma et al. 2012; Orsillo 2005; Weichelt 2007).

11.6.1 Compassion Focused Therapy

Gale et al. (2014) designed a study to investigate the effect of CFT on shame, self-criticism and self compassion in a program where psychoeducational components, CBT and CFT were added sequentially. This stepwise intervention revealed that both shame and self-criticism increased following psychoeducational and the CBT component probably because of the increased focus on negative cognitions and exercises to challenge them. It was only when the CFT component was introduced that levels of self-compassion increased and levels of self-criticism and shame significantly reduced.

Self-compassion is described as the ability to view one's failures and moments of imperfections with kindness rather than being harshly self critical and unforgiving (Gilbert 2014). For those who are shame-prone, self compassion is an area of deficit and a difficult goal to achieve. CFT directly focuses on increasing

self-compassion, tolerance and warmth instead of challenging negative thoughts. The premise of CFT is that developing a universal sense of compassion enhances mental health and alleviates distress pan disorders. As a technique, CFT integrates multiple influences from different disciplines although it works with three main principles revolving around compassion; cultivating openness to the helpfulness and compassion from others, being helpful and compassionate towards others, and developing an encouraging, supportive, and compassionate approach to oneself (Gilbert 2014). Another strong working point of CFT is its direct work with affect regulation (Gilbert and Procter 2006). At the heart of CFT lies the value of human connections and CFT tries to generate caring relationships as a part of developing affect regulation (Macbeth and Gumley 2012). A compassionate therapeutic relationship is inherently essential to CFT and the attributes of compassion like warmth, empathy, non judgement, sensitivity, and distress tolerance have to first be modeled by the therapist through compassionate engagement (Gilbert and Procter 2006). The compassion and kindness experienced from the therapist offers a corrective emotional experience and fosters the experience of healthy attachment. Jazaieri et al. (2013) were able to demonstrate that compassion was a teachable quality in a program called compassion cultivation training (CCT). Participants in this program demonstrated enhanced compassion following training even in the background of a deficit in early development.

Over the years since CFT was developed, treatment programs have been developed and applied in treating shame based experiences in SAD, eating disorders, substance abuse and PTSD (Gilbert and Procter 2006; Leaviss and Uttley 2015; Twohig 2008). Clients who adhered to a more frequent regimen of mindfulness practice made more improvement and this indicates that treatment dose is important to the effectiveness of CFT (Boersma et al. 2014). Self criticality is especially resistant as a lifetime of self-criticality is hard to change. Practicing compassion based exercises like compassionate letter writing to oneself and compassion meditation have been associated with immediate effects like an increase in positive affect and a decrease in negative affect (Leaviss and Uttley 2015). They have also been associated with more long term changes at the brain level and development of empathy in relationships. Other studies have shown significant reductions in anxiety and depression scores, shame, self-hatred, social comparison, inferiority and submissive behavior across a range of disorders. A concomitant increase in self-compassion, self-reassurance, self-safeness, relational warmth and closeness were also achieved through CFT (Leaviss and Uttley 2015). CFT has been specifically modified for treating self criticality in eating disorders and has been attempted in the group and the individual format and significant improvements are seen across the entire range of symptoms (Goss and Allen 2009). Among the different kinds of eating disorder symptomatology, bulimia nervosa has shown the maximum improvement with CFT and even though anorexia did not show similar increment, development of self compassion was.

11.6.2 Acceptance and Commitment Therapies

Similar to CFT, Acceptance and Commitment Therapies (ACT) with its focus on experiential avoidance and cognitive fusion, seems particularly suited for treatment of shame (Hayes 2004). ACT conceptualizes clients struggling with shame firstly as being fused with denigrating thoughts about themselves while simultaneously attempting to avoid coming in contact with the thoughts, feelings, and memories associated with the shame. Experiential avoidance is a pathological emotional regulation strategy which requires spending enormous amount of time and energy trying to avoid, control and suppress internal experiences. Suppression of negative emotions and cognitions is known to be counter-effective as they result in rebounding of the same cognitions that are being avoided. The aim of ACT is to help clients develop awareness of their thoughts and feelings without giving into their habitual avoidance tendencies or trying to change them, therefore moving towards a better acceptance of self (Hayes 2004). AGT suggests six processes or skill sets to promote psychological flexibility in clients: (a) acceptance; (b) cognitive defusion; (c) contact with the present moment; (d) self as context; (e) values; and (f) committed action (Hayes 2004).

ACT uses a mindfulness-based approach to dealing with shame memories and experiences. Mindfulness approaches are used to enhance awareness of the "here and now", reduce a judgmental attitude towards oneself and disengage from unhelpful thoughts. Basic grounding techniques, noticing things in the environment, centering on the breath and other simple ways of becoming mindful are taught. ACT views substance abuse as a kind of experiential avoidance of shame and it has found success in reduction of shame in substance abuse population through it's promotion of self acceptance (Hayes 2004). Treatment of substance abuse through ACT has shown slow and steady improvement over a period of time with higher outpatient treatment attendance during follow up (Luoma et al. 2012). ACT has been found particularly helpful in disorders of shame, guilt like PTSD and BPD (Gratz and Gunderson 2006; Lang and Sharma-Patel 2011; Luoma et al. 2012; Gratz and Tull 2011). Twohig (2008) reported ACT's successful treatment of a woman with history of abuse and post-traumatic symptoms who had not been responsive to CBT based interventions. The client used acceptance and mindfulness processes to stop herself from unnecessary attempts at controlling her experiences and make value based choices for her life.

11.6.3 Comprehensive Distancing

Comprehensive Distancing (CD) is one aspect of mindfulness-based therapies which has been tried as a treatment for shame especially in PTSD. CD is a facet of ACT in which one attempts to tolerate negative thoughts, emotions, memories by "distancing" one- self from them (Zettle 2005). The goal of CD is primarily emotional

regulation by using the stance of a distanced observer. By achieving the goal, one becomes a neutral observer to negative mental events and therefore, negative events lose their emotional valence (Orsillo 2005; Zettle 2005). There is evidence to show that writing about a traumatic event from an observer perspective is far better than writing about it as if it was being experienced. A person who repeats the experiences from one's own perspective probably strengthens the association with the memory and it gets more tightly integrated within oneself. Getting a distance to one's thoughts and emotions encourages the view that "we are not our thoughts" and we are something larger. Considering thoughts as "just thoughts" and not the truth decreases associated emotional distress with them (Orsillo 2005).

The field of shame-focused therapies is narrow. The acceptance and mindfulness based approaches provide a flexible approach to treatment of shame as they borrow from humanistic, cognitive and emotion focused schools even as they primarily remain mindfulness based in their practice. The premise of treatment lies with the broad idea that the suppression and non-acceptance of shame results in an unhealthy denial of emotions. The above mentioned techniques aim to develop healthy acceptance towards shame so that a person can develop resiliency towards shame memories and experiences. These approaches need wider use and application with different disorders and a clearer understanding of the aspects of treatment that contribute to reduction of shame-proneness.

11.6.4 Shame Therapy: Implications for Non-western Cultures

Shame does exist in every culture. However, it can have different conceptualization and linguistic representations across cultures. A therapist needs to be aware of these contextual differences as the idea of elimination of shame may be more beneficial to certain cultures as compared to others. The internal, global, stable conceptualization of shame is primarily a Western model of shame which gives it an inherent, pathological quality (Kitayama et al. 1995). Unlike the Western culture, shame is a key emotion in Eastern cultures. It is routinely experienced in different kinds of relationships and even deliberately used as a disciplining strategy. The focus on the opinion of others and the fear of shame sensitizes individuals to promote socially responsible behavior within them. This self improvement focus of shame might be the factor which results in Asians trying harder when shamed in comparison to Caucasians who tend to disengage or give up when experiencing shame (Bagozzi et al. 2003). Therefore, the dominant, Western model of shame which theorizes that shame is a passive emotion and does not generate reparative behaviors may not be generalizable. This also implies that in collectivist cultures, shame and guilt are not demarcated sharply like in American and many of the attributes of guilt may apply to shame. Collective societies also rely less on legal structures and more on social structures to identify and modify problematic behavior. The idea of losing face or

family honor and the shame of disconnection can act as a deterrent to problematic behaviors like substance abuse or unfaithfulness and promote pro-social behavior. Many cultures in the collectivistic world believe that an act of shame does not dishonor only the living guardians but also the souls of ancestors. Overall, shame may not be as catastrophic to self or relationship as viewed by North American culture. The removal of all shame in psychotherapy may not be a desired goal for someone from a collectivist culture as shame is the necessary compass that guides behavior and maintains relationships.

On the other hand, this positive conceptualization does not imply that shame is not a problem in collectivistic culture. A collectivistic culture may promote shame excessively as a way of binding individuals to social structures and this would limit and restrict the individual from recognizing their potential. A person in an interdependent culture may be more prone to shame when there is public ridicule and not as much about internal characteristics. Shame may be more devastating in the context of having disappointed a significant other rather than failed achievements. In these contexts, individuals have to work on separating their own needs and desires from what is expected of them and negotiate the fear of shame that comes with doing so.

Overall, it appears that there is a need to move away from a unilateral view of shame as pathological. Shame can be well regulated and adaptive and shying away from discourse of shame pushes all shame under the realm of maladaptiveness. Divorcing shame from its contextual aspects and focusing on shame-proneness, which is by definition a pathological disposition, categorizes all maladaptive self-evaluation as shame. This doctrine, which is the prevalent model of shame in American culture asserts that shame is a negative feeling and the clinical objective is to help patients recognize it and then get rid of it. Shame is forever within us and between us. It would be hard to imagine a society with “no shame”. Therefore, creating societies of shame phobics does not serve the function that it was meant to serve. Shame does not necessarily take away from one’s strengths and abilities but it can help to develop a more cooperative and thoughtful approach to interpersonal interactions. It is the guide which points us to who or what got hurt and what needs to be made right. It is the warning bell which if heard can stop us from committing many a faux pas. When we learn to successfully negotiate with our shame, which is what is being attempted in the mindfulness based approaches, we will have nothing to hide and achieve better mental health.

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