A qualitative exploration of twelve licensed professional counselors' perspectives on the construct of shame

Mary Katharine Kresser
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A QUALITATIVE EXPLORATION OF TWELVE LICENSED PROFESSIONAL COUNSELORS’ PERSPECTIVES ON THE CONSTRUCT OF SHAME

A Dissertation
Presented to
The Faculty of the School of Education
The College of William & Mary in Virginia

In Partial Fulfillment
Of the Requirements for the Degree of
Doctor of Philosophy

by
Mary Kresser
February 2003
A Qualitative Exploration of Twelve Licensed Professional Counselors’ Perspectives On the Construct of Shame

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A Qualitative Exploration of Twelve Licensed Professional Counselors' Perspectives On the Construct of Shame

Abstract

The purpose of this study was to explore counselors' understanding of the construct of shame and its meaning in the practice of counseling. Twelve licensed professional counselors were individually interviewed twice over the period of a year. This study utilized an exploratory qualitative approach in which thematic analysis was used to analyze the data. The hidden nature of shame emerged as one major theme that included discussions about the culture's avoidance of shame, the general societal prohibition of discussion of shame, the human tendency to avoid shame, the lack of emphasis on the construct of shame in counselor education, in the counseling field, and in counseling theories. The general agreement among the participants that shame is an important construct that helps explain human behavior; that shame is an issue for many of their clients; that shame is associated with a broad spectrum of psychological disorders; and that its impact on an individual is pervasive suggest that the construct of shame should be given more attention both in counselor education as well as counseling practice.
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CHAPTER ONE

Introduction

Shame Through the Millennia

The construct of shame has been around for ages; it is found in the myths of the ancient Greeks and Romans (Turner, 1995), as well as in Biblical stories (Scheff, 1997). It is found in many cultures (Scheff, 1987; Pattison, 2000), and several social and psychological theorists (Braithwaite, 1989; Cooley, 1922; Darwin, 1872; Goffman, 1967; Lewis, 1971; Lynd, 1958; McDougall, 1908) over the span of more than a hundred years have suggested that “shame is the primary social emotion, in that it is generated by the virtually constant monitoring of the self in relation to others” (Scheff, 1997, p. 210).

Statement of the Problem

“Shame” is an important construct in the counseling field for a variety of reasons. Chronic dysfunctional shame with its feelings of isolation, unlovability, guardedness, lack of trust, powerlessness, submissiveness, and debasement presents a considerable challenge (Pattison, 2000). It is the source of much social and personal alienation, and plays a major role in inhibiting human beings from growing to mature accountability (Pattison, 2000). Shame plays an influential role in the operations of conscience (Fowler, 1993; Kaufman, 1996; Lansky, 1995). The central position that shame occupies in social experience gives it a primary place in human motivation (Mokros, 1995; Retzinger, 1989; Scheff, 1994). Shame is a significant factor in identity development (Kaufman, 1996; Lansky, 1995; Mokros, 1995; Morrison, 1996) and is linked to a multitude of psychological problems (Bradshaw, 1988; Cook, 1996; Fossum & Mason, 1986; Kaufman, 1996; Lansky, 1995; Mokros, 1995; Morrison, 1996; Nathanson, 1992). Many therapeutic impasses have...
resulted from shame experiences that occurred and were unacknowledged in sessions (Jacobs, 1996; Lewis, 1971; Morrison, 1996; Yontef, 1996).

Shame is the hidden power behind much of what occupies us in everyday life. One might think that shame, this most deeply personal of emotional experiences, would be a common subject in the world of psychotherapy. It is, after all, in our personal therapy that most of us learn to overcome the shame associated with the revelation of our most cherished and painful secrets (Nathanson, 1992, p. 21).

Although shame has been established as a significant construct in the counseling literature of the last 15 years (Kaufman, 1992, 1996; Scheff, 1991; Pattison, 2000), it has not been the focus in the training of counselors (Yontef, 1996). If, as the literature suggests, shame plays a meaningful role in the human experience (Bradshaw, 1988; Fossum & Mason, 1986; Kaufman, 1996; Lee & Wheeler, 1996; Lewis, 1992; Morrison, 1996; Nathanson, 1992; Pattison, 2000; Retzinger, 1989; Scheff, 1994) and is not dealt with appropriately in counseling sessions (Jacobs, 1996; Lansky, 1995; Morrison, 1996; Simon & Geib, 1996), ought not counselors and counselor educators place more emphasis on the construct of shame? The proliferation of theoretical books and articles (Bradshaw, 1988; Fossum & Mason, 1986; Kaufman, 1996; Lee & Wheeler, 1996; Lewis, 1992; Morrison, 1996; Nathanson, 1992; Retzinger, 1989; Scheff, 1994), as well as the increasing number of empirical studies (Cook, 1991, 1996; Harder & Lewis, 1987; Hoblitzelle, 1987; Perlman, 1958; Tangney, 1990) on shame strongly suggests that the construct of shame should be brought to the forefront in the counseling profession.

The construct of shame has important implications for the practice of counseling and counselor education. Although some empirical studies have been done and numerous
theoretical books and articles on shame have been written in the past several years, the leap from the literature to clinical application has not been made. Much that is found in the literature on shame represents theoretical perspectives rather than findings supported by data.

Shame in Human Development

Origins

Toxic shame develops in the source relationships of our original families, between members, often between parent and child (Bradshaw, 1988; Erikson, 1950; Karen, 1992; Kaufman, 1992; Morrison, 1996; Yontef, 1996). The feeling of shame in a shame-oriented person is rooted in the earliest struggles and interpersonal experiences of the infant and young child (Yontef, 1996). The shame process starts before awareness is verbal; therefore, shame feelings are often not in verbal awareness (Yontef, 1996). Dysfunctional shame is usually a result of the internalization of a derisive voice, usually parental (Karen, 1992). An environment of intermittent rejection or unrelenting disrespect gradually wears away the child’s sense of self-worth and makes her or him predisposed to shame (Karen, 1992).

Conscience

Shame plays an important role in the operations of conscience (Fowler, 1993; Kaufman; 1996; Lansky, 1995). To an individual the experience of shame signals the need for one to assess and possibly amend her or his ways (Fowler, 1996). Shame alerts us not only to perceived transgression and “motivates necessary self-correction” but also alerts us to “any affront to human dignity” which motivates “the eventual correction of social indignities”
Shame can be an inhibiting force that prevents individuals from doing something they may be ashamed of; thus, shame has positive value asserted Hanson (1997).

Behavior

Shame is central to an understanding of human action and experience; it plays a key role in social experience and human motivation (Retzinger, 1989; & Scheff, 1994). Feelings of shame and pride regulate an individual’s behavior by alerting one to her or his place and responsibility to the social bond; shame makes one mindful of self as dependent upon others and one’s place within the social bond (Mokros, 1995). Gilbert (1998) identified four behaviors associated with shame: (1) behaviors that are part of the shame experience; (2) behaviors used to cope with shame; (3) behaviors employed to avoid being shamed or to avoid being exposed; and (4) behaviors intended to repair shame. Shame is linked with depression and anger in a cycle that produces a range of antisocial behavior; consequently, anger and violence are ways that people may protect themselves against undeserved shame that threatens their fragile sense of identity and self-respect (Cushman, 1993).

Identity

Shame is a significant factor in identity development (Kaufman, 1996; Lansky, 1995; Mokros, 1995; Morrison, 1996). Mokros (1995) submitted that the self is experienced within the context of social bonds, through actions and reactions of the other (including the self as other) to the self. Individuals achieve a sense of identity through social bonds, and shame appears to be intrinsically related to the experience of self in social bonds, that is, in relationship to another or others (Mokros, 1995). The feeling of shame in a shame-oriented
person is rooted in the earliest struggles and interpersonal experiences of the infant and young child (Yontef, 1996). Dysfunctional shame is usually instilled at a young, as a result of the internalization of a disapproving voice, usually parental (Karen, 1992). An understanding of shame is related to “an understanding of social systems of every sort—from the internal world of internalized ‘objects’; to the family system; to the broader social order, large or small, in which shame and shame-related phenomena are key to the regulation of selfhood and esteem” (Lansky & Morrison, 1997, p. xv). Shame impacts the self through a developmental process that consists of affect magnification in which the intensity, duration, and frequency of shame increases systematically, and secondly shame becomes internalized so that the self can reproduce shame (Kaufman, 1996).

A Link to Psychological Problems

Shame has been linked to a multitude of psychological problems such as addictions (Bradshaw, 1988; Fossum & Mason, 1986; Kaufman, 1996), phobias (Kaufman, 1996), sociopathic and psychopathic syndromes (Kaufman, 1996), narcissism (Kaufman, 1996; Lewis, 1992), schizoid and paranoid syndromes (Kaufman, 1996), depression (Kaufman, 1996; Lewis, 1992; Morrison, 1996), mania, (Morrison, 1996), suicide (Mokros, 1995; Morrison, 1996), and compulsive behaviors (Bradshaw, 1988). The Internalized Shame Scale (ISS) was developed to identify an enduring constellation of shame feelings that result from frequent shaming experiences that have become internalized over time, beginning with childhood experiences. The scale correlates, in both clinical and nonclinical populations with most measures of pathology; the implication is that shame is present in most psychopathologies (Cook, 1996). Experiences of shame not integrated into one’s awareness in a healthy way, are defended against in one of four manners: withdrawal;
avoidance; attack of self; attack of other (Nathanson, 1992). These four patterns encompass almost the full range of psychopathology (Nathanson, 1992). Kaufman (1996) sorted shame-based syndromes into six general classes: compulsive syndromes; schizoid, depressive, and paranoid syndromes; phobic syndromes; sexual dysfunction syndromes; and sociopathic and psychopathic syndromes.

Shame in Western Culture and Counseling Theories

Shame as a principle means of social and individual control has been associated with less individualized and more group-oriented cultures such as the Japanese, while guilt has been seen as more typical of Western cultures where there is a extraordinary degree of individualization from the group (Benedict, 1954). Benedict (1954) has been criticized for her work, because of the difficulty of classifying a culture solely as a shame or a guilt culture (Cairns, 1993; Demos, 1996). Shame has been neglected in counseling and personality theories in the past 150 years because achievement and success are worshipped in this culture making shame a forbidden topic (Kaufman, 1992). “It is shameful to have shame, particularly in this culture. Thus, although people experience shame and often rage in a shame attack, they most likely won’t show their shame …” (Lee, 1994, p. 269).

Several notable books and articles (Bradshaw, 1988; Fossum & Mason, 1986; Kaufman, 1996; Lee & Wheeler, 199; Lewis, 1992; Morrison, 1996; Nathanson, 1992) focusing on the construct of shame have been written in the last fifteen years. The issue of shame seems to be emerging now due to the link between shame and a multitude of psychological problems and the recent advance in addictive, compulsive, and abusive behaviors (Kaufman, 1992).
Shame in Clinical Application

A client's shame often activates a therapist's shame (Kaufman, 1996; Lewis, 1971; Morrison, 1996). A collusion of avoidance between therapist and client tends to occur when shame emerges in therapy. Embarrassed, both tend to "avert the eyes" and turn away from shame in order to deal with less awkward problems such as anxiety, depression, or anger, problems which are less likely to prompt evasion (Morrison, 1996; Tangney, 1995; Tangney, Wagner, Burggraf, Gramzow, Fletcher, 1991). Therapists, like all human beings, have suffered shame, and when their clients' disturbing shame experiences trigger similar ones in their own lives, they collude to avoid investigating them (Morrison, 1996).

The lack of awareness of shame on the counselor's part can result in the counselor shaming the client that may lead to an impasse in therapy (Jacobs, 1996). Therapy is a place in which the client is particularly vulnerable to being shamed; the therapist's silence or words have a greater impact than those of a friend who occupies a more mutual position (Simon & Geib, 1996). H.B. Lewis (1971) used detailed transcripts of treatment sessions to mark shame experiences in those interchanges. She concluded that many therapeutic impasses resulted from shame experiences that were unacknowledged.

Purpose of the Study

The purpose of this study was to explore the understanding of the construct of shame and its meaning in the practice of counseling through the process of interviewing twelve licensed counselors. This study may also begin to fill the lack in the literature about the clinical application of the construct of shame. An exploratory qualitative design is focused on face-to-face interviews with participants.
As the researcher, I have an abiding interest in the construct of shame. I initially became interested in the construct of shame when, I, as a counselor, attended a workshop on shame associated with substance abuse and began to read articles and books on shame. Later on, I, as a client, became aware of my own shame issues and intensified my reading about shame. This research study proposes to explore the construct of shame through the eyes of twelve licensed counselors by identifying their perspectives and the meaning they give to it in the practice of counseling.

Research Questions

The research questions formulate what the researcher wants to understand while the interview questions are what the researcher asks the participants in order to acquire that understanding (Maxwell, 1996). This exploration of the construct of shame was guided by the following overarching questions:

1) What is the understanding that licensed counselors have of the construct of shame?
2) How does education and training, particularly graduate counseling programs, influence counselors' understanding of the construct of shame?
3) How is the construct of shame meaningful to licensed counselors in the practice of counseling?

Significance of the Study

This study has the potential to make numerous contributions to the field of counseling in the areas of counselor education, counseling, program development, legislation, and research. Although there has been a proliferation of books on shame in the last fifteen years, more emphasis on shame is needed in therapist training, "including teaching about shame, shame treatment, and shame induction or shame sensitivity in training" (Yontef,
1996, p. 379). The traditional counseling theories do not address shame; rather, the focus has been on libidinal drives, psychosocial stages of development, ego states, irrational thoughts, and conditioned responses (Kaufman, 1996). It is important for counselors to be well informed of developments in the field of counseling and imperative for those who are educating and training counselors.

**Methodology**

This study utilized an exploratory qualitative approach. This exploratory study provided a detailed view of how counselors understand the construct of shame and what meaning it has for them in the practice of counseling.

**Procedures**

I developed two written questionnaires about the construct of shame and used them to interview twelve licensed counselors twice. I used the questionnaires to explore the understanding that the counselors have of the construct of shame and its meaning to them in the practice of counseling.

Before I began collecting data, I wrote down my assumptions and presuppositions about what I thought I would find by conducting this study. This process of setting "aside all prejudgments, ... experiences and relying on intuition, imagination, and universal structures to obtain a picture of the experience ") (Creswell, 1998, p. 52) is called "bracketing." After analysis of the data, I compared what the literature suggested with the actual findings.

I used inductive analysis to analyze the data. In this method, the researcher looks for recurrent issues that become categories. As the data is collected, the researcher looks for diversity as well as consistency (Bogdan & Biklen, 1998). I then reduced the categories to
major themes. Finally, I compared these major overarching themes to the literature
(Creswell, 1998). In addition to a narrative summary of the data, I created visual displays
of information in the form of tabular matrices to make comparisons of the twelve licensed
counselors (Miles & Huberman, 1984).

Delimitations and Limitations of the Study

This study confines itself to conducting two interviews with and examining two
reflective pieces by twelve licensed counselors regarding the construct of shame. Because
this study is qualitative, its findings are not intended to be generalizable; rather, it seeks an
understanding of the participants’ perspectives, pluralism, and complexity (Glesne &
Peshkin, 1992). Individuals may, of course, decide based upon personal experience or other
research to make such connections.
Definitions of Terms

Affect magnification is part of the developmental process by which shame dynamically impacts the self in which the intensity, duration, and frequency of shame increases systematically (Kaufman, 1996).

Affect theory is Silvan Tomkins’ theory in which affect is identified as the primary innate biological motivating mechanism. Tomkins holds that affect itself is the amplification. Affect both amplifies and extends the duration and impact of whatever activates it (Kaufman, 1996).

Attachment Theory is a theory that developed from British psychoanalysis during the middle of the twentieth century. “It encompasses both the quality and strength of the parent-child bond, the ways in which it forms and develops, how it can be damaged and repaired, and the long-term impact of separations, losses, wounds, and deprivations” (Karen, 1998, p.3). “Bowlby, the founder of attachment theory, believed that it is in our first relationship, usually with our mother, that much of our future well-being is determined (Karen, 1998, p.5).

Bypassed shame occurs when the therapist responds to a painful or sensitive self-disclosure in a way that wounds the patient or fails to give importance to what the patient has risked (Lewis, 1971).

Cognitive-behavioral therapy is based on the philosophy that “humans are born with potentials for rational thinking but also with tendencies toward crooked thinking. They tend to fall victim to irrational beliefs and to reindoctrinate themselves with these beliefs” (Corey, 1991, p. 448). Therapy is “didactic and directive” and “a process of reeducation” (p. 448).
Dysfunctional shame is "that feeling of self-castigation which arises when we are convinced that there is something about ourselves that is wrong, inferior, flawed, weak, or dirty. ... a feeling of loathing against ourselves, a hateful vision of ourselves through our own eyes (Morrison, 1996, p. 13).

Functional shame provides a regulatory function in everyday experience that brings to awareness one’s sense of place and self as contingent upon others and one’s place within the social bond (Mokros, 1995).

Gestalt therapy is based on the concept that the individual strives for wholeness and integration of thinking, feeling, and acting. Growth consists of moving from environmental support to self-support (Corey, 1992).

Guilt is a hurtful feeling of disappointment and responsibility for one’s actions. Guilt is about something that one has done or contemplated doing (Fowler, 1993).

Humanistic psychology is a theory that is based on the concept that each person has within a nature and potential that she or he can actualize and through which she or he can find meaning (Corey, 1992).

Internalization, in Kaufman’s (1996) framework, is the process by which the self internalizes, and so reproduces, its own experience. “The self unfolds, evolves, and becomes shaped through ongoing interaction with the interpersonal environment. ... What is internalized are images or scenes that have become imprinted with affect” (Kaufman, 1996, p. 57).

Internalization, in object relations theory, is a process by which the relationship with the external object (the significant other) becomes a part of the child’s self (Scharff & Scharff, 1997).
**Introjection**, in object relations theory, is a process in which the infant, to cope with the intolerable feelings of anxiety and abandonment, holds onto Mom (the object) by taking the image of her inside. Introjection is the ego’s first defense against unbearable pain and separation from the object (Fairbairn, 1952).

**Introjection**, in Gestalt theory, is the disposition to uncritically accept others’ beliefs and standards without digesting them to make them consistent with oneself (Corey, 1991).

**Object relations theory** is a theory that developed from psychoanalytic theory. It is a “theory of the human personality developed from study of the therapist-patient relationship as it reflects the mother-infant dyad. The theory holds that the infant’s experience in relationship with the mother is the primary determinant of personality formation and that the infant’s need for attachment to the mother is the motivating factor in development of the infantile self” (Scharff & Scharff, 1997, p. 3).

**Projection**, in Gestalt theory, is the process of disowning certain aspects of oneself by assigning them to the environment (Corey, 1991).

**Psychoanalytic theory** is based on the tenet that “normal personality development is based on successful resolution and integration of psychosexual stages of development. Faulty personality development is the result of inadequate resolution of some specific stage. … Unconscious processes are centrally related to current behavior” (Corey, 1991, p. 448).

**Reaction formation** is an ego defense mechanism in which an individual defends against a threatening impulse by actively expressing the opposite impulse (Jacoby, 1994).

**Self-actualization** is a concept that suggests that there is an inner, biological force to develop one’s abilities and aptitudes to the fullest (Corey, 1992).
Self-esteem is “essentially a self-evaluative construct representing how a person appraises him-or herself, in general, across situations over time” (Tangney & Dearing, 2002, p. 56 -57).

“Self-respect is the conviction of being whole, worthwhile, and valued from within. With self-respect we have the security to pursue satisfaction, the capacity for intimacy, and the ability to be alone” (Nichols, 1995, p. 16).

Self-worth is roughly synonymous with self-respect (Nichols, 1995).

Shame is “an emotion—an affective state. The feeling of shame involves a negative evaluation of the global self, but one that is in response to a specific failure or transgression, not necessarily reflective of one’s general level of self-esteem (Tangney & Dearing, 2002, p.57). “1. (a): a painful emotion caused by consciousness of guilt, shortcoming, or impropriety; (b) the susceptibility to such emotion; 2. a condition of humiliating disgrace or disrepute; 3. (a) something that brings censure or reproach; also: something to be regretted … (b) a cause of feeling shame (Merriam-Webster’s Collegiate Dictionary, 2000).

Shame binds occur when there are sufficient and necessary repetitions of a particular affect — shame sequence that will create an internalized linkage, or bind. Drives and interpersonal needs can be bound to shame through the process of internalization (Kaufman, 1996).

Shame-proneness is “a trait or disposition, a tendency to experience the emotion shame (as opposed to, say, guilt) in response to specific negative events” (Tangney & Dearing, 2002, p. 57).
Social bonds theory is the concept that the primary motivation of human beings is directed toward the establishment and maintenance of secure social bonds, and that through social bonds human beings achieve a sense of place and a sense of identity (Mokros, 1995).
CHAPTER TWO
A Selected Review of the Literature

Introduction

In this review of the literature, views of shame by leading shame theorists, distinctions between shame and guilt, and a look at shame through the millennia are presented. Shame in human development, including the origins of shame, and both functional and dysfunctional shame (the focus of this study) are explored. Shame in Western culture and counseling theories is discussed. The construct of shame is examined by looking at it through the lenses of three major theoretical frameworks in psychology: humanistic; psychoanalytic (including object relations theory and attachment theory); and cognitive-behavioral theory. Although the pioneers (except Freud) of the major theoretical frameworks who are presented here have not specifically addressed the construct of shame, by looking at the basic philosophies and key concepts of these theories, a reasonably accurate determination can be made of how they might have conceptualized shame. In addition, a discussion of how recent theorists of the major theoretical frameworks have addressed the construct of shame occurs. A look at affect theory and how Gershen Kaufman, a pioneer in the study of shame, conceptualizes shame is included. Also, the perspectives of other selected theorists addressing the construct of shame are scrutinized. Commonalities among the three major perspectives and leading shame theorists are discussed. The construct of shame as it applies to clinical application is investigated. Finally, a summary of the literature concludes this chapter. Because much that has been written about the construct of shame is conceptual rather than databased, most of the statements presented in this dissertation are theoretical rather than factual.


Definitions & Descriptions of Shame

Shame is like an onion; at times there are layers that overlap, and sometimes there are distinct meanings and understandings (Pattison, 2000). There are numerous insights and approaches in looking at shame (Gilbert, 1998). A substantial problem in a thorough understanding of shame is that it is a phenomenon that is hidden in a number of ways (Pattison, 2000). Many writers on shame noted that a chief feature of shame is a sense of unwanted and uncontrollable exposure (Lewis, 1992, Kaufman, 1996). Mindell (1994) defined shame as:

(T)he experience of feeling intensely unacceptable, worthless or inferior, as if one is no one who counts, as if one is nothing. It is accompanied by the experience of being unable to think clearly and of being completely exposed to the critical view of another person, with an intense wish to hide oneself (p. 33).

In fact, the English word “shame” comes from the German word “scham” which means to cover (Schneider, 1992). Studies have consistently revealed that feelings of shame are often associated with a desire to hide or flee (Barrett, Zahn-Waxler, & Cole, 1993; Lewis, 1971; Lindsay-Hartz, 1984; Tangney, 1993). In a cross-sectional study of 302 children (grades 4-6), 427 adolescents (grades 7-11), 176 college students, and 194 adult travelers passing through a large urban airport (Tangney, Wagner, et al., 1996), shame-proneness and guilt-proneness were measured using the Anger Response Inventory (ARI) and the Test of Self-Conscious Affect (TOSCA). The TOSCA, developed by Tangney, was fashioned from participant-generated scenarios and responses. It was a revision of the Self-Conscious Affect and Attribution Inventory (SCAAI), also developed by Tangney (1990), which was
made up of a series of negative and positive scenarios with a choice of multiple responses, two of which represent guilt-proneness and shame-proneness.

Shame proneness was associated with not only anger, but with anger held in and a tendency to withdraw.

Shame can be defined simply as the feeling we have when we evaluate our actions, feelings or behavior, and conclude that we have done wrong. It encompasses the whole of ourselves; it generates a wish to hide, to disappear, or even to die (Lewis, 1992, p. 2)

Novak (1986) found from his study of whether there are multiple factors involved in the experience of shame that there was high intercorrelation among fear of exposure, embarrassment, and inferiority.

The experience of shame often results in a failure of words (Pattison, 2000). Lewis (1971) proposed that shame’s roots are located in the child’s prelinguistic experience. The confusion that a person feels during an experience of shame often renders her speechless. “Shamed people are left without words or the capacity to use them … The shame experience itself is impossible to articulate at the time, and may be so even afterwards” (Pattison, 2000, p. 74). “Shame is a relatively wordless state. The experience of shame often occurs in the form of imagery, of looking or being looked at” (Lewis, 1971, p. 37).

There is a problem with the English language regarding shame (Pattison, 2000). A distinction exists between “discretionary shame” (in French pudeur), which refers to shame that is felt prior to and as a warning against an action, and “disgrace shame” (honte), which relates to shame felt after an action (Schneider, 1992). Distinction between shame as disgrace and shame as modesty has survived from the Greek language in all European
languages except English (Scheff & Retzinger, 1991). Perhaps language constructs rather than reflects experience (Gergen, 1994) There may be such a problem with clarity and nuance in the language precisely because the phenomenon of shame is in the process of construction in many disciplines and across many cultures. However, the lack of clarity regarding shame plays a role in its obscurity (Pattison, 2000).

A recurring theme in many definitions was shame’s connection to the self, a feeling of inadequacy and worthlessness as a human being, of being bad or defective. Bradshaw (1988) said, “To have shame as an identity is to believe that one’s being is flawed, that one is defective as a human being (p. vii).” Morrison (1996) defined shame as “that feeling of self-castigation which arises when we are convinced that there is something about ourselves that is wrong, inferior, flawed, weak, or dirty” (p. 13). Nathanson (1992) described shame as “uncomfortable feelings, ranging from the mildest twinge of embarrassment to the searing pain of mortification” (p. 19). He further stated that “shame is about the quality of our person or self” (p. 19). Kaufman (1996) talked about shame as “the affect of inferiority” (p. 16). “(W)e feel fundamentally deficient as individuals, diseased, defective. To live with shame is to experience the very essence or heart of the self as wanting” (p. 17). Fowler (1993) said, “Shame is about the self—its adequacy and its worth, its defectiveness and its unworthiness” (p. 816).

Shame is an inner sense of being completely diminished or insufficient as a person. It is the self judging the self. ... A pervasive sense of shame is the ongoing premise that one is fundamentally bad, inadequate, defective, unworthy, or not fully valid as a human being (Fossum & Mason. 1986, p. 5)

Bradshaw (1988) said that toxic shame...
...is experienced as the all-pervasive sense that I am flawed and defective as a human being. Toxic shame is no longer an emotion that signals our limits, it is a state of being, a core identity. Toxic shame gives you a sense of worthlessness, a sense of failing and falling short as a human being. Toxic shame is a rupture of the self with the self. (p. 10)

*Guilt vs. Shame*

There seemed to be agreement among many shame theorists that guilt is feeling bad about discrete actions, either committed or omitted, while shame is global and has to do with the inadequacy, worthlessness, or badness of the self (Emde and Oppenheim, 1995). While guilt is a hurtful feeling of disappointment and responsibility for one’s actions, shame is a hurtful feeling about oneself as a person (Fossum & Mason, 1986). Guilt is about something that one has done or contemplated doing; shame is about something one is or is not (Fowler, 1993; Nichols, 1995; Yontef, 1996). Furthermore, to the shameful person, there exists no possibility to repair the damage because shame is a matter of identity, not behavioral transgression (Fossum & Mason, 1986).

In psychoanalytic theory, Piers and Singer (1971), identified guilt as internalized fear of punishment and shame as internalized fear of rejection. The guilty conscience is haunted by the unconscious image of the castrating father; shame rests on the even more frightening threat of abandonment. Guilt comes from defiance of the father; shame comes from the failure to live up to his internalized example. They proposed that both shame and guilt arise from superego functions, but that shame involves the ego ideal and guilt involves conscience. Shame occurs when a person fails to live up to the expectations of her or his ego ideal. Shame involves shortcomings rather than rule violations. Guilt, however,
involves transgressions, performing acts that violate the rules enforced by the superego (Piers and Singer, 1971).

Shame is an awareness of a discrepancy between the ideal self and the perceived self; it is a complex emotion that contains within it the experience of helplessness and a loss of self-esteem, both of which occur as a result of failure. In contrast, guilt is often more precise and linked to having done something forbidden or with a deed of omission (Emde and Oppenheim, 1995). Guilt makes one “feel like a bad person because she or he has “done something or – perhaps only thought about doing something” that he “should not have done;” whereas “shame has the power to make one feel completely worthless, degraded …, without … having done anything bad at all” (Jacoby, 1994, p. 1).

Guilt is an experience that acknowledges one’s commitment to social relationships and the norms accompanying them, whereas shame is an experience of discovering oneself to be deficient, unacceptable, or incompetent relative to established norms or within interpersonal relationships (Lynd, 1958; Shott, 1979). Shame involves the total self and cannot be externalized in the way that guilt can (Lynd, 1958). When one experiences shame, one does not “even try to argue … that the total self is not involved;” with guilt, it is possible that one “will successfully rationalize a way out of the situation” … (Capps, 1993, p. 74 & 75).

Several studies, both quantitative and qualitative, support the distinction between shame and guilt (Ferguson, Stegge, & Damhuis, 1991; Ferguson & Stegge, 1995; Lindsay-Hartz, 1984; Lindsay-Hartz, de Rivera, & Mascolo, 1995; Tangney, 1993; Wicker, Payne, & Morgan, 1983). For example, in two independent studies, young adults were asked to describe a personal shame experience and a personal guilt experience and then to rate these
experiences along several phenomenological dimensions (Tangney, 1993; Tangney, Miller, Flicker, & Barlow, 1996b). The results across the two studies were quite consistent. Shame experiences were rated as significantly more painful and intense than experiences of guilt. People, when experiencing shame, felt physically smaller and more inferior to others. A sense of exposure and a preoccupation with others’ opinions were more likely to be involved in shame experiences. Also, people, when feeling shame, were more driven to hide and less likely to admit what they had done (Tangney, 1995).

In a study of autobiographical accounts of shame and guilt experiences (Tangney, Marschall, Rosenberg, Barlow, & Wagner, 1994), systematic differences were found in the nature of participants’ interpersonal concerns as they described their personal misbehaviors. Guilt experiences tended to involve a concern with one’s impact on others, whereas shame experiences tended to involve a concern with others’ evaluations of the self. Lewis (1971) had previously observed that focus on a specific behavior is part of the guilt experience, whereas focus on the self is part of the shame experience. When individuals described their guilt experiences, they conveyed more empathy towards others than when they described their shame experiences (Tangney, et al., 1994). Lindsay-Hartz et al. corroborated this:

Comparing shame with guilt, we can see that the opportunity for empathy is much reduced during experiences of shame. While ashamed, one focuses on the painful experience of being a negative self. Beyond a conviction that others view one negatively, one is not likely to be thinking much about any feelings that others may be experiencing (Lindsay-Hartz et al. 1995, p. 296).
People convey more other-oriented empathy when describing guilt-inducing events than when describing shame-inducing events (Tangney, 1995).

In focusing on an offending behavior (as opposed to an offending self), the person experiencing guilt is relatively free of the egocentric, self-involved process of shame. Rather, because the focus on the specific behavior is likely to highlight the consequences of that behavior for a distressed other, guilt serves to foster a continued other-oriented empathic connection. In contrast, feelings of shame are incompatible with other-oriented empathy reactions in several respects (Tangney, 1991, 1995) (Tangney, 1995, p. 1137).

The links between guilt and empathy and shame and lack of empathy extend beyond specific situations. Connections between the disposition of guilt-proneness and interpersonal empathy have been established; whereas, shame-proneness has been negatively related to other-oriented empathy and positively related to ‘self-oriented’ personal distress (Tangney, 1995).

Shame is typically an acutely painful experience that involves a marked self-focus. This preoccupation with the self is likely to draw one’s focus away from a distressed other, thus precluding or interrupting other-oriented feelings of empathy. Shamed individuals are less likely to be concerned with the hurt that was caused or with the pain that is experienced by the harmed other. Rather, they are consumed with a focus on negative characteristics of the self… (Tangney, 1995, p. 1137).

A study by Tangney et. al. (1994) challenged the notion that shame is a more public emotion than guilt (Tangney, 1995).
Among both children and adults, shame and guilt were each most likely to be experienced in the presence of others, but a substantial number of respondents (17.2% of children and 16.5% of adults) reported shame experiences occurring alone—when not in the presence of others. More importantly, ‘solitary’ shame was about as prevalent as ‘solitary’ guilt (Tangney, 1995, pp. 1133–1134).

**Shame Through the Millennia**

“Shame may restrain what law does not prohibit.” (Seneca)

However understood and utilized, shame has always played a significant role in human cultures and relationships since documented history began (Pattison, 2000). Since the Greeks and Hebrews and probably beyond, shame has been a regulating force in Western societies (Williams, 1993). In feudal societies, people tended to act out their emotions of love and hate, often with violence and killing. Through the civilizing process, manners and customs dictated that physical force should be abandoned. Internal personal control replaced external factors such as violence in a coordinated, interdependent social order. The state became the only entity that could legitimately administer physical force (Elias, 1994). The state eventually moved from physical force to more psychological controls (Rose, 1989).

More and more the locus of social control moved from external power to internal control and repression. Shame became the means used to internalize standards of taste and revulsion (Elias, 1994). “The prohibitions supported by social sanctions are reproduced in the individual as self-controls” (p. 105). Elias pointed out that there is a “continuous correspondence between the social structure and the structure of personality (Elias, 1994,
p. 156). He further stated that “the sociohistorical process of centuries ... is reenacted in abbreviated form in the life of the individual human being” (Elias, 1994, p. 105). Shame anxiety is psychologically experienced and understood in a really individuated psyche in a complex, interdependent, differentiated society where social control is, for the most part, internalized within the self (Pattison, 2000). “Inner fears grow in proportion to the decrease of outer ones ... The direct fear inspired in men by men has diminished, and the inner fear mediated through the eye and through the super-ego is rising proportionately” (Elias, 1994, p. 497). “In modern Western society, shame is an intensely personal feeling of psychological rejection ... Shame used as a method in social control is perhaps all the more effective for not being recognized as shame” (Pattison, 2000, p. 152).

It has been proposed that ‘shame-based’ cultures, those cultures based on conforming to unwritten rules and the maintenance of honor and appearance preceded the ‘guilt-based’ cultures, those based on written laws and procedures, internalized conscience, and the idea of punishment to fit the crime (Benedict, 1954). However, the distinction between the two kinds of cultures and the notion that one succeeds another in the evolutionary process has been questioned (Cairns, 1994). Different cultures use shame in different ways. Sometimes it is more external and official, and sometimes internal and less formal. However, it is common for cultures and groups of all kinds to use shame to achieve individual and social control (Pattison, 2000). “One common denominator that may unite experiences and use of shame down the centuries is the fact that to those who are shamed it is an unpleasant, unwanted state of alienation and rejection” (Pattison, 2000, p. 152).

Nathanson (1992) sketched the history of a dimension of shame by observing “the cultural attitude toward the naked human body” (p. 434). The statuary of ancient Greece
and Rome portrayed men and women unclothed. From the Middle Ages, there are
woodcuts showing families happily running naked together on their way to the communal
baths. During the Middle Ages, ivory carvings of the Christ child depicted him naked with
genitals exposed; he wears a loincloth from the 17th century on. A new sense of modesty
arose at the arrival of the Renaissance at which time both male and female genitals were
covered and hidden. A growing propensity to cover the female breast occurred during the
18th century and continued for the next 100 years and more (Nathanson, 1992).

"Some deeply shameful act" is found "at the origin of the human world" in the
foundation myths of many cultures (Turner, 1995). From the Biblical stories, there is "the
shame of Adam and Eve at their disobedience, their lies, and their nakedness," the shame
of Cain for murdering his brother, and the shameful Christmas story, "of the infant god
born between the two places of excrement, urine and feces," and placed in a manger among
the beasts "because there was no room at the inn" (p. 1061). Turner (1995) further pointed
out that in the Greek myths there is "the shameful story of Cronus castrating his father
Uranus with a sickle", and the generally incestuous behavior of the gods. The "shameful
murder of the corn god" in American Indian mythology and "murder and incest in the
Australian aboriginal creation myths" are further examples of myths embedded in shame
(p.1061). According to Turner (1995), these myths express the basic issue of the human
plight. The essential problem is the "coexistence of a reflective mind with a smelly, sexed,
and partly autonomous body; the horror of death ... the crimes of our ancestors against the
peoples or species they displaced" (p. 1061).

"With the acquisition of objective self-awareness comes shame and the need for
concealment" (Broucek, 1991, p. 3). The creation of humans by God and the shift from a
life of paradise to a self-conscious life found in the book of Genesis represent the physical
and psychological phases of the evolution of human nature in which shame is connected
with both (Scheff, 1997). “The Genesis myth thus suggests that history began with shame
and the suddenly altered perception of the world associated with that shame” (Broucek,
1991, p. 4).

Many factors have contributed to the disregard of emotions historically (Averill, 1996).
Outside the disciplines of biology, psychology and some kinds of philosophy, emotions
have received little serious academic consideration (Lindholm, 1990). The chief reason
may be that emotions have been perceived to be anti-rational (Averill, 1996).
Apprehension, lack of understanding, and disregard of the emotions are factors that led to
their being dismissed as important elements of human experience and knowledge. The
introduction of feminism and the decline of narrow rationalism have encouraged an
exploration of them (Pattison, 2000).

Several developmental theorists (Kaufman, 1996; Nathanson 1992; Tomkins, 1962)
believed that shame has its roots in biology. In addition, the universality of facial
expressions across several cultures, indicates a biological component (Scheff, 1997). The
self-conscious aspect of shame suggests a psychological component, and the variation from
one society to another and the social aspect of shame implies a cultural element (Scheff,
1997).

Shame in Human Development

Origins of Shame

Toxic shame originates interpersonally, in the source relationships of our original
families (Bradshaw, 1988; Erikson, 1950; Karen, 1992; Kaufman, 1992; Morrison, 1996;
The feeling of shame in a shame-oriented person usually extends back before the age of distinct memory; it is rooted in the earliest struggles and interpersonal experiences of the infant and young child (Yontef, 1996). The shame process starts before awareness is verbal; therefore, shame feelings are often not in verbal awareness (Yontef, 1996). Dysfunctional shame is usually instilled at a delicate age, as a result of the internalization of a contemptuous voice, usually parental (Karen, 1992). Many parents, because of their own unmet needs, are not able to accept the child for who she or he is. They may want a child who is more attractive, smarter, more athletic, or charming; thus, they may not give the developing child the appreciation and respect she or he needs (Karen, 1992). "Shame is an acute collapse of self-esteem, developmentally linked to parental failures to respond with adequate attention and appreciation to the child as a whole and worthwhile human being" (Nichols, 1995, p. 140). A climate of periodic rejection or pervasive disrespect steadily erodes the child’s sense of self-worth and makes her or him predisposed to shame (Karen, 1992).

In Morrison’s (1996) view, the quality of interaction within the family, particularly between baby and mother, determines the degree of security, trust, and self-esteem felt by the baby. Shame sensitivity results when maternal responsiveness is not adequately present. The child, lacking a positive sense of self, readily reacts with shame to the inevitable slights of childhood. Passive unresponsiveness on the part of the preoccupied or self-involved parents can induce shame sensitivity or a predisposition to shame (Morrison, 1996).

Yontef (1996) suggested that a child may experience a bewildering, bad feeling in the puzzling interactive experience in which parental negativity and her own forming sense of
self are not distinctly clear. The child then turns the anger that was originally directed at the parent inward against the her "needy, weak self." She blames her need rather than the field responses, that is the rejecting behaviors of the parent. In adulthood, when a sense of need or feeling arises, nonverbal reactions from others can trigger the old globalized shame at which point the mental and interactional contact processes are interrupted. She blames her need, anger, or hunger for this sense of shame (Yontef, 1996).

Introjection and projection play major roles in the shame process (Yontef, 1996). In Gestalt theory, introjection is the propensity to uncritically accept others' beliefs and standards without digesting them to make them consistent with oneself; it is the passive incorporation of what the environment provides without getting clear what one wants or needs (Corey, 1991). Parents often give the introjected shame message of "never enough." The child is never enough to get the love of her parents and see the look that tells her she is a gift just as she is (Yontef, 1996). Projection, in Gestalt theory, is the process of disowning certain aspects of oneself by assigning them to the environment (Corey, 1991). With shame, individuals often experience other people treating them as they unconsciously treat themselves. If one looks at herself with disgust, she imagines that others find her disgusting. She projects her feelings onto others (Yontef, 1996).

Erikson (1950) indicated that the emergence of shame occurs between 18 and 24 months of age, when the child first becomes consciously aware of the evaluations of others. The child is cognitively and socially inexperienced; her or his knowledge of expectations and standards is not clear. Therefore, these early experiences of self-evaluation have a global or "whole-self" quality to them. Erikson (1950) located shame in the second of eight stages or identity crises that span the life cycle. He thought that the inception of shame is
related directly to the field of toilet training and the outcome of that stage is *autonomy* versus *shame and doubt*.

Not surprisingly, the most powerful adult experiences of being shamed are based upon the types of painful humiliation that we suffered during our tender developmental years. Feelings of lack of legitimate entitlement replay the shameful and humiliating events of our past. We tend to see in another’s response to our overtures for intimacy and friendship reflections of how we have been led to regard ourselves from early life. Crippling feelings of shame and pessimism … from the limited ways we were permitted to be useful and attractive in our own families and in the countless other significant experiences we have had growing up (Goldberg, 1996, p. 260).

The emergence of shame in childhood is supported by a series of studies conducted by Lewis, Sullivan, Stanger, & Weiss (1989). Lewis et al. (1989) that showed that young children first display signs of embarrassment (smiling together with gaze aversion, patting the face, etc.) in embarrassing situations between 15 and 24 months. This is the same phase in which a primitive sense of self emerges. Self-recognition is assessed by surreptitiously placing rouge on a child’s nose and then observing how the child behaves when she or he faces a mirror (Amsterdam, 1972; Bertental & Fischer, 1978). Before 15 months of age, children may look at “the red nose in the mirror,” but they do not appear to link the image with themselves. However, between 15 and 24 months, children start to display sign of self-recognition, impulsively patting or dabbing their reddened nose. Children between 15 and 24 months who displayed self-recognition in the “rouge” test are the same children who showed signs of embarrassment in an unrelated task. The results of Lewis et al. (1989)
are consistent with the idea that a recognized self is a precondition for emotions such as shame, guilt, embarrassment, and pride.

Many theorists point to the development of shame in childhood, but it is possible for shame to develop at any time during the lifespan (Tantum, 1998). Rape victims, those who have experienced any abuse or trauma (Walker, 1992), those who have endured cruelty in prison camps or who have lived under oppressive regimes (Bettelheim, 1986), are examples of adults who may develop shame later in life (Pattison, 2000).

Since shame is not a well-defined clinical condition, any attempt to determine its causes will be fragmentary and less than coherent. There is no main cause to which shame can be attributed (Pattison, 2000).

It seems plausible to suggest that any experience that constitutes a rejection, objectification, or boundary invasion of the person that induces a sense of social or individual worthlessness, alienation or abandonment if severe enough, long enough, or repeated enough, is likely to contribute to the development of a chronic sense of shame (Pattison, 2000, p. 96).

**Functional and Dysfunctional Shame**

Not all experiences of shame are deleterious. Quite the contrary! In small doses, shame can be a prod to self-improvement. In digestible amounts, shame spurs freedom by providing a means for penetrating self-discovery. ... Healthy responses to feeling shame derive from our willingness to openly examine and do something constructive about aspects of ourselves that have been causing us to feel badly about ourselves that we can reasonably change (Goldberg, 1996, p. 265).
When an individual experiences shame, she returns to her own sense of subjectivity and individuality (Broucek, 1991). Merging with another can be destructive, as in an abusive relationship in which the victim is objectified and feels she has no will of her own (Walker, 1992). Shame plays a valuable defensive role in distinguishing between self and others; it serves as a defense against being objectified (Broucek, 1991).

Shame interrupts interest and joy between people in a relationship and squelches the previous positive affects (Kaufman, 1996). Shame reveals a disturbance in the interpersonal bridge between the self and others (Tompkins, 1987; Kaufman, 1996). By paralyzing the self, shame acts to prevent negative reactions such as violence and anger that might threaten the renewing of the interpersonal relationship (Kaufman, 1996). “Shame provisionally interrupts the pursuit of sin in order to provide for a time for self-aware evaluation for the sake of avoiding a more serious breach” (Fowler, 1996).

Fowler (1996) discussed the relationship between shame and grace, contending that the Genesis story of Adam & Eve is about shame, not pride and lust followed by guilt. Fowler’s interpretation of the story is a ‘fall’ into self-consciousness, separation, and responsibility that all human beings experience. Adam and Eve are children who grow up and enter a world in which they must relate to other people who are different. Shame is a part of human evolution and growth (Fowler, 1996).

Conscience (Functional Shame).

Although the focus of this study is dysfunctional shame, it is important to see that not all shame is crippling, and, in fact, is necessary for the development of one’s conscience (Fowler, 1993). Shame is activated when one expects disapproval or rejection by those who matter to her or him; shame is based on the underlying human motive to preserve
interpersonal relationships (Leary, 2000). Shame is the "custodian of one's relatedness with others" and communicates one's "vulnerability," one's "essential humanity" (Fowler, 1993, p. 818). As well, Fowler (1993) stated that to an individual "the experience of shame signals the need" for one to assess and "possibly amend" her or his ways (p. 818). Hence, shame plays an important role in the operations of conscience. "Aligned with the child's first awareness of 'the way things are supposed to be,' shame provides a foundational element for conscience" (Fowler, 1993, p. 816). "The optimal development of conscience depends on adequate and appropriately graded doses of shame that do not overwhelm the child ..." (Kaufman, 1996, p. 147).

Hanson (1997) discussed the positive potential of shame. Individuals may be ashamed of, not only past behavior, but also contemplated behavior and planned behavior. Thus shame can be an inhibiting and preventive force. It can also be a determining force in that individuals may act because they would feel ashamed if they did not. Shame may be "part of the very operation of the uncorrupted conscience. The person who is ashamed of a malicious act is a deeply different sort of person from the one who is not ashamed,..." (Hanson, 1997, p. 168).

Conscience (Dysfunctional Shame).

From a Freudian perspective, the superego is composed of the conscience, which contains behaviors for which an individual as a child has been punished, and the ego-ideal, which contains the moral or ideal behaviors for which a person should strive and for which she, as a child, was praised (Corey, 1994). These rules that earn rejection or acceptance from her parents are, in time, internalized, and she self-administers rewards and punishments. As a result of the internalization, she experiences shame or guilt when she
does something that violates this moral code (Corey, 1994). From a psychoanalytic perspective, shame results from the “internal (intrapsychic) conflict from clashing aggressive or sexual drives (the id), opposed by principles of reality (the ego) and conscience (the superego) (Morrison, 1996, p. 150). Shame is a tension between the ego and the ego-ideal; in other words, tension between what one wishes to be and what one is (Piers and Singer, 1971). The deepest shame is a perception of weakness in one’s own eyes, falling far short of one’s ego-ideal (Wurmser, 1981).

When conscience is not internalized, the result is an antisocial or psychopathic person. This individual is not without shame, but the shame is externalized, present only in the presence of others. When no one knows about the crime, the person feels no shame (Kaufman, 1996).

The failure of conscience to become internalized is a result of prior failure to attach to and identify with the parents. Identification is a necessary developmental precursor that causes one to want to care about the feelings of others; it also causes the shame response itself to become internalized (p. 148).

Behavior (Functional Shame).

Shame is central to an understanding of human action and experience (Retzinger, 1989; Scheff, 1994). The central position that shame occupies in social experience gives it a primary place in human motivation. Furthermore, people behave and follow social mores, in order to fit in, be accepted, and escape the pain of shame and humiliation. “When its manifest and hidden aspects are understood, shame points, then, to the deepest levels of comprehension of the bond between self and others and the regulation of that bond by manifest affects signaling success or failure within that bond – pride or shame” (Lansky &
Morrison, 1995, p. xv). The establishment and maintenance of social bonds is the fundamental aim of human experience (Retzinger, 1989; Scheff, 1994). This stance is supported by Stern's (1985) research of the individual within the context of the mother-infant relationship. A baby cannot survive alone, but is fundamentally part of a relationship (Winnicott, 1987). Shame that is acknowledged and addressed with mutual respect between individuals and groups can generate strengthened bonds (Scheff and Retzinger, 1991).

Mokros (1995) asserted that feelings aroused along the shame-pride continuum regulate an individual's behavior by calling attention to one's place and responsibility to the social bond. When a person experiences pride, she or he experiences integration into the social bond. When one feels shame, she or he experiences separation and the pull to social reintegration. Shame thus provides a regulatory function in everyday experience that brings to awareness one's sense of place and self as contingent upon others and one's place within the social bond (Mokros, 1995).

Behavior (Dysfunctional Shame).

There are behaviors that are initiated in order to cope with or mask shame as it transpires (Gilbert, 1998). Anger and aggression often fill-in for shame; an individual becomes angry at having her or his flaws pointed out and commented on (Nathanson, 1992; Retzinger, 1991; Tangney et. al., 1996a). The prototype of shame is the childhood experience of having aspects of oneself repeatedly turned away from by one or both parents. Shame-as-signal is developed to protect oneself from this experience because shame is so painful that one works out ways of protecting oneself. Contempt is one way of protecting oneself (Tangney et. al., 1996a).
Gilbert (1998) maintained that some behaviors are aroused in order to avoid being shamed. Shame can serve as a safety device when it stops us from doing things that we might like to do but would feel shame for doing. There is the shame of being discovered. In an effort to avoid shame, individuals may withdraw from those situations where it could be experienced. One way of dealing with shame is to keep it secret. "I don't want to be seen" is the frequent message from shame-oriented people (Gilbert, 1998). "Being seen means being exposed, and shame-oriented people project their own self-critical eyes and expect others to be as critical of them as they are of themselves" (Yontef, 1996, p. 362). Individuals hide their shame "behind the guises of anger, contempt, depression, denial, or superiority" (Morrison (1996, p. 10). Nathanson (1992) contended that some people strive to reach high standards as a way of compensating for inferiority and avoiding shame. Competitiveness and the constant need to draw attention to one's positive characteristics are symptoms of shame (Nathanson, 1992).

Identity (Functional Shame).

The self is experienced "within the context of social bonds ... through actions and reactions of the other (including the self as other) to the self" (Mokros, 1995, p. 1095). Since the mother-infant relationship is so critical in the development of self, it is to be expected that the beginning of this sense of self is connected to the quality of the mother's attunement. If shame is a dominant quality in the mother, then the qualities of weakness and incompetence will be taken in through identification, by the infant (Morrison, 1995). The sense of self first develops in contact between members of the family system. The social shaping process can support, build up, or hamper self functions (Yontef, 1996). The "experience of the self in relation to the other is internalized" in early childhood, and ...
individuals achieve a sense of identity through social bonds (Mokros, 1995, p. 1095). Early family interactions may support the formation of a self that identifies with its forming figure, one that values the contact and differences between people; or it may interrupt the forming figure and the forming sense of self and leave the child with a negative reaction to oneself as a whole (Yontef, 1996).

Identification is a human process. The identification need continues throughout the life cycle; it is by no means confined to childhood. To the degree that the need is responded to sufficiently, and differentiation is equally supported, the emerging adult is able to navigate life autonomously while discovering others with whom to identify, such as mentors when entering a trade, career, or profession (Kaufman, 1996, p. 73).

An understanding of shame is related to “an understanding of social systems of every sort—from the internal world of internalized ‘objects’; to the family system; to the broader social order, large or small, in which shame and shame-related phenomena are key to the regulation of selfhood and esteem” (Lansky & Morrison, 1997, p. xv).

Identity (Dysfunctional Shame).

“Shame is the affect of inferiority. No other affect is more central to the development of identity. None is closer to the experienced self, nor more disturbing” (Kaufman, 1996, p. 16). “Identification is one vital source from which identity evolves” (Kaufman, 1996, p. 72). “Shame is what we feel when we have failed to meet our own expectations” and “shame and the self are intimately related” (Capps, 1992, p. 72).


(T)he totally self-involving nature of shame ... tends to involve one’s body as well as one’s mind. Whereas guilt is usually described as felt in the conscience (i.e., the...
mind), shame is deeply visceral and gut-wrenching; it is usually felt in the pit of the stomach. Shame involves the bodily self, not just the thinking self but also the feeling self, and this is perhaps why shame experiences often have debilitating physical effects, making one lethargic, apathetic, and susceptible to physical illnesses (p. 75).

Kaufman (1996) pointed out that in each of Erikson's (1950) eight stages, the negative pole of each crisis is actually an expansion of shame. Each subsequent crisis involves, in part, a reworking of shame. The poles of each identity crisis are basic trust vs. mistrust, autonomy vs. shame and doubt, initiative vs. guilt, industry vs. inferiority, identity vs. role confusion, intimacy vs. isolation, generativity vs. stagnation, ego integrity vs. despair.

Shame is critical to the development of mistrust, guilt inferiority, isolation, stagnation, and despair; it is involved in each crisis of identity. Shame is the affect most central to the sense of identity (Kaufman, 1996).

Internalized shame can exert a critical influence on identity.

This more pernicious internalization process starts when shame becomes linked with various affects, needs, or goals (the formation of negative introjects). The imagery, language, and affects associated with various shame-binds can then merge to form linkages of shame with more global aspects of one's personality such as body image, relationship, competence, and overall character. Shame then resides as part of the ground that reinterprets new experience in the light of prior experience and inevitably reproduces shame (Lee, 1994, p. 269).

Kaufman (1996) asserted that shame is felt as an inner agony and that no other affect is closer to the experienced self or more crucial to the development of identity. Shame divides
us from ourselves and others. The attention turns inward in the midst of shame, thereby producing self-consciousness. This excruciating observation of the self becomes so penetrating as to create a binding, almost incapacitating effect (Kaufman, 1996).

The experience of shame is an image of the "other" rejecting the self (Lewis, 1971). Morrison (1996), a psychiatrist and psychoanalyst, defined shame as "a feeling of loathing against ourselves, a hateful vision of ourselves through our own eyes — although this vision may be determined by how we expect or believe other people are experiencing us (p. 13).

The root of shame lies in abrupt, unexpected exposure in which one is revealed as inferior, painfully diminished in one's own eyes and the eyes of others (Kaufman, 1992). Self-consciousness and increasing self-doubt follow quickly, immersing the self further into hopelessness. Kaufman (1992) further asserted that living with shame is feeling alienated and overcome, not quite good enough to belong, and one blames oneself for this deficiency. Shame calls one's entire identity into question and shatters basic trust in the world; it is a form of self-punishment, a vicious denunciation of the self that is rooted in the utter sense of being unlovable (Wurmser, 1991). Yontef (1996) stated, "Shame is the experience of negative evaluative and emotional reactions to one's own being" (p. 353). Shame can be situational, a reaction to specific experiences, or existential, about one's global sense of self. Often situational shame points to more persistent, profound, and intense reactions to one's entire sense of self. There is also group shame which refers to shame that is experienced as a result of membership in a class, race, religion, or other social groups (Yontef, 1996).
Tangney (2002) made the following distinction between shame and self-esteem: Global self-esteem is a stable trait involving one’s general evaluation of the self, largely independent of specific situations. ... The feeling of shame involves a negative evaluation of the global self, but one that is in response to a specific failure or transgression, not necessarily reflective of one’s general level of self-esteem (pp. 56-57).

(Cook (1991) suggests an association between shame and self-esteem. The Internal Shame Scale (ISS) correlates significantly with the Tennessee Self Concept Test (-.66) for 118 college subjects and correlated with other shorter self-esteem measures ranging from .52 to .79 (Cook, 1991). Tangney (2002) criticized Cook’s (1989) hazy distinction between shame and self-esteem, and stated that this haziness was reflected in items on the ISS. She described his distinction in the following manner: “(W)hereas internalized shame is an extremely painful affect experienced around a basic sense of inferiority, negative self-esteem is a ‘less dynamic’ concept centering on self-description or self-rating” (Tangney, 2000, p. 32). Tangney (2002) talked about a negative correlation between shame proneness and self-esteem (r = -.42). While Tangney (2002) suggested that feelings of shame contribute to low self-esteem, and, also that low self-esteem leads to a susceptibility to shame feelings, she found people with low self-esteem who were not shame prone and people with high self-esteem who were shame prone. Tangney (2002) speculated that a tendency to experience shame is based on a broad range of factors “including early temperament, parental (and other) socialization factors, and cultural environment” (p. 62).

The Internalized Shame Scale (ISS) was developed to identify a continuing cluster of shame feelings that result from frequent shaming experiences that have become internalized over time, beginning with childhood experiences (Cook, 1987). The scale correlates, in both clinical and nonclinical populations with most measure of pathology; the implication is that shame is present in most psychopathologies (Cook, 1996). This scale is a frequency scale (from never to almost always) and contains 24 negatively worded items that indicate deep shame feelings. Examples of some of the items are: “I feel intensely inadequate and full of self doubt; I have an overpowering dread that my faults will be revealed in front of others; At times I feel so exposed I wish the earth would open up and swallow me” (Cook, 1987, p. 414). The scale correlates, in both clinical and nonclinical populations with most measures of pathology; the implication is that shame is present in most psychopathologies (Cook, 1996). Clinical subjects scored significantly higher on the ISS when compared with non-clinical subjects (Cook, 1991). "ISS means for the different groups were as follows: non-clinical (N = 514), 33.98; alcohol/drug patients (N = 247),
49.34, affective disorders (N = 84), 48.51; other psychiatric disorders (N=36), 48.75; post-traumatic stress patients (N = 47), 58.59; eating disordered women (N = 25), 68.92” (Cook, 1991, p. 414).

Nathanson (1992) contended that experiences of shame not integrated into one’s awareness in a healthy way, are defended against in one of four manners: withdrawal; avoidance; attack of self; attack of other. These four patterns encompass almost the full range of psychopathology. The person who defends against shame in the “attack other” mode is usually extremely sensitive to slights or insults. The “attack other mode” is intended to make the shaming other lower than oneself. The attacking behaviors can consist of verbal sarcasm, abusive language, or physical attacks of all kinds. The initial feeling of shame turns quickly to anger, often before the individual feels the shame. Shame is almost always the triggering event for the attack (Nathanson, 1992).

If shame is triggered often across childhood and adolescence, with infrequent or inadequate reparation of those experiences, the individual typically develops a defensive script to enable the management of the painful emotions associated with the triggering of shame. The resulting defensive ‘affect management scripts’ can take many forms and are analogous to the various symptoms described in Axis I disorders or in the personality styles/disorders of Axis II (Cook, 1996, p. 155).

The degree of psychopathology is more or less commensurate with the degree to which shame affect has become internalized within the personality (Kaufman, 1992). Shame lies at the core of all compulsive/addictive behaviors because “the drivenness in any addiction is about the ruptured self, the belief that one is flawed as a person” (Bradshaw (1988, p. 15).
Suicide with its underlying depression is the most severe expression of shame (Morrison, 1996). Whereas rage, contempt, and envy manifest shame focused on other or the environment, depression and suicide conveys shame focused on the self (Morrison, 1996). Mokros (1995) believed that the link of shame to suicide occurs when the regulatory function of shame becomes dysfunctional such that the individual experiences "no sense of social place." This occurs when shame is not acknowledged and becomes internalized. Usually a cycling between shame and anger occurs. In shame one feels rejected from the social bond, and in anger, one rejects one's place in the social bond.

According to Mokros (1995), when shame becomes dysfunctional, there is a desperate preoccupation with one's identity, one's sense of place in an environment of deeply felt, at times, intolerable pain. From the perspective that shame serves as a psychosocial regulatory process, intimately connected with the self, acts of suicide are seen as solutions to intolerable self-ridicule (pathological shame) and the impossibility of achieving or reestablishing a sense of social place (Mokros, 1995).

The strength of the social bond between persons in an intimate relationship depends upon the extent of healthy pride; the opposite of healthy pride is shame (Retzinger, 1989). Couples often become involved in shame-rage spirals that can intensify to physical violence (Retzinger, 1989).

"...in a shame attack, the person may be flooded with shame and self-hate—or might be frantically trying to fend off this flooding. He or she may want to 'sink through the earth.' The person may then experience 'shame-rage,' which leads to a further sense of shame because he or she is partially aware that the rage is inappropriate. Thus the shame becomes 'locked in' in a self-escalating spiral of misery, self-abuse,

Anger is a typical experience of feeling shamed (Tangney et al., 1996a). The couple’s unwillingness or inability to address their shame can lead to marital breakdown (Retzinger, 1989). The tendency to experience shame was positively correlated with measures of trait anger and indexes of indirect hostility, irritability, resentment, and suspicion in a study of young adults (Tangney, 1995). Shame-proneness was positively correlated both with boys’ self-reports of anger and teacher reports of aggression in a study of 363 fifth-grade children (Tangney et al., 1991).

(S)hame was clearly related to maladaptive and nonconstructive responses to anger across individuals of all ages (8 years through adulthood), consistent with Scheff’s (1987, 1995) and Retzinger’s (1987) elegant descriptions of the ‘shame-rage’ spiral’ (Tangney, 1995, p. 1140).

In a cross-sectional study of 302 children (grades 4-6), 427 adolescents (grades 7-11), 176 college students, and 194 adult travelers passing through a large urban airport (Tangney, et al., 1996a), shame-proneness and guilt-proneness were measured using the Anger Response Inventory (ARI) and the Test of Self-Conscious Affect (TOSCA). Shame-prone individuals were prone to anger and tended to do destructive things with their anger compared to those less shame-prone. These results were replicated in a study of 256 college students (Tangney, 1995b).

The need to keep the shame repressed often drives people to perfectionism, withdrawal, and combativeness (Scheff, 1994). Much of the shame that therapists treat is repressed, defended against, unfelt (Scheff, 1994). When bonds are delicate and shame is unacknowledged or acknowledged with disrespect, violence will eventually occur (Fowler,
Not all shame erodes intimate relationships, only unacknowledged shame; shame is a painful part of close relationships and can destroy intimate bonds if it is not recognized and processed (Thompson, 1996). Normal shame is necessary; personalities and civilizations thrive with normal shame, but unacknowledged shame is a toxin (Scheff, 1994). The viability and stability of a committed relationship hinges upon whether individuals can acknowledge and resolve humiliating interactions (Retzinger, 1989).

The ISS correlated substantially with measures of depression. “A non-clinical sample (N = 193) produced a correlation of .75 with the Multiscore Depression Inventory. On studies with the Beck Depression Inventory, the ISS correlates .72 for 300 college subjects and .75 for a clinical sample of 185 psychiatric patients” (Cook, 1991, p. 414). Shame is linked with depression and anger in a cycle that produces a range of antisocial behavior (Cushman, 1993). Anger and violence is one way that people may protect themselves against undeserved shame that threatens their fragile sense of identity and self-respect (Cushman, 1993). Fear of making a fool of oneself is a prime example of anxiety’s connection to shame; shame-anxiety involves the fear of not being able to live up to others’ expectations as well as one’s own (Jacoby, 1994).

Kaufman (1992) saw eating disorders and sexual and physical abuse as disorders of shame. People with bulimia and anorexia feel there is something wrong with them inside. The ISS was used to measure the link between shame and severity of sexual abuse in a group of alcoholic women.

When the effect of abuse was examined, the mean of the combined groups of abused women (N = 40), 57.6, was significantly different from the mean of the not-abused women (N = 52), 45.1 (F = 11.6, p = < .001). When the severely abused women were
compared with the moderately abused and not-abused, the mean ISS score for the severely abused women (N = 19), 66.0, was significantly higher than both the moderately abused women (N = 21), 50.0 and the not-abused group (45.1) (Cook, 1991, p. 414).

Sexual and physical abuse produces excessive shame. Whenever a person’s body is violated, she or he feels humiliated and defeated (Kaufman, 1992).

Results clearly indicate that proneness to shame is associated with an array of psychological symptoms, whereas proneness to shame-free guilt is essentially unrelated to psychological maladjustment. This pattern of results is consistent across independent studies of children as well as adults (Burggraf & Tangney, 1990; Gramzow & Tangney, 1992; Tangney, 1994; Tangney et al., 1995; Tangney et al., 1991; Tangney, Wagner, & Gramzow, 1992) (Tangney, 1995, p. 1141).

“Often the hidden dimension shame has been called the ‘veiled accompaniment’ of clinical phenomena as widespread and divergent as narcissism, social phobia, envy, domestic violence, addiction, identity diffusion, post traumatic stress disorder, dissociation, masochism, and depression” (Lansky & Morrison, 1997, p. xv).

Shame in Western Culture and Counseling Theories

In this Western culture in which achievement and success are worshipped, shame has been a forbidden topic (Kaufman, 1992). Because of Freud’s enormous impact, not only on psychology but also the culture (Schultz & Schultz, 1994), shame has been largely ignored while guilt has been stressed (Kaufman, 1992). Freud was only minimally interested in shame, which was seen primarily as a reaction formation against exhibitionistic tendencies (Jacoby, 1991). Lansky and Morrison (1997) proposed that shame had not been appreciated
in psychoanalytic theory because there was a deficient view of the social bond and attachment in human experience and the role that shame plays in regulating relationships. There was a failure to recognize the veiled role that shame plays in social dynamics, often hiding as anger, contempt, anxiety, or guilt. The collusion between patient and therapist to avoid shame has also played a part in the neglect of shame in psychoanalytic theory (Lansky & Morrison, 1997).

Before the recent proliferation of books and articles on shame, psychological theorists, beginning with Freud, had emphasized guilt, which had concealed the role of shame (Kaufman, 1992). Because of Freud’s enormous influence, the primitive instincts of sex and aggression were believed to be the central forces motivating human behavior. “By focusing on guilt and sidelining shame, Freud sent psychoanalytic theory off in a particular direction that was not corrected until well into the second half of the twentieth century (Pattison, 2000, p. 44).”

In theology with its Western bias, guilt is seen as a deeper experience than shame because it is deemed to be more characteristic of Western societies, societies seen as more advanced than the more primitive Asian societies (Capps, 1993). The male-oriented bias of theology also judges guilt to be a deeper experience than shame because guilt is more predominant among males while shame is more prevalent in women (Lewis, 1971). Even the language in modern societies acts to hide shame from view and from awareness (Scheff & Retzinger, 1991). “It was an awkward moment” is an example in which shame is denied and projected onto the world. The message is “I was not embarrassed, it was the moment that was awkward (Scheff & Retzinger, 1991, p. 6).” Shame has been hidden from view by being assimilated to the concept of guilt (Kaufman, 1993). In everyday language shame and

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guilt are used interchangeably (Cairns, 1993). In Western culture, guilt has been used to describe any feeling of negative self-assessment or self-condemnation (Gordon, 1996).

Shame is extremely difficult to recognize or distinguish from guilt (Pattison, 2000). Shame is an illogical and primal reaction that leaves a person inarticulate (Lewis, 1971). It is often fused with guilt; what prompts shame also evokes guilt so that shame reactions are mistaken for guilt (Pattison, 2000). Shame is experienced in imagery and has little cognitive content and is often followed by denial or by-passed shame (Lewis, 1971).

“(A)ssimilating shame experience to guilt has meant that shame itself has been inadequately discerned and understood (Pattison, 2000, p. 45).” Kaufman (1993) noted that most therapists find it “easier and safer to explore ‘guilty’ impulses rather than the shameful self” (Kaufman, 1993, p. 4). What happens in therapy is a reflection of the general cultural trend (Pattison, 2000). Kaufman (1992) asserted that shame has been neglected in counseling and personality theories. The issue of shame seems to be arising now due to the recent propagation of addictive, abusive, and eating disorders. Because shame plays a central role in these disorders, there has been a growing focus on shame (Kaufman, 1992).

Personality theorists have never accorded shame the status of a central construct. Libido, drive, sexuality, aggression, dependency — these have been the organizing constructs of our science. Observers of psychopathology have likewise universally ignored shame in construing the sources of psychological disorder. They refer to drive conflicts, guilty impulses, interpersonal dynamics, cognitive self statements,
dysfunctional family systems, but not shame. Why is shame consistently overlooked:
Because shame remains under taboo in contemporary society. (Kaufman, 1996, p. 3).

*The View of Shame From the Major Theoretical Frameworks*

**Psychoanalytic Theory**

From a Freudian point of view, symptoms and disturbing feelings (including shame) are seen as stemming from intrapsychic or internal conflict, specifically from incompatible aggressive or sexual drives (the id) against principles of reality (the ego) and conscience (the superego). Shame is viewed as the result of internal conflict between intolerable drive impulses and the inflexible defenses raised against them. (Morrison, 1996). Shame, in Freud’s classical model, is the immature form of guilt; that is, shame is the child’s fear of being seen or caught and then punished by the threatening paternal authority (with castration as the implicit threat) (Wheeler & Jones, 1996). In the oedipal crisis, the little boy resolves the situation of his sexual interest in his mother by identifying with the aggressive male authority, thereby internalizing society’s or the father’s standards into a new internal structure called the superego. In psychoanalytic theory, after the development of the superego, shame is replaced by guilt. The boy has no more need of rejection or judgment from the field to keep him in line; he does that for himself (Wheeler & Jones, 1996). “Freud first indicted parents as seducers of innocent children, and later as agents of cultural repression, the source of all guilt and anxiety. If children grow up ashamed, unconsciously afraid of their own natural instincts, whom else do we blame except the parents?” (Nichols, 1995, p. 127).

In psychoanalytic drive theory, shame is seen as a reaction-formation to exhibitionistic drives (Freud, 1965.) Reaction formation is an ego defense mechanism in which an
individual defends against a threatening impulse by actively expressing the opposite impulse. According to this theory, feelings of shame appear whenever conscience prohibits the urgent desire to show oneself (Jacoby, 1994; Miller, 1985). Shame masks an exhibitionistic impulse, an impulse to exhibit an erotically viewed self or body (Miller, 1985). One feels ashamed of wanting to show something off (Jacoby, 1994).

Earlier psychoanalytic thinking connected shame experiences with children’s toilet training, in accordance with Freud’s anal stage of psychosexual development (Freud, 1905/1953), a theme that Erikson (1950) later broadened to include a theory about the child’s development of autonomy (Emde & Oppenheim, 1995). In Erikson’s (1950) view, shame is associated with being seen by others, and therefore precedes a sense of guilt, in which one is alone with the voice of the superego or the internalized “other.” One who is ashamed is exposed to the eyes of the world (Jacoby, 1994).

Wheeler (1996) alleged that in Freud’s psychoanalytic theory, dependency is seen as inferior, infantile, and weak. Shame hinges on dependency, that is, reference to and acceptance by others; to experience shame is seen as inferior. In shame, the person is reactive to acceptance or rejection by others. In guilt (following the oedipal crisis), the person internalizes the standards of power and authority (out of castration fear), and from that point can be seen as autonomous. According to psychoanalytic theory, the degree of this autonomy is the degree of health, maturity, and morality of the individual. In the psychoanalytic perspective, women, who undergo a less severe oedipal threat and crisis, remain comparatively immature and shame-sensitive; thus, shame again is seen as infantile, weak, dangerously dependent—in a word, feminine (Wheeler, 1996). Because it is shameful, in Freud’s individualistic self model, even to be bothered by shame, one tends to
cover it up which leaves the person alone with her or his private shame, imagining that she or he is the only one who experiences this emotion. In an individualistic social system, the role of shame is difficult to talk about and deconstruct (Wheeler, 1996).

Object Relations Theory.

Object relations theory grew out of psychoanalytic theory; rather than the drives of sex and aggression in Freud's psychoanalytic theory, the infant's need for relationship is seen as primary (Scharff & Scharff, 1997). Individual personality is formed in interaction with a significant other as experience is taken deep inside the self (Scharff & Scharff, 1997). Fairbairn's (1952) view is that the unpleasant aspect of experience is split off from the good aspect and repressed into the unconscious where it is divided into two categories. Along with repressed objects goes that part of self that was in relation to those objects plus the feelings that connected them. To cope with the intolerable feelings of anxiety and abandonment, the infant held onto Mom by taking the image of her as this rejecting object inside, a process called introjection. In Fairbairn's (1952) theory, introjection is the ego's first defense against unbearable pain and separation from the object. Introjection of bad objects, such as an angry face, is a crude and global form of taking in. If the mother yells, images of a bad mother and a deficient self are retained. Internalization is a process by which the relationship with the external object (the significant other) becomes a part of the child's self. Identification is a higher level of internalization and involves the internalization of a role. The result of identification is that the child takes on certain roles and behaves in much the same way as the parents do (Scharff & Scharff, 1997).

According to Fairbairn (1952), the libido is not primarily pleasure-seeking, but object-seeking. In other words, intimacy and a connection to others is the primary motivation in
human beings, and pleasure is a secondary motivation derived from this more primary motivation. Unlike Klein (1948), he saw that internal objects are not inevitable consequences of development, but rather the result of compensations for a real connection with others and stem from disruptions in early object relations with primary caregivers (Scharff & Scharff, 1997).

In Klein's (1948) view, the infant is struggling with great anxiety stemming from fears for its life. In projective identification, the infant exports these anxieties onto Mom. The infant is then afraid of Mom. The infant then introjects these feelings and has even more fearsome feelings to get rid of. Klein (1948) asserted that the good-enough Mom is able to metabolize these feelings, to cope with them and return to the infant a view of himself as not overly damaging or endangered. Bion (1962) described the mother's process as containment of her child's anxieties. Containment refers to the mother's ability to hold her baby and his needs in her mind. If mothers are not able to contain their infants' worries, the babies then receive a view of themselves that confirms the poor sense of themselves as unmanageable. When the mothers are good enough, they take in their mothers' good containing function and then become able to manage themselves and their feelings now and in the future, in a progressively more competent and reliable way. Bion (1962) felt that the mother teaches the child to cope with anxiety. Stemming from this insight, Bion (1962) felt that one of the key tasks of the therapist is to contain the anxiety of the client. These processes rely on the use of projective identification by which the child or client projects intolerable anxiety onto the mother or therapist, who in turn 'contains' and gives back to the child or client the experience in a more manageable form (Scharff & Scharff, 1997).
Like Fairbairn, Winnicott (1956) conceptualized the psyche of the child as developing in relation to a real, influential parent. For a child to develop a healthy, genuine self, as opposed to a false self, the mother must be a “good-enough mother” who relates to the child with “primary maternal preoccupation.” A good-enough mother allows herself to be used by the infant so that he or she may develop a healthy sense of omnipotence which will naturally be frustrated as the child matures. Winnicott (1956) conceptualized the psychic space between the mother and infant, neither wholly psychological or physical, as the “holding environment” which allows for the child’s transition to becoming more autonomous. A failure of the mother to provide a “holding environment” would result in a false self disorder in which the true self is denied. The true self is the inner core that stems from biological givens. The false self is a part of the self that protects the core and enables the self to accommodate the needs of others. In health, the false self is not so split off from the true self. It enables one to preserve one’s selfhood while negotiating with others. A discrepancy between the true self and the false self results when child rearing emphasizes the needs of others at the expense of the self. The self is the initial psychic structure the person is born with (Winnicott, 1956). It matures by building into it tinges of significant and formative relationships. The self becomes the encompassing structure that includes both its original potential for structure and a sense of identity based on all the internal object relations within it. The therapist’s work is to offer a “holding environment “ for the client so that the client might have the opportunity to meet neglected ego needs and permit the true self of the client to emerge (Scharff & Scharff, 1997).

From an object relations theory perspective and according to Bion’s (1962) theory, shame develops when the primary caregiver or the therapist does not contain the anxiety of
the individual. It is the primary caregiver's and the therapist's task to contain the child's or client's anxiety and give it back to the child or the client in a more manageable form. The person experiencing shame feels inadequate to cope with his or her own anxiety and ashamed of her or his inadequacy. In line with Winnicott's (1956) position, shame develops when either the primary caregiver or therapist does not provide a "holding environment" in which the individual can meet ego needs and allow the true self to emerge. A false self disorder follows because the individual is ashamed of the needs of her or his true self. From Klein's (1948) perspective, shame develops when Mom is unable to metabolize the infant's anxieties or help him cope with them, and thus returns to the infant a view of himself as incapable of managing his feelings. In Fairbairn's (1952) theory, if the child has introjected more images of a bad mother and a deficient self than images of a good mother and a proficient self, then the images of a bad mother and a deficient self are retained and the result is feelings of shame. As has been discussed earlier, shame encompasses the feelings of incompetence, inadequacy and deficiency.

Attachment Theory.

In 1939, John Bowlby read a paper before the British Psycho-Analytic Society in which he asserted that it was important for psychoanalysts to scientifically study childhood experiences and relationships. Although psychoanalysis firmly held that the roots of emotional life are located in infancy and childhood, it had spent little time on the impact of upbringing on character development (Karen, 1998). Psychoanalysts were more interested in children's psychic structures and fantasy life than in family conditions that caused emotional problems in children (Karen, 1998). Bowlby, the founder of attachment theory, thought that the infant-mother relationship was critical for healthy emotional and social
development. In his study of antisocial children, Bowlby found that prolonged early mother-child separations were common (Levy & Orlans, 1998).

Other clinicians and researchers concurred with Bowlby's findings regarding the mother-child bond (Levy & Orlans, 1998). David Levy studied children who experienced early maternal deprivation, had several out-of-home placements, and later failed to attach to adoptive parents (Levy & Orlans, 1998). These children had many conduct disorders such as "lying, stealing, and aggression," as well as being "full of rage, indiscriminately affectionate, demanding, and incapable of genuine affection (Levy & Orlans, 1998, p. 14)."

James Robertson made films depicting the deterioration of children in British hospitals who were separated from their parents for long periods of time. The famous experiments of Harry Harlow "showed that monkeys isolated for the first six months of life displayed severe problems over time, including abnormal social and sexual behavior and abusive parenting when they became adults (Suomi & Harlow, 1978)" (Levy & Orlans, 1998, p. 15). Mary Ainsworth extended Bowlby's experiments by discovering three distinct attachment patterns.

*Securely* attached babies actively sought out mother when distressed, maintained contact on reunion, and were easily comforted by mother. *Ambivalently* attached babies were extremely distressed by the separation, but were difficult to soothe on reunion and resisted their mother's comfort. *Avoidantly* attached babies seemed disinterested in their mothers and, in fact, rejected them on reunion (Ainsworth & Wittig, 1969)” (Levy & Orlans, 1998, p. 16).

On scales of acceptance, cooperation, sensitivity, and availability, vast differences in parenting style were found. On all four scales, mothers of securely attached babies were
rated higher; they were more responsive to baby's needs and signals and showed more pleasure in their reactions. Mothers of anxiously attached babies were less likely to respond to baby's needs in sensitive, attuned, and consistent ways. Mothers of ambivalent babies were inconsistent and unpredictable. Mothers of avoidant babies were rejecting (Levy & Orlans, 1998, p. 16). A questionnaire study of 204 college undergraduates by Gross and Hansen (2000) established a negative association between secure attachment and shame and a positive correlation between preoccupied and fearful attachment.

To the extent that undesirable qualities such as "too squirmy, too docile, too dark, too plain" arouse anxiety in the parent and are responded to with punishment, derision, or remoteness, they will become sources of shame (Karen, 1998). The ISS correlated significantly although modestly with the Parental Bonding Instrument (PBI), a retrospective measure of parental caregiving (Parker, 1983). "The direction and significance levels of these correlations indicated that the lower the level of care and nuturance from mother or father, the higher was the reported level of internalized shame. Also the higher the level of parental control and overprotectiveness, the higher was the level of internalized shame" (Cook, 1991, p. 416).

Repeated experiences of shame affect triggered by neglect or rejection lead the child to develop a sense of self as unworthy, unwanted, and inferior. This self structure (representational self, self schema or working model of the self) is a deep cognitive structure (Guidano & Liotti, 1983). Shame theorists regard parental neglect and rejection, particularly if early and wide-ranging, as forces that generate feelings of being unattractive and unwanted in the child. Parental rejection can be global or limited to specific characteristics of the child that the parent dislikes. When these characteristics arouse
anxiety in the parents and are responded to with reprimand, derision, or aloofness, they will become sources of shame in the child (Karen, 1998).

*Cognitive-Behavioral Theory*

The basic philosophy of behavior therapy is that behavior is the product of learning (Schultz & Schultz, 1993). Individuals are both the product and the producer of environment. The key concepts are: focus on overt behavior; precision in specifying goals of treatment; development of specific treatment plans; and objective evaluation of therapy outcomes. Therapy is based on the principles of learning theory. Normal behavior is learned through reinforcement and imitation. Abnormal behavior is the result of faulty learning. This approach stresses present behavior. The goals of therapy are to eliminate maladaptive behaviors and learn more effective behaviors; to focus on factors influencing behavior and find what can be done about problem behavior. Clients have an active role in setting treatment goals and evaluating how well these goals are being met. The therapist is active and directive and functions as a teacher or trainer in helping clients learn more effective behavior. Clients must be active in the process and experiment with new behaviors. Although a personal relationship between client and the therapist is not highlighted, a good working relationship is the groundwork for implementing behavioral procedures. Diagnosis or assessment is done at the outset to determine a treatment plan. Contracts and homework assignments are also typically used. Emphasis is on assessment and evaluation techniques, thus providing a basis for accountable practice. Specific problems are identified, and clients are kept informed about progress toward their goals (Schultz & Schultz, 1993).
B.F. Skinner (1948), an early central figure in the behaviorist movement, contended that human beings are primarily products of learning, shaped more by external variables than by genetic factors. To Skinner (1948), humans function like machines, in lawful, orderly, predetermined ways. He rejected all notions of an inner being, an autonomous self, determining a course of action or choosing to act freely and spontaneously. Individuals are operated upon by factors in the environment, not by forces within themselves. Like Freud, Skinner (1948) was completely deterministic in his viewpoint. He allowed not the slightest hint of free will or spontaneity in behavior. All aspects of behavior are controlled from without by whoever controls the reinforcers. Skinner’s (1948) view is that although it is true that human beings are controlled by the environment, they are responsible in the first place for designing that environment (Schultz & Schultz, 1993).

The approach has undergone extensive expansion. Since the 1970’s the behavioral movement has conceded that cognitive factors play a central role in the understanding of and treating of behavioral problems (Bandura, 1969, 1986; Beck, 1976; Lazarus, 1971, 1981, 1989; London, 1985; Meichenbam, 1977, 1985 as cited in Corey, 1991). Although the radical behaviorists such as B.F. Skinner (1948, 1971) rejected the possibility of self-determination and freedom, the present trend is toward developing procedures that actually give control to clients and thus extend their range of freedom (Corey, 1991).

The basic hypothesis of rational-emotive therapy (RET) which was developed by Albert Ellis, and other cognitive-behavioral theories is that ones’ emotions stem mainly from one’s beliefs, evaluations, interpretations, and reactions to life situations (Corey, 1991). RET is based on the assumption that cognitions, emotions, and behaviors interact significantly and have a reciprocal cause-and-effect relationship (Corey, 1991). The focus
is on working with thinking and acting rather than primarily with expressing feelings. Cognitive-behavioral therapy is based on the assumption that a reorganization of one's self-statements will result in a corresponding reorganization of one's behavior (Corey, 1991).

In both RET and other cognitive-behavioral therapies, shame would be viewed as irrational thinking. An RET tenet is that human beings are born with a potential for both rational and irrational thinking. According to RET, human beings originally learn irrational beliefs from significant others during their childhoods. In addition, they create irrational superstitions and dogmas by themselves. Individuals actively reinstill false beliefs by the processes of autosuggestion and self-repetition. It is largely their own repetition of early indoctrinated irrational thought, rather than a parent's repetition, that keeps dysfunctional attitudes alive and operative within them (Corey, 1991). Therefore, adults who experience shame are essentially reinstilling beliefs that they learned from parents or other significant caretakers.

**Humanistic Psychology**

Humanistic psychology emerged in the 1960s as the “third force” following psychoanalytic theory and behaviorism. Humanistic psychologists objected to psychoanalysis as offering a narrow and degrading picture of human beings, by studying only the emotionally disturbed side of human nature. They viewed behavioral psychologists, who did not acknowledge conscious and unconscious forces, as limited in their perspective which was based exclusively on conditioned responses to stimuli. Humanistic psychologists thought that human behavior is more complex than the mechanistic image that behaviorism portrayed (Schultz & Schultz, 1994).
Pioneers, such as Carl Rogers and Abraham Maslow, characterized humanistic psychology as having four essential principles (Robbins, 1999). The first principle states that the experiencing person is of primary interest (Robbins, 1999). The second principle proposes that human choice, creativity, and self-actualization are the preferred topics of investigation. This principle is directed at psychoanalytic theory which historically has based its findings on the clinical observations of individuals who are suffering from psychological disorders (Robbins, 1999). The humanistic psychologists contended that the study of crippled people led to a crippled psychology. Instead, they submitted that psychology should study healthy individuals, people who are creative and fully functioning (Schultz & Schultz, 1994).

A fundamental belief of humanistic psychology is that human beings have an innate drive to develop their potentialities and capabilities, that is, a natural drive toward health or self-actualization (Corey, 1992). Pathology results from a disruption of this natural process (Corey, 1992). In humanistic psychology, growth, rather than mere adjustment, is the criterion of health (Corey, 1992). The third principle states that meaningfulness must precede objectivity in the selection of research problems (Robbins, 1999). The fourth principle is that ultimate value is placed on the dignity of the person (Robbins, 1999). Human beings are accepted as unique and having the potential to be noble. It is important for psychologists to understand people, rather than predict and control their behavior (Robbins, 1999).

Carl Rogers (1961), a central figure in the humanistic orientation, developed Person-Centered Theory which emphasized the concept of “self-actualization.” This concept suggests that there is an inner, biological force to develop one’s abilities and aptitudes to
the fullest. The person’s key motivation is to learn and to grow. Growth occurs when human beings face problems, strive to overcome them, and through that struggle develop new aspects of their skills, capabilities, and views about life (Schultz & Schultz, 1994). Life is an unending process of creatively going forward, even if only in small ways.

Rogers’ (1961) theory suggests individualism, a Western value which is culturally biased, not to mention gender-biased, in that it tends to downplay interpersonal interdependence. However, Rogers (1961) acknowledged that such a resiliency develops from the nurturance of others. According to Rogers (1961), “self-actualization” is a natural process, yet it calls for the nurturance of a caregiver (Corey, 1992). He suggested that individuals develop a self-concept, in part, by internalizing the attitudes of others. Rogers (1961) felt that “unconditional positive regard” is required for “self-actualization,” that is, human growth involves the experience of being valued for oneself rather than for one’s specific behaviors that are approved of or disapproved of. Conversely, self-actualization is thwarted by “conditional positive regard,” when acceptance depends upon the positive or negative evaluation of a person’s actions. “Conditional positive regard” can lead to alienation from true feelings and, therefore, to anxiety and threat, which blocks self-actualization.

“Children’s hunger for affection and approval is fed by parents who respond conditionally, often more in terms of their own needs and values than what is necessarily good for the child. Consequently, children don’t so much learn what’s best for them as how to placate powerful but capricious parents” (Nichols, 1995, p. 127). Finally, Rogers (1961) kept to the strict criteria that genuineness, empathy, and unconditional positive regard are necessary attributes of the therapist if the client is to be healed and “self-actualize” (Corey, 1992).
In line with humanistic principles, shame would be seen as an aspect of an individual’s subjective experience. Shame would be described in terms of how the individual perceives and values him or herself. Dysfunctional shame would result from the disruption of the natural process of an individual’s natural drive toward self-actualization. Based on Rogers’ Person-Centered Theory, dysfunctional shame would likely occur in the absence of “unconditional positive regard” and in the presence of “conditional positive regard.” Positive regard is a need for acceptance, love, and approval from others, particularly from the mother during infancy. The mother’s love and approval are granted freely and are not conditional on the child’s behavior in unconditional positive regard. A state of conditional positive regard exists when love and approval are conditional. Conditions of worth (similar to the Freudian superego) involve an individual seeing herself or himself as worthy only under those conditions acceptable to her or his parents. According to Rogers, “self-actualization” can occur only in the presence of a nurturing caregiver (Schultz & Schultz, 1993).

Recent Humanistic Theorists.

In the last 25 years, the field of psychology shifted from a focus on guilt to more of a shame orientation (Yontef, 1996). Gestalt therapy, a humanistic therapy, is based on the concept that the individual strives for wholeness and integration of thinking, feeling, and acting (Corey, 1992). Growth consists of moving from environmental support to self-support (Corey, 1992). Gestalt therapy has made this shift by emphasizing “the difference between beliefs and values that are assimilated— that is, integrated in the organismic self system of the individual (“digested”)— and those that are introjected— that is, internalized uncritically (“swallowed whole”) and that are not
harmoniously integrated with the organismic needs and desires of the person.

Assimilation supports integration of self; introjection results in inner conflict (Yontef, 1996, p.351).

Gestalt therapy takes a holistic view and puts forth that people try to unify their field of experience, which includes "their experience of themselves and their experience of their environment in relation to themselves (their whole context of perceived risks and resources), according to their own felt needs and goals (Goldstein, 1939; Koffka, 1935; Lewin, 1935)" (Lee, 1996, p.8). It is the interactive act of contact between self and other (environment) that people live and grow in the context of relationships (Lee, 1996).

Finding/receiving enough support leads to fulfillment of needs and goals...The opposite of finding/receiving enough support in the field is the experience of frustration. One result of frustration is shame (Tomkins, 1963). Shame is the experience that what is me is not acceptable ... There is a breakdown ... in the self-process, the process of organizing the field into self and other. Under these conditions, resolution of the field can be accomplished only through distortion of the self-other boundary: the need that is not received by the other is disowned and made 'not me.' Thus the field is brought back into alignment through shame and, in the process, disowning the unacceptable need (establishing a linkage between shame and the need that is not supported by the other or by the environment) (Lee, 1996, pp. 8 & 9).

Lee (1996) further stated that in case of low frustration, the unacceptable need is temporary and embarrassment or shyness may result. The individual may simply find another way to meet her need in the environment.
In cases of more severe frustration and shame..., the rupture in the self-process is bridged but not healed, because the price of the bridging is an ongoing connection being made between shame and the unacceptable need, with the consequent loss of access to the need (Kaufman, 1989). As a result, the person 'loses a voice' for this need and is left with a sense of worthlessness, inadequacy, and/or isolation. This is the price of the fit between self and other, when the needs of the self are felt to be rejected, wholly or in part, by the other (Lee, 1996, p. 9).

Risk-taking behavior is encouraged by support. Pulling-back behavior is supported by shame. Shame lets an individual know that her or his interest is not being received and permits the reframing of interest so that it might be more readily received. Or shame gives one the options to stop and listen to the other person or forsake the interest in a particular situation (Lee, 1996).

The shame-support polarity, when functioning optimally, allows the person to be at the edge and to venture beyond old organizations of the field—that is, to grow.

Together, shame and support have the potential of enabling contact. (Lee, 1996, p.10).

Shame can result when beliefs and values are introjected— that is, internalized uncritically and not integrated with the organismic needs and desires of the individual rather than values that are assimilated— that is, integrated in the organismic self system of the individual. If an individual introjects the message given to him by significant others that he is inadequate, then he will experience shame.

Lee (1996) believed that not receiving support for a need could lead to frustration, which, in Tomkins' (1963) view, leads to shame. The need that is not received by the other
is disowned, and a linkage between shame and the need that is not supported by the other is established. The person ‘loses a voice’ for this need and suffers a sense of worthlessness, powerlessness, and loneliness.

With the loss of voice comes a sense of alienation and inferiority, a sense of disconnection and worthlessness. This sense of alienation and inferiority is due not only to the child experiencing the voice as shameful and not worthy of being heard, but also from the fact that without the voice the child is now less able to inform the world about who he or she is, in the event an empathic listener does come along.

This is all part of the experience of internalized shame (Lee, 1994, p. 264).

While support allows the person to take risks, shame persuades the person to draw back when there is no immediate support.

Kaufman's Framework

The framework of Gershen Kaufman (1996) is focused on because he is a pioneer in the study of shame and has integrated three distinct theoretical perspectives into a developmental theory of the self which includes one of the major theoretical frameworks, namely, object relations theory, and the affect theory of Silvan Tomkins which is referenced by several shame theorists (Broucek, 1991; Gilbert, 1998; Goldberg, 1991; Lee, 1996; Lewis, 1998; Miller, 1996; Morrison, 1996; Nathanson, 1992; Scheff, 1997; Scheff & Retzinger, 1997; Wheeler, 1996; and Yontef, 1996) and the interpersonal theory of Harry Stack Sullivan. In addition, Kaufman has been referenced by many shame theorists (Bradshaw, 1988; Broucek, 1991; Gilbert, 1998; Goldberg, 1991; Lee, 1996; Miller, 1996; Nathanson, 1992; Simon & Geib, 1996; Wheeler, 1996; and Yontef, 1996).
Affect Theory

Silvan Tomkins (1962) presented in *Affect/Imagery/Consciousness* a model for an affect theory of motivation in which he distinguished nine innate affects. In his view, affect or feeling is the primary innate biological motivating mechanism, as opposed to Freud’s view of human motivation which is located in the drives of pleasure, sex, and aggression, and as opposed to interpersonal relationships as found in object-relations theory and interpersonal theory (Kaufman, 1996). These affects are “hard wired, preprogrammed, genetically transmitted mechanisms that exist in each of us and are responsible for the earliest form of emotional life” (Nathanson, 1992, p. 58).

The major concept of Nathanson’s (1992) book, *Shame and Pride: Affect, Sex, and the Birth of the Self*, “is Tomkins’s idea that the function of any affect is to amplify the highly specific stimulus that set it in motion (p.59).”

Affect, says Tomkins, makes good things better and bad things worse. Affect makes us care about different things in different ways. The reason that emotion is so important to a thinking being is that affect controls or acts upon the way we use thought, just as it takes over or influences bodily actions at the sites specific for it. Whenever we are said to be motivated, it is because an affect has made us so, and we are motivated in the direction and form characteristic of that affect. Whatever is important to us is made so by affect. Affect is the engine that drives us (Nathanson, 1992, p. 59).

Affect is particularly contagious. The infectious nature of affect assists the primary caregiver to communicate with her infant. Another characteristic of affect is that “it feels good to resonate with another person’s affect (Nathanson, 1992, p.62). The caregiver
entering the internal system of the infant is the beginning of empathy. A peculiar feature of
the affect system is that it is general. There are no links to other systems, either body or
mind.

Affect can amplify cognitive activity like the storage and retrieval of memory; it can
alter body mobility, as when we fight angrily or romp gaily; it can be linked with
sexuality, or with pain, or with hunger, or with thirst. Like a wonderful kind of
building block, affect can be assembled with any drive, with any voluntary action,
with any function of the mind, even with other affects. It is entirely and perfectly
general (Nathanson, 1992, p.70).

Nathanson (1992) stated that shame is a physiological emotion that weakens or lessens
the positive affects of interest-excitement and enjoyment-joy. Since these two affects fuel
social interaction, shame serves to modulate affective communication.

“...Any mechanism capable of causing a painful limitation of what we most enjoy is a
mechanism capable of involvement in nearly any aspect of human existence” (Nathanson,
1992, p.138). Shame is the most recent affect to evolve.

Unlike the other innate mechanisms, the existence of which can be traced as far back
in evolution as the reptile, it is quite recent. Shame-humiliation could not appear until
life forms had developed powerful tools for the perception, storage, retrieval, and
comparison of complex images (Nathanson, 1992, p. 140).

During a lifetime, an individual has stored reminiscences of shame. Each time shame is
triggered, a person is drawn backwards in time to some recollected experiences of shame.

Tomkins (1962) regarded the skin of the face as of primary importance in producing
the feel of affect. When shamed, human beings blush and avert the face, and then later
register cognitively that they are undergoing shame. Human beings experience shame first in their faces; then they become aware of it and its possible meanings. Affect is activated by neural firing; the source of neural firing can be either internal or external. Tomkins (1962) conceived affect itself as amplification; affect amplifies a particular response. Affect both amplifies and extends the duration and impact of whatever activates it.

Emulating Tompkins (1962), Kaufman (1996) depicted inner states as complex coassemblies. The affect organizing a particular state is preceded by an activator or cause and followed by various targets and consequences. This combination of stimulus and innate affect mechanism produce the wide variety of responses known as what Wurmser (1981) described as the "shame family of emotions." According to Tomkins (1962), the differentiated inner states of discouragement, self-consciousness, embarrassment, shyness, shame, and guilt do not reflect differences in affect, but rather difference in their coassembled activators, targets, and reducers. Nathanson (1992) went beyond Tomkins to postulate along with shame and humiliation the affect confidence-pride. Pride, also, exhibits a neurophysiological pattern of expression and experience. It is characterized by uplifted head and eyes that meet and hold the gaze of others. The body feels supple and the face reflects poise and happiness (Nathanson, 1992).

Lewis, Alessandri, and Sullivan (1992) examined the development of shame and pride as they related to the difficulty of a task and the gender of 33-37 month-old participants. The occurrence of shame and pride was measured from scoring videotapes for the defined indicators. Shame was defined as "body collapsed, corners of the mouth are downward/lower lip tucked between teeth, eyes lowered with gaze downward or askance, withdrawal from task situation and negative self-evaluation (i.e., 'I'm no good at this')."
Pride was defined as "erect posture (i.e., shoulders back and head up), smile — either open or closed mouth — eyes directed at parents, points at outcome or applauds, and positive self-evaluation (i.e., ‘aah!’ or ‘I did it!’)" (Lewis et al., 1992, p. 632). These definitions of shame and pride are in accord with the physical descriptions offered by Nathanson (1992).

The findings of the study by Lewis, Alessandri, and Sullivan (1992) suggested that when participants failed, they never showed pride, and when they succeeded, they never showed shame. Pride at success was displayed more often than shame at failure. When failing the easy rather than the difficult tasks, the participants showed significantly more shame while they showed significantly more pride when they were successful in the difficult rather than the easy tasks. The researchers concluded that the relation of task difficulty to expressed emotion indicates that by the age of three children are able to discriminate task difficulty and are able to evaluate their behavior in accordance with this factor. They also found that children’s evaluative processes influence their emotional response.

In line with Tomkins (1962), Kaufman (1996) held that the inherent activator of shame is the partial reduction of interest or joy. He thought that shame is generated whenever basic expectations of a significant other or those basic expectations of oneself are unexpectedly exposed as wrong or are thwarted. Shame can be activated in three different ways: by severing interpersonal bonds; by internalization through imagery; and by repetition of a particular shame sequence that will create an internalized shame bind (Kaufman, 1996).
Severing the Interpersonal Bridge

Shame becomes activated by “severing the interpersonal bridge” (Kaufman, 1996, p. 32). An interpersonal bridge develops out of mutual interest and shared experiences of trust. Consistency and predictability are critical to building an interpersonal bridge, whether with a child, friend, or client. Any event that ruptures the interpersonal bridge linking an individual to someone significant will activate shame. The failure to completely hear, directly validate, and understand another’s need by openly communicating its validity can break the interpersonal bridge thereby generating shame” (Kaufman, 1996).

Helen Lewis (1971) emphasized the relational character of shame and the importance of attachment to significant others. She regarded a rejection by a loved one as a prototype of the shame experience because it is often interpreted as global and uncontrollable. Children are particularly vulnerable when a parent breaks the bridge because the parent is seen as infallible; therefore, the child feels there is something wrong with herself or himself (Kaufman, 1992). “Shame is invariably associated with social relationships and is most frequently triggered with regard to social situations where there is a breaking off of the connection between individuals where one is seeking to establish or maintain that connection (Cook, 1991, p. 410).” Shame originates interpersonally, primarily in significant relationships, but later can become internalized so that the self is able to activate shame without an engendering interpersonal event (Kaufman, 1992).

Internalization of Shame

At some stage in development, shame comes to an end as an exclusively social emotion and becomes internalized (Lansky & Morrison, 1997). “We internalize, literally take inside, mainly through identification. Specific ways of thinking and feeling about ourselves are
learned in relationship with significant others, parents most especially, but including anyone who becomes important to us” (Kaufman (1992) p. 42).

Once shame becomes internalized, a shame spiral or ‘shame attack’ can be set off by an otherwise benign external or internal event. The event may be purely internal (such as a person experiencing a feeling or desire that has been shame bound) or it can be more external, such as a communication from another in which the person notices some nonverbal or verbal cue that he or she interprets as rejection or devaluation—or both. As another example, a person’s internal shame might be triggered by something as simple as comparing himself or herself with the experiences, skills, abilities, or status of a friend with whom he or she is talking (Lee, 1994, p. 267).

Like H. B. Lewis (1971), who postulated that the judgments of significant others are internalized as part of the private audience in subsequent shame experiences, Kaufman (1996) asserted that the self internalizes experience through imagery (visual, auditory, and kinesthetic dimensions). Scenes or images that have become imprinted with affect are internalized. Interpersonal needs are “imagined scenes of positive affect” (p. 58). Kaufman (1996) identified the following innate and interpersonal needs: “need for relationship; need for touching/holding; need for identification; need for differentiation; need to nurture; need for affirmation; and need for power” (p. 58). In his view, to need is to expect something from another. These needs/expectations are experienced as images of desired events: a trip to the zoo, a bedtime story, a hug. Shame may become intertwined with aspects of three motivation systems: a) affect or emotions, b) interpersonal needs, and c) biological drives (sex and hunger). Language is one of the most powerful ways for making images; it gives
personal meaning to recurring shame scenes. Language not only directly links scenes together; it can reactivate an entire scene (Kaufman, 1996).

**Shame Binds**

Kaufman (1996) proposed that repetitions of the particular affect — shame sequence will create an internalized link, or bind. When the expression of anger, fear, excitement, or distress (any affect) becomes associated with shame, later experiences of the affect will activate shame automatically by triggering the entire scene. Shame no longer needs to be directly generated. The particular affect itself becomes bound by shame. In Kaufman’s (1996) view, the expression of the affect becomes constricted. Expression of the shame-bound affect may become completely stilled, covered up, replaced by a more acceptable affect, or hidden from view as a result of shame’s binding effects. The same process takes place as far as human needs are concerned. When the basic needs such as the need for relationship, touch, the need to nurture or be nurtured, the need for affirmation and to affirm others, the need for belonging, and the need for positive identity have been shamed, the individual represses these needs because they trigger shame. Whenever these needs arise, the person experiences shame. Both affects and needs become shame-bound (Kaufman, 1996).

*Commonalities Among the Three Perspectives and Leading Theorists*

**Childhood and Parents**

The humanistic, cognitive-behavioral, psychoanalytic, and object-relations theories share the view that shame originates in childhood and that parents play an important role in the development of shame. In Rogers’ (1961) humanistic perspective, self-actualization is nurtured by a caregiver. In RET, the cognitive-behavioral framework, human beings
originally learn irrational beliefs from significant others during childhood. Fairbairn (1952), who represents the object-relations theory, viewed internal objects not as inevitable consequences of development, but rather the result of compensations for a real connection with others and stem from disruptions in early object relations with primary caregivers (Scharff & Scharff, 1997).

Several psychological theorists (Bradshaw, 1988; Erikson, 1950; Karen, 1992; Kaufman, 1992; Morrison, 1996; Yontef, 1996) suggested that toxic shame originates interpersonally, in the source relationships of our original families. Kaufman’s (1996) view of how shame can be activated by severing interpersonal bonds resonates with the humanistic and object-relations theories’ view that the child’s relationship with primary caretakers is paramount. Karen (1992) stated that many parents, because of their own unmet needs, are not able to accept the child for who she or he is. The psychologists Karen (1992) and Morrison (1996) concurred that parents’ periodic unresponsiveness, disrespect, and rejection predispose their children’s to shame.

Internalization/Introjection

Kaufman’s (1996) concept of internalization (the process by which the self internalizes “interaction with the interpersonal environment,” (p. 57) and so reproduces its own experience evokes Fairbairn’s (1954) concept of introjection as a crude and global form of taking in, in which the infant takes the rejecting object inside. If the mother yells, images of a bad mother and a deficient self are retained. This global form of taking in is reflected in Erikson’s (1950) idea that these early experiences of self-evaluation have a global quality to them because shame emerges between 18 and 24 months of age when the child is cognitively and socially inexperienced. Karen (1992) also spoke about the child’s
internalization of the contemptuous voice of a parent. From object relations theory, Fairbairn’s (1954) concept of introjection in which the infant introjects images of a bad mother and a deficient self is reflected in the Gestalt concept of introjection— that is, beliefs and values that are internalized uncritically and not integrated with the organismic needs and desires of the individual. The child becomes aware of a need that the parent cannot tend to at that moment. Instead of being met with a receptive attitude, the child feels rejected because the parent, possibly because of other immediate concerns, does not meet the child’s need. The child may feel shame about this rejection around this need. In the future when the child feels needy, she feels ashamed. Thus, neediness becomes bound with shame. (Yontef, 1996).

From a gestalt perspective, this loss of voice, this shame-bind, is a negative introject—a given belief or internalized message about the self, the world, and the possibilities of contact. The converse is also true. Negative introjects are shame-binds (Lee, 1994, p. 265).

“The introjected shame message from parents is often ‘never enough’—the child is never enough to get the love of her parents (Yontef, 1996, p. 360).”

The Self

In most theories, shame is viewed as closely connected to the self. Cognitive-behavioral therapy is based on the assumption that a reorganization of one’s self-statements will result in a corresponding reorganization of one’s behavior (Corey, 1991). In Rogers’ person-centered theory, “self-actualization” can occur only in the presence of a nurturing caregiver (Schultz & Schultz, 1993). Rogers (1961) suggested that the individual develops a self-concept by internalizing the attitudes of others. In object relations theory, the infant
introjects images of a bad mother and a deficient self (Fairbairn, 1954). In Erikson’s (1950) theory of psychosocial stages, the child’s emerging shame is about the self, its adequacy, deficiencies, and deficits. In affect theory, repeated experiences of shame affect triggered by neglect or rejection lead the child to develop a sense of self as unworthy, unwanted, and inferior (Guidano & Liotti, 1983). In Gestalt theory, shame can result when beliefs and values are introjected— that is, integrated in the organismic self-system of the individual.

Dunn’s (1982) research of the individual within the context of the mother-infant relationship indicates that the experience of the self in relation to the other is internalized in early childhood, and individuals achieve a sense of identity through social bonds. The “experience of the self in relation to the other is internalized” in early childhood, and individuals achieve a sense of identity through social bonds (Mokros, 1995, p. 1095). “Since the mother-infant relationship is so crucial in the development of self, it is likely that the beginnings of this sense of self are linked to the quality of the mother’s attunement. If a dominant quality of the responding mother is one of shame stemming from feelings of her weakness and incompetence, these qualities will also be taken in through identification, by the infant” (Morrison, 1996, p. 63). Yontef (1996) also stated that the sense of self first develops in contact between members of the family system. The social shaping process can support, build up, or hamper self functions. Yontef (1996) went on to say that early family interactions may support the formation of a self that identifies with its forming figure, one that values the contact and differences between people; or it may interrupt the forming figure and the forming sense of self and leave the child with a negative reaction to oneself as a whole. There is a connection between Winnicott’s (1956) “false self disorder,” from object relations theory, in which the part of the self that protects the core and
accommodates others, is split off from the true self and Lee’s concept of “loss of voice” from Gestalt theory. One loses her voice when “the needs of the self are felt to be rejected ... by the other (Lee, 1996, p. 9).

Social Bonds

In object relations theory, the infant’s need for relationship is seen as primary (Scharff, 1998). Kaufman’s (1996) concept of interpersonal bonds corresponds with Mokros’ (1995) position that shame appears to be intrinsically related to the experience of self in social bonds and with Fowler’s (1993) idea that shame is triggered when one anticipates disapproval, rejection or exclusion by those who matter to her or him. Kaufman’s (1996) image of the interpersonal bridge echoes the finding of Lewis’s (1971) “bypassed shame” in analytic encounters in which the therapist responds to a painful self-disclosure in a way that wounds the client or fails to attribute importance to what the client has risked. She concluded that many therapeutic impasses resulted from shame experiences that were unacknowledged.

The sociologists, Scheff (1994) and Retzinger (1989) contended that shame is central to an understanding of human action and experience. They believed that the central position that shame occupies in social experience gives it a primary place in human motivation. They held that the establishment and maintenance of social bonds is the fundamental aim of human motivation. Mokros (1995) believed that shame thus provides a regulatory function in everyday experience that brings to awareness one’s sense of place and self as contingent upon others and one’s place within the social bond. When a person experiences pride, she or he experiences integration into the social bond. When one feels shame, she or he experiences separation and the pull to social reintegration. In Freud’s
Shame in Clinical Application

Shame in the Therapy Session

Many theorists (Jacobs, 1996; Lansky, 1995; Morrison, 1996; Simon & Geib, 1996; Yontef, 1996) have written about the power dynamics of the helping relationship. Morrison (1996) stated: “From its very inception ... the therapeutic relationship is an unequal and hierarchical one between the patient as supplicant and the therapist as expert (p. 138). Therapy is a place in which the client is particularly vulnerable to being shamed because the therapist’s silence or words have a greater impact than those of a friend who occupies a more mutual position (Simon & Geib, 1996). Jacobs (1996) maintained that the therapist is usually more important to the client than contrariwise because the client reveals more of herself than the therapist. She further asserted that this differential exposure breaks the social code of reciprocity in which the one who discloses too much usually feels ashamed.

It is especially helpful when the therapist lets the patient know that he or she also has feelings of shame. In a sense, the shameful patient needs not to be the only one who is psychologically exposed. Of course, this need requires a therapist with enough self-support to be able to be so exposed and also maintain a good and loving sense of him- or herself. It also requires a therapeutic theory and methodology in which “I statements” by the therapist are a regular and recognized part of the treatment. (Yontef, 1996, p. 371).
The difference in exposure places the therapist in a comparatively more powerful position (Jacobs, 1996). Thus, through inattention, lack of attunement, or defensiveness, the therapist can more easily hurt the client (Jacobs, 1996).

Yontef (1993) has suggested that the therapist must often bring up the subject of shame in order to teach the client about the prospect of shame and together fashion a shame language. The sharing of observation, personal experiences, and knowledge encourages self-observation in the client (Yontef, 1996). "In this regard, shame is no different from many other areas in which the therapist prepares the ground for the development of the patient's awareness" (Yontef, 1996, pp. 368-369).

Therapists (Jacobs, 1996; Kaufman, 1996) identified the therapist's human tendency to avoid her own shame. The therapist does this through defenses such as denial, blaming, contempt, and efforts to transfer the shame onto the client. Kaufman (1996) declared, "Therapists who avoid or otherwise defend against their own shame, however activated, unfortunately recreate their client's familial patterns" (p. 158). In Jacobs (1996) view, all human beings have developed character patterns designed to reduce their potential for being shamed. However, if a therapist is generally organized around avoiding experiences of shame, she is inclined to be very constrained in her therapeutic approach. The authoritarian or expert is an example of such a constricted therapeutic style that is rationalized as an appropriate therapeutic stance. Jacobs (1996) asserted that shame-provoking incidents often occur when a therapist is too centered in her own perspective and out of touch with the client's experience.

According to Jacobs (1996), many therapists operate from the perspective that they have privileged access to what is "real" and label the viewpoints of their clients as
“projecting” or “distorting.” This perspective can serve as a defensive shield for therapists who avoid shame. She has further contended that shame-avoidant therapists are frequently reluctant to expose their work, seek out supervision, or go into therapy themselves. Their tendency to hide is unfortunate because they rarely have an opportunity to learn about their own shaming tendencies. A possible explanation for why shame has been consistently overlooked by psychotherapists may be the contagious nature of shame (Lewis, 1971; Morrison, 1996).

In contrast to guilt (which has to do with harmful actions or thoughts against other), shame is difficult to encounter in another without recalling and even reexperiencing one’s own shame experiences. Since guilt-inducing behavior is specific to a given person, it doesn’t usually reverberate with someone else’s experience. On the other hand, another person’s shame recalls our own feelings of failure, inferiority, and incompetence. Shame begets shame, but this time, between people (Morrison, 1996, p. 8).

Several psychologists and sociologists (Lewis, 1971; M. Lewis, 1992; Retzinger, 1998; Scheff, 1998) have concentrated on unacknowledged shame. In 1971, shame emerged as a major focus in psychoanalytic thinking with Helen Lewis’s book, Shame and Guilt in Neurosis. Lewis (1971) used detailed transcripts of treatment sessions to mark shame experiences in those interchanges. She concluded that many therapeutic impasses resulted from shame experiences that were unacknowledged. Furthermore, hostility, overt anger, and outright rage in the sessions themselves immediately followed a clear-cut experience of shame that was not acknowledged either by the therapist or the patient. Lewis (1971) identified “bypassed shame “ in analytic encounters. The therapist, in bypassed shame,
responds to a painful or sensitive self-disclosure in a way that wounds the patient or fails to give importance to what the patient has risked. Initially the patient experiences anger at the therapist, then guilt about the anger (How can I feel anger toward this person who is trying to help me get better?) followed by depression and then shame as the anger that was directed toward the therapist turns back upon the self.

Mindell (1994) focused on contempt as a client’s means of protecting oneself from shame. Contempt, according to Mindell (1994), is “the attempt, internally or overtly to reduce the other or others to feeling like nothing, nobody, someone worthless and unacceptable, as we experience ourselves to be (p. 41). He further asserted that shame and contempt are often key to impasses in psychotherapy. Jacobs (1996) and Kaufman (1996) both discussed the connections between shame and impasse in therapy. Jacobs (1996) stated that “perhaps the most common therapist contribution to the development of an impasse — is the therapist’s difficulty with her own shame” (p. 308).

Mindell (1994) discussed treating a client who is contemptuous towards the therapist during a session. It involved searching for the error that the therapist made which prompted the outbreak, and acknowledging what happened to the client in order to appreciate how the client perceived it. This process helped the client feel, once again, that he was accepted by the therapist and recreated a bridge between them.

Lewis (1971) suspected that therapists often create bypassed shame by neglecting to hear things their clients present that elicit their own unaddressed and bypassed shame. As Lansky (1995) said, “Shame, overt or hidden, and its more visible consequents—envy and rage—result from interpretations; lapses of attention; failures of acknowledgement or
unresponsiveness that make the patient feel fragmented disconnected, or relegated to inferior status (p. 1083).”

Impasses in the relationship are inevitable and often triggered by mistakes made by therapists. Mistakes are natural, to be expected; they are even necessary. When therapists are able to recognize their mistakes, openly acknowledge them with their clients, and directly own them, the relationship is restored: therapist and client become allies once again. But impasses will generate shame for therapists who cannot allow themselves to be human and imperfect. Their further refusal to acknowledge the natural shame initially caused by the impasse will prevent their restoring the relationship with the client (Kaufman, 1996, p. 221).

An observer may identify that a person is having a shame reaction. The person herself may identify that it is retreating, but while shame is occurring, the person herself is unable to communicate (Macdonald, 1998). She may only report feeling “bad,” “tense,” or “blank.” This kind of shame is called overt, unidentified shame (Macdonald, 1998). A second kind of unidentified shame involves cognitive activity focused on “doubt about the self’s image from the other’s viewpoint” (Lewis, 1971, p. 197). There seems to be little feeling component, only a “wince,” a “jolt,” a “peripheral, nonspecific disturbance in awareness” (Lewis, 1971, p. 197).

Despite how intensely sufferers of shame are afflicted, they cannot do anything about their despair because they are not even aware that their suffering is a result of shame. Few people have the prerequisite language skills to put their feelings of shame into words. No matter how deeply shaken they are by a shame reaction, rarely are they
able to tell themselves, let alone anyone else, just what is taking such a tenacious hold on their psyches (Goldberg, 1996, p. 255).

Shame’s proximity to other emotions such as guilt, embarrassment, or humiliated rage makes it hard for people to identify it. Shame may be difficult for people to distinguish from other emotions such as shyness, guilt, social anxiety, and embarrassment (Macdonald, 1998). The states of guilt and shame may occur more or less at the same time (Lewis, 1971). An individual may feel guilty for having done something, but she may also experience shame for not having lived up to her own ideal or to others’ expectations of her. A person can feel ashamed, then angry for feeling ashamed, and then guilty for having aggressive feelings (Pattison, 2000). “Insofar as guilt is a more articulated experience than shame, and a more dignified one, it may actually absorb shame affect” (Lewis, 1971, p. 42). Shame is such a painful experience that leaves one feeling confused, exposed, helpless, passive, and inarticulate that guilt with its negative self-evaluation about committing a specific offense seems preferable (Pattison, 2000).

There are many such situations in which we fail to recognize that we are in a moment of shame, so it is important to acknowledge that the affect is not always interpreted as one of the feelings normally associated with shame. In general, what we call ‘hurt feelings’ is caused by shame affect—these are always moments when a positive affect is interrupted by the painful affect of shame (Nathanson, 1993, p. 145).
Kaufman (1996) asserted that alienation is what brings people into therapy and that what is needed is a sense of belonging and connectedness. Creating an environment where the patient is able to speak the awful "truths" she nurses about herself seems to be a crucial first step in freeing oneself of the crippling shame (Karen, 1992). Morrison (1996) asserted that accepting, affirming relationships, whether current, remembered, or imagined, help to overcome those experiences which have created shame. In order for lasting alleviation to take place, the acceptance and affirmation must be integrated as part of self-experience. Just as the negative judgments leading to shame were internalized during childhood, acceptance must be internalized if the shame is to be healed. Moreover, Morrison (1996) declared that the process may require the continuing presence of affirming relationships or availability of vivid memories or fantasies of such experiences as a way of reminding the individual of these qualities. The more acquainted the person becomes with the feeling of acceptance, the easier it is for her to produce this response for herself (Morrison, 1996).

Of course, hiding is usually appropriate in the environment in which it originates. In that environment, further exposure often meant a continuation of the shaming.

Ideally, the therapy environment is not shaming and is much more loving than the patient's internal environment, which is based on early childhood experience. Unfortunately, this is not always true (Yontef, 1996, p. 364).
Morrison (1996) stated that observations of mother-infant interactions show that infants are social and attached to another human being, the mother, from the beginning of life. He believed that because shame is first experienced in relationship, it can be alleviated only in a relationship with another (or others) whom are perceived as accepting, attuned, and receptive. Morrison (1996) held that the developmental wounds generated by shame cannot be undone by the nurturing person, but she or he can assist in softening the harshness of the individual’s self-judgments and give a more positive outlook on how the individual is experienced by others. Kaufman (1996) saw parenting as a model for the therapeutic alliance.

When we turn to consider the not unrelated question of child development, it is not technique but parenting that emerges into focus. And parenting is a better model for psychotherapy than any technique could ever be ... A reparative relationship is a relationship that repairs developmental deficits. These deficits are both relational and intrapsychic. Just as children require a security-giving relationship for optimal growth, so do clients. The conditions for growth do not change upon becoming an adult or entering into a therapeutic alliance. A therapeutic relationship is not identical to a parenting relationship, but they are functionally equivalent. ... And shame becomes healed through experiences of identification between client and therapist (p. 157).

Kaufman’s perspective reflects Winnicott’s (1956) “holding environment” in which the client has the opportunity to meet neglected ego needs and Bion’s (1962) concept of “containment” in which the therapist “contains” the client’s anxiety and returns it to him in a more manageable form.
Gestalt theory stresses contact in the present between therapist and client as the chief method of therapy. The individual is seen as invariably resolving the field into self and other. A mutual relationship presents the best opportunity for developing new conceptualizations of self and other. Gestalt theory promotes therapists’ availability to engage (be in contact with) their clients (Lee, 1996). The connection between shame and the self that interfere with present contact were learned. Shame occurs in the context of a relationship and can only be deconstructed in a relationship. Shame was linked to parts of the self that were found unacceptable by others. These linkages helped to protect the client in a past significant relationship from exposing those parts of the self. These shame linkages continue to operate in current relationships in which they may not be needed (Lee, 1996).

This mapping of self and other cannot be changed without a new experience in the field, a new sense of self and other in a relationship. Thus, as previously stated, re-owning (regaining access to) the shame-linked need requires first being in an environment in which the need will be noticed and appreciated. In individual therapy, the relationship that is available is the relationship between client and therapist (Lee, 1996, p. 17).

Therapist-client contact around procedural issues such as fees, method of payment, length of session, phone availability, cancellation policy, should be carefully delineated so that “it offers a positive message that the clients are important, valid, and worthy of careful treatment and consideration (since the absence of these is what the development of shame is all about)” (Lee, 1994, p. 276). Issues of physical and emotional safety should be discussed in couples or family therapy so that the therapy will not support shaming.
behavior by allowing situations to take place or persist during the therapy process that jeopardize the physical or emotional safety of any member of the family (Lee, 1994).

In his discussion of a theology of shame, Donald Capps (1993) follows Kohut who underscores the integrating effects of positive mirroring between the two inner selves that wage war against one another.

Self mirroring is a more powerful and dynamic expression of self-love than is acceptance because it involves a positive regard for the other self, one that eschews any note or form of superiority or condescension. Whereas ‘acceptance’ implies a tolerant attitude toward the weaker self, mirroring says that I cannot live without my other self, that I am lost without the other. Thus, whereas a hierarchy of inner selves seems to be the inevitable corollary of a theology of guilt, a theology of shame views the inner selves as equals (Capps, 1993).

Lansky (1995) thought that, in theory, the therapist takes a neutral position about the unconscious conflict, not about the client, which transmits a powerful corrective measure to the patient's shame. The explication of an unconscious conflict with all its byproducts, gives the patient a sense that her struggles can be understood and felt by another, and can be recognized by another without judgment, disappointment, or scorn. The act of interpreting in this manner removes some of the isolation and shame that is associated with repressed, unconscious material, material that was repressed in part because it was shameful (Lansky, 1995). Karen (1992) held that most shame therapists advocate making an effort to help the client see the connection between shame and its offshoots, such as rage, obsessiveness, or overeating. They support a more empathic, accepting posture
toward the client, especially when needed in order to make up for what parents failed to provide.

Summary of the Literature

For the purposes of this study, dysfunctional shame, the focus of this study, was generally defined as “the ongoing premise that one is fundamentally bad, inadequate, defective, unworthy, or not fully valid as a human being (Fossum & Mason, 1986, p. 5). A distinction made between functional and dysfunctional shame pointed out that shame plays a necessary and positive part in the development of conscience (Hanson, 1997) and identity (Yontef, 1996), as well as an influential role in behavior (Scheff & Retzinger, 1997). On the other hand, dysfunctional shame, the focus of this study, is “a powerful but unquestioned conviction that in important ways one is flawed and incompetent as a human being” (Goldberg, 1996, p. 254). While shame that is acknowledged between people can strengthen bonds (Retzinger, 1989; Scheff, 1994), unacknowledged shame plays a detrimental role, particularly in the encounter between counselor and client (Jacobs, 1996; Kaufman, 1996; Lewis, 1971: Mindell, 1994). In addition to the significant roles that it plays in the development of identity and conscience, its influence on behavior and the detrimental role unacknowledged shame plays in encounters between counselor and client, shame has been associated with a myriad of psychological problems (Bradshaw, 1988; Cook, 1996; Kaufman, 1992).

Shame has been neglected in the counseling theories because shame is taboo in Western culture and Freud has emphasized guilt at the expense of shame (Kaufman, 1992). Because a client’s shame often activates a therapist’s shame (Kaufman, 1996; Morrison,
1996), a collusion of avoidance between therapist and client tends to occur when shame emerges in therapy (Morrison, 1996).

All three of the traditional psychological theories, humanistic, cognitive-behavioral, and psychoanalytical, plus the frameworks of the leading shame theorists share common beliefs about the construct of “shame.” All theories suggest that shame originates in childhood, and that parents play a significant role in its development. Internalization is a concept found in all theories as well as the intimate connection between shame and development of the self. Finally, the essential role that shame plays in relationships and social bonds is shared.

Shame has been overlooked by psychotherapists because of the contagious nature of shame (Morrison, 1996). A therapist can sometimes be an instrument of shame (Jacobs, 1996; Lansky, 1995; Morrison, 1996; Simon & Geib, 1996). Many theorists (Jacobs, 1996; Lansky, 1995; Morrison, 1996; Simon & Geib, 1996) have written about the power dynamics of the helping relationship. The therapeutic relationship between the patient and the therapist is hierarchical (Morrison, 1996). In hierarchical relationships in which one person is dependent on another for protection, such as therapist-client, “... in which a person’s feelings, desires, or ways of being in the world are consistently not noticed, validated, or responded to respectfully has the potential for engendering shame-binds” (Lee, 1994, p.266). Jacobs (1996) and Kaufman (1996) both saw a connection between shame and impasse in therapy.

Most shame therapists support helping the client see the link between shame and psychological problems such as rage, obsessiveness, or overeating (Karen, 1992). They advocate an accepting posture toward the client, especially when needed in order to make
up for what parents failed to provide (Morrison, 1996). The developmental wounds created by shame cannot be invalidated by the nurturing person, but she or he can help to temper the severity of the individual’s self-judgments and give a more positive attitude on how the individual is experienced by others (Morrison, 1996).

One of the gaps in the literature on shame is a description of how counselors understand the construct and a description of how they use it in counseling. This study was designed to fill the lack of information about counselors’ perspectives on shame. The purpose of this exploratory study was to examine the understanding of the construct of shame of twelve licensed professional counselors and its meaning to them in the practice of counseling.
CHAPTER THREE
Methodology

Introduction

The purpose of this chapter is to describe the exploratory qualitative research methodology that was used for examining the construct of shame through the eyes of twelve licensed counselors. This chapter presents the nature of this form of qualitative research and its application to this study. Next, the methodology section focuses on the interviews, the participants, the setting of the study, and data collection. Data analysis, verification, the time line, and the researcher’s role are described. Ethical dimensions of the research are then considered, along with a discussion of the delimitations and limitations of the study.

Qualitative Research

Qualitative vs. Quantitative

Stake (1995) pointed out three major differences in qualitative and quantitative research: qualitative research seeks “understanding the complex interrelationships among all that exists” whereas quantitative seeks “explanation and control” as “the purpose of inquiry;” qualitative research embraces a “personal” role for the researcher rather than the “impersonal role” of quantitative research; qualitative research focuses on “knowledge constructed” whereas quantitative research focuses on “knowledge discovered” (p. 37). Qualitative research generally takes a constructivist approach to knowledge, that is, “reality is socially constructed” (Glesne & Peshkin, 1992, p.7) while quantitative research believes in an external reality, that is, “social facts have an objective reality” (p.7).
Qualitative research focuses on the inductive component of the scientific method in order to generate new theories or hypotheses whereas quantitative research relies more on the deductive form of the scientific method for the purpose of testing or confirming hypotheses (Johnson & Christensen, 2000). In the qualitative model, the researcher and the participant interact to affect one another and are unalterably linked; however, in quantitative research, strategies are used to minimize the effects of researcher/subject interaction (Borg & Gall, 1989). “Unlike quantitative inquiry, with its prespecified intent, qualitative inquiry evolves, with a problem statement, a design, interview questions, and interpretations developing and changing along the way” (Glesne & Peshkin, 1992, p. 6).

Generally “a few variables and many cases” are included in quantitative research, whereas “a few cases and many variables” are involved in qualitative research (Ragin, 1987). A quantitative study adopts a broad view as opposed to the more focused view of a qualitative study (Ragin, 1987).

**Similarities Between Qualitative Research and Counseling**

Qualitative research is appropriate for counseling research precisely because it shares many of the characteristics of counseling. As in counseling, qualitative research deals with the complexities and paradoxes of life (Corey, 1991; Glesne & Peshkin, 1992). Like counselors, those who do qualitative research examine constructs which cannot be measured such as values, beliefs, feelings, and attitudes (Corey, 1991; Glesne & Peshkin, 1992). Furthermore, counseling, like qualitative research, involves the processes of analysis and interpretation (Glesne & Peshkin, 1992; Hackney & Cormier, 1994). As in counseling, intuition and language, play vital roles in qualitative research (Glesne &
Peshkin, 1992; Ivey & Ivey, 1999). Therefore, it is fitting that qualitative research be used in the exploration and clarification of the constructs, issues, and processes of counseling.

In qualitative research, the researcher is the instrument that participates in the situation and makes sense of it (Eisner, 1991). Similarly, the counselor is the instrument that elicits, receives, analyzes and interprets behavior, thoughts, and feelings (Corey, 1991; Ivey & Ivey, 1999). Relationship is an important value in both qualitative research and counseling. In qualitative research, “the interviewer’s goal is to transform his or her relationship with the participant into an ‘I—Thou’ relationship that verges on a ‘We’ relationship (Seidman, 1998, p.80). Likewise, in most counseling therapies, the relationship between the counselor and client is one which emphasizes interaction, joint responsibility, mutual determination of goals, mutual trust and respect, and equality (Corey, 1991). The outcome of a qualitative study is the process of the study rather than the product of the study as in a quantitative study (Merriam, 1988). In counseling, also, process is deemed of great importance (Corey, 1991).

Denzin and Lincoln (1994) asserted that qualitative researchers attempt “to make sense of or interpret phenomena in terms of the meaning people bring to them” (p. 2). Interpretation by the counselor provides the client with an alternative frame of reference from which to view life situations and generate new stories (Ivey & Ivey, 1999). Eisner (1991) identified sensitivity and perceptivity as necessary in the context of qualitative research. Similarly, the development of these qualities are essential for a counselor in the practice of therapy (Hackney & Cormier, 1994). Because the role of the researcher in the qualitative mode is that of the primary data collection instrument, it is necessary for her or him to identify personal values, assumptions, and biases at the outset of the study.
(Creswell, 1994). Likewise, counselors should be aware of what they value and how it affects their work with clients (Corey, 1991). The counselor is the instrument that analyzes, interprets, and makes meaning of patterns of behavior, thoughts, feelings, and language (Corey, 1991; Ivey & Ivey, 1999) just as the researcher doing qualitative research is the instrument that analyzes, interprets, and makes meaning of data (Creswell, 1994).

Qualitative research, with its emphasis on process and meaning, has a much closer connection to the experience of counselors than does quantitative research. This study is framed within the assumptions and characteristics of the qualitative approach, which includes an evolving design, the presentation of multiple realities, the researcher as an instrument of data collection, and a focus on participants’ views (Creswell, 1998). Qualitative research best models the raw data of counseling, constructs which are themselves not quantifiable.

**Similarities Between Qualitative Research and the Humanistic Approach**

A qualitative approach to eliciting counselors’ understanding of the construct of shame and its meaning for them in their practice of counseling is a good fit. Qualitative research shares many of the assumptions that guide a humanistic approach to counseling, which Gestalt and person-centered counseling theories are based upon. The first principle of humanistic psychology states that the experiencing person is of primary interest (Robbins, 1999). Similarly, in qualitative research, the participant’s frame of reference is used by the researcher to reconstruct reality (Borg & Gall, 1989).

Humanistic psychologists also propose that a holistic approach, rather than a fragmentary approach, is necessary to understanding human beings. Humanistic psychology means “the study of the person, the individual as a whole (as opposed to the
study of his discrete traits and performances)” (Ellis, p. 1 & 2). In a similar vein, qualitative research is holistic, that is, focusing on the totality rather than its component parts (Stake, 1995).

Humanists proposed that human beings should be studied in real-life circumstances (Robbins, 1999). In like manner, the researcher undertakes qualitative research in a natural setting (Denzin & Lincoln, 1994). In humanistic counseling theories, such as Gestalt and person-centered theories, the relationship between the counselor and the client is of primary importance; the client uses the relationship with the counselor to transfer her or his learning to other relationships (Corey, 1991). Likewise, the relationship between the researcher and participant is important because “the researcher is the instrument of the research, and the research relationship is the means by which the research gets done” (Maxwell, 1996, p. 66).

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Table 3.2

Similarities Between Qualitative Research and A Humanistic Approach

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<td>the relationship between the researcher and participant is important (Maxwell, 1996)</td>
<td>the relationship between the counselor and client is important (Corey, 1991)</td>
</tr>
</tbody>
</table>

Exploratory Design

Qualitative research is frequently exploratory and is often used when little is known about a topic or when an inductive approach is considered more suitable (Johnson & Christensen, 2000). “Some research studies are exploratory in nature ...because the researcher does not have sufficient understanding of the phenomena to form conjectures about relationships between constructs (Borg & Gall, 1989, p. 32).” One of the primary purposes of an exploratory study is to discover new realms of the subject matter (Kvale, 1996). “One of the chief reasons for conducting a qualitative study is that the study is exploratory … and the researcher seeks to listen to informants and to build a picture based on their ideas ” (Creswell, 1994; p. 21). “Open-ended questions are usually used in exploratory research … Open-ended questions are valuable when the researcher needs to know what people are thinking and when the dimensions of a variable are not well defined” (Johnson & Christensen, 2000, p.131). This exploratory study thus provides an introductory look at how counselors think about and understand the construct of shame and give meaning to it in the practice of counseling. The overarching research questions for this study are:
1) What is the understanding that licensed counselors have of the construct of shame?

2) How does education and training, particularly graduate counseling programs, influence counselors’ understanding of the construct of shame?

3) How is the construct of shame meaningful to licensed counselors in the practice of counseling?

Interviews

In an interview, the researcher listens to participants themselves express their views in their own words. The researcher attempts to understand the world from the points of view of the interviewees and to uncover the meaning of their experience. Kvale (1996) used the miner metaphor.

... knowledge is understood as buried metal and the interviewer is a miner who unearths the valuable metal. Some miners seek objective facts to be quantified, others seek nuggets of essential meaning. In both conceptions the knowledge is waiting in the subjects' interior to be uncovered, uncontaminated by the miner (p. 3).

Qualitative interviews are generally composed of open-ended questions or semi-structured interviews (Johnson & Christensen, 2000). An open-ended question creates the terrain to be explored while letting the interviewee go in any direction she or he wants (Seidman, 1998). “The open-ended, in-depth interview is best carried out in a structure that allows both the participant and the interviewer to maintain a sense of the focus ...” (Seidman, 1998; p.13) They are called “depth interviews because they can be used to obtain in-depth information about a participant’s thoughts, beliefs, knowledge, reasoning, motivations, and feelings about a topic” (Johnson & Christensen, 2000; p. 144).

The Semi-Structured Interview:

The semi-structured interview “has a sequence of themes to be covered, as well as suggested questions. Yet at the same time there is an openness to changes of sequence and forms of questions in
order to follow up the answers given and the stories told by the subjects” (Kvale, 1996, p. 124).

The semi-structured interview consists of both close-ended and open-ended questions (Creswell, 2002). The close-ended questions can net useful information to support theories and concepts in the literature while the open-ended questions can permit the participants to provide personal experiences that may be outside the boundaries of close-ended questions (Creswell, 2002).

One approach is to use an interview guide, a protocol of topics and questions (Johnson & Christensen, 2000). An interview guide specifies the topics and the order in the interview (Kvale, 1996). The protocol provides the interviewer with the likelihood of covering the same general topics and questions with all the interviewees (Johnson & Christensen, 2000).

Even when an interview guide is employed, qualitative interviews offer the interviewer considerable latitude to pursue a range of topics and offer the subject a chance to shape the content of the interview. When the interviewer controls the content too rigidly, when the subject cannot tell his or her story personally in his or her own words, the interview fall out of the qualitative range (Bogden & Biklen, 1998, p. 94).

**The Semi-Structured Interview Guide**

I developed the interview guide by determining what aspects of shame I was interested in exploring based on the literature review that I conducted. I fashioned some introductory remarks designed to establish rapport and put interviewees at ease. I then asked them some introductory questions associated with why they became a counselor, why they became licensed, and when they became licensed. I also asked questions about the education and training that they have received, particularly, the education that they had received about the construct of shame. The other areas that I explored were: shame in counseling; definitions; human development; link to psychological problems; practice of counseling (including
treatment); and impasses in counseling (See Appendices D, E, & F for clarification of interview guides).

Methods

Type of Sampling

Most sampling in qualitative research is purposeful sampling (Patton, 1994) or criterion-based selection (LeCompte & Preissle, 1993). This strategy involves selecting particular settings, events, or persons in order to provide important information that cannot be gained as well from other choices (Mawell, 1996). One reason for using purposeful sampling is achieving typicality or representativeness of, individuals, activities, or settings selected (Maxwell, 1996).

Participants

A faculty member of the graduate counselor education program where I attend provided me with names and telephone numbers of licensed professional counselors (LPCs) in nearby cities whom he thought might be willing to be participants in this study. The criteria for participants were that they be licensed professional counselors and that they do primarily individual counseling with adults or have a general counseling practice. I contacted several who agreed to participate in the study. Those whom I interviewed provided me with more names of LPCs. I found some participants through the Yellow Pages where they were identified as licensed professional counselors. When I called each participant, I inquired about the type of practice they had and the kinds of clients they saw.

Each person was telephoned and informed about the nature and process of the research. I asked for volunteers for the study; that is, none were given any stipend for her or his involvement. They were informed that their identities would be kept confidential, and that I would remove any references in the text that might point to who they are. Along with a description of the study, they were sent a letter of consent to sign. At the beginning of each interview, I reminded the participants of the nature and process of the research.
**Setting**

The in-depth interviews took place in the participants’ own environment, i.e., in their homes or offices. Once the counselors agreed to participate in the study, I set up appointments and traveled to their locations in order to conduct the interview sessions. As mentioned earlier, one purpose behind using qualitative methodology is to glean an understanding of some aspect of an individual’s life experience in her or his natural environment (Creswell, 1998).

**Data Collection Strategies**

According to Eisner (1991) flexibility, adjustment, and repetition are three features of the qualitative method. The course of a qualitative study is subject to a future that no one can entirely foresee. Qualitative inquiry does not aim to control variables in a laboratory-like setting; rather, its function is to highlight the complexity of the counseling process and issues and its dependency on the perception and good sense of the qualitative researcher (Eisner, 1991).

I developed the two interview protocols by formulating questions from the issues I found salient in the shame literature and piloted them with two colleagues in the doctoral counseling program prior to the study. I interviewed each of the twelve licensed counselors twice and completed the first interview with all participants before beginning the second interview with any of the interviewees. Following this sequence enabled me to examine each interview and do preliminary analysis before conducting the series of second interviews. Through the analysis of the first interviews, I was able to identify responses that needed to be clarified in the second interview. Each questionnaire consisted of questions that were increasingly more personal. The interviews lasted between one and two hours. After obtaining permission for tape-recording each participant, I interviewed and tape-
recorded each counselor two times. I then transcribed the interviews. “The primary method
of creating text from interviews is to tape-record the interviews and to transcribe them”
(Seidman, 1998, p. 97). The researcher retains the original data by saving the words of the
participants. The researcher can go back to the source and check for accuracy if something
is unclear in a transcript (Seidman, 1998). The participants can feel confident that their
words will be treated responsibly because there is a record of what they have said to which
they have access (Seidman, 1998).

Data Analysis

The copious amount of text generated from verbatim transcription must be ultimately
reduced to what is most interesting and useful (McCracken, 1988; Miles & Huberman,
1984; Wolcott, 1990). The researcher must reduce the data inductively, that is, without
hypotheses to test and with an open attitude “seeking what emerges as important and of
interest from the text” (Seidman, 1998, p. 100). Inductive analysis, which involves the
constant interplay between the researcher and the data (Johnson & Christensen, 2000), was
used in this study. The researcher, using inductive analysis, analyzes data using multiple
levels of abstraction. “Often, writers present their studies in stages (e.g., the multiple
themes that can be combined into larger themes or perspectives)” (Creswell, 1998, p. 21). I
conducted a multilevel analysis. Level I analysis consisted of examining the responses to
each actual question and looking at the commonality and the diversity of responses. Level
II analysis consisted of looking at themes that arose across all questions in the interviews.
Finally, in Level III analysis, I reduced the themes to major categories. In effect, I took an
enormous amount of information and reduced it to certain patterns or categories and then
interpreted this information. Finally, I conducted cross-case analysis, that is, I examined all
themes and sub-themes that emerged from within-case analysis of each of the twelve participants. Cross-case analysis for this study explored themes found to occur across participants (cases) and unique to certain cases. I then looked at these major overarching themes in light of the literature for interpretation purposes (Creswell, 1998).

**Verification**

The researcher demonstrates the accuracy of the account using one of the many procedures for verification (Creswell, 1998). I followed acceptable and commonly used methods in data analysis for qualitative research as suggested by Creswell (1998). The data analysis was conducted simultaneously as I collected the data, interpreting the data and writing the narrative report. I also looked for unusual and useful quotes to integrate into the narrative report (Creswell, 1994). I discussed how I came to be interested in the construct of shame and shared past experiences, biases, and orientations that have shaped my interpretations and approach to the study. I also bracketed my personal observations. Clarifying researcher bias from the outset of the study is important so that the reader understands the researcher’s position and any biases or assumptions that impact the inquiry (Creswell, 1998).

I tape recorded and transcribed each interview. I then returned the typed transcribed interview to each participant and asked that each check for accuracy and determine whether they would like to make any additions or deletions, a process known as “member checking.” This technique is considered by Lincoln and Guba (1985) to be “the most critical technique for establishing credibility” (p.314). External audits allow an external consultant, the auditor, to examine both the process and the product of the account,
assessing their accuracy (Creswell, 1998). My dissertation committee composed of three faculty members audited my research study.

The Researcher's Role

I was the research instrument of this study. I observed, interviewed, analyzed, and interpreted. I brought my talents, experience, strengths, values, and skills that I have developed as a counselor, a student, as well as the other roles I have played during my life. Creswell (1994) asserted that because the role of the researcher is that of the primary data collection instrument, it is necessary for her or him to identify personal values, assumptions, and biases at the outset of the study. Rather than detrimental to the research setting, the investigator's contribution can be helpful and favorable. I discussed my biases and described how I came to be interested in the construct of shame based on my personal and clinical experiences with shame.

I initially became interested in the construct of shame when, in 1993, I, as a substance abuse counselor, attended a two-day substance abuse workshop that focused on shame in substance abusers. In 1995, I had the opportunity to attend a meeting of Gestalt therapists that featured Lynn Jacobs, a therapist who has written about shame and is referenced in this paper, discussing how therapists inadvertently shame clients. I was impressed with the clarity of Jacobs thinking and her ability to articulate her thoughts and disclose her experiences both as a therapist and as a client. This encounter that I had with Lynn Jacobs influenced my decision to focus on shame in writing a program proposal for the masters' counseling program, a requirement for the program in which I was enrolled. Further reading on the construct of shame encouraged me to examine the counseling that I provided with increased awareness in how I may inadvertently shame clients. I also was motivated to
look at how my own shame issues influence my counseling. As part of a course requirement, I developed an experiential and didactic program to familiarize students in the graduate counseling program in which I was enrolled with the issue of shame.

Ethical Considerations

Kvale (1996) identified informed consent, confidentiality, and consequences as the chief moral qualities of an interview. I followed the code of Ethics and Standards of Practice of the American Counseling Association (ACA) pertaining to research and publication. Informed consent consisted of informing the participants about the purpose and the procedure of the interview (Fontana & Frey, 1994).

In obtaining informed consent for research, counselors use language that ...accurately explains the purposes and procedures to be followed; ... describe the attendant discomforts and risks; ... offers to answer any inquiries concerning the procedures; ... describes any limitations on confidentiality and ... instructs that subjects are free to withdraw their consent and to discontinue participation in the project at any time (ACA, 1997, p. 9).

In my initial telephone contact, I provided each participant with the above information. I had a written agreement, signed by myself, the interviewer, and the participant, obtaining the informed consent of the interviewee to participate in the study and permit future use of the interviews. Included in the written agreement was information about confidentiality and who will have access to the interview, the researcher’s right to publish the whole interview or parts of it, and the interviewee’s right to see the transcription (Kvale, 1996).

Participants have a right to expect the researcher to preserve their confidentiality and anonymity (Glesne & Peshkin, 1992). In accordance with the ACA Code of Ethics and
Standards of Practice (1997), “counselors ... take due care to disguise the identity of respective subjects in the absence of specific authorization from the subjects to do otherwise” (p.9). “Fictitious names and possibly changes in participants’ characteristics may be used in the published report in order that participants will not be identifiable” (p.9). In this study names of participants were changed in order to protect their identity.

Concerning consequences, the interview topic of shame could have brought forth deeper personal issues that required therapeutic assistance. “Counselors who conduct research with human subjects are responsible for the subjects’ welfare throughout the experiment and take reasonable precautions to avoid causing injurious psychological, physical, or social effects to their subjects (ACA Code of Ethics and Standards of Practice, 1997). I had a list of licensed counselors in the area to provide the participants a “backup” for dealing with personal problems that might have been brought up by the interviews (Kvale, 1996).

There were also benefits to participants in this qualitative study. A counselor “describes the benefits or changes in individuals or organizations that might be reasonably expected (ACA Code of Ethics and Standards of Practice, 1997).” The interviewing process can provide an opportunity for participants to engage in self-reflection and thereby give themselves a better understanding of their own theoretical frameworks and counseling processes (Glesne & Peshkin, 1992). “...Reinforcement, catharsis, and self-enlightenment are the major returns” that interviewees can obtain from participating in a qualitative study (p. 123).

As a final assurance that ethical considerations were honored was the requirement by the School of Education’s Human Subjects Research Committee and the College’s
Committee for the Protection of Human Subjects that all dissertations must receive approval by them before any data may be collected (School of Education, 1998).

**Delimitations and Limitations of the Study**

This study was delimited in the following fashion: twelve licensed counselors who conduct primarily individual counseling with adults and practice in a southeastern state of the United States were asked to discuss their understanding of the construct of shame and how the construct of shame is meaningful to them in the practice of counseling. There is no intention on the part of the researcher to suggest that the results of this study should be generalizable to any other sample. The reader must decide the extent to which information from these participants may be generalized or applied to other groups of licensed counselors.
CHAPTER FOUR

Within-Case Analyses

Chapter Four describes the within-case analyses of this exploratory study. A separate section is devoted to each of the 12 participants. Individual descriptions were derived from the words of the participants themselves. Each participant section is divided into smaller sections for themes and sub-themes in which they are briefly discussed and supported by participant quotations. Each analysis is followed by researcher interpretation.

Overview of Analytical Procedure

Each participant was interviewed twice over the period of a year. The data was analyzed using inductive analysis, as outlined in Chapter Three of this text, (p. 100). In inductive analysis, the data is analyzed using multiple levels of abstraction (Miles & Huberman, 1994). Level I analysis involved examining the responses to each actual question and looking at the commonality and the diversity of responses (Appendix G) (Miles & Huberman, 1994). Level II analysis entailed looking at themes that arose across all questions in the interviews (Miles & Huberman, 1994). In Level III analysis the themes were reduced to major categories (Miles & Huberman, 1994). The major overarching themes were looked at in light of the literature for interpretation purposes. In this chapter Level II analysis, an examination of themes that appeared across all questions in the interviews, is presented.

Interviews were read and re-read for each participant in order to get a sense of the whole and to begin to discover patterns present in the material. The text was segmented and assigned a code word that accurately described the meaning of the text segment. These codes were examined for overlap and redundancy and then collapsed into themes. In other
words, themes were developed by first examining the participant’s statements in the transcribed interviews and generating meanings for each significant statement. Statements related in content were then clustered under specific topics determined by the researcher, and then examined for redundancy and collapsed into broader themes. Those themes that were selected for discussion were those that occurred most frequently in the text. Smaller chunks of related information within a theme were labeled sub-themes, but not all themes included sub-themes. The titles of themes, with the exception of “Multiple Views of Shame,” sub-themes, and codes are in the participants’ own words. Names of the participants were changed for confidentiality purposes.
### Table 4.1
**Descriptions of Participants**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Sex</th>
<th>Years as Counselor</th>
<th>Years as LPC</th>
<th>Formal Education</th>
<th>Orientation</th>
<th>LMFT?</th>
<th>Shame Education</th>
<th>School</th>
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<tbody>
<tr>
<td>Ash</td>
<td>M</td>
<td>27</td>
<td>17</td>
<td>B.A. psychology</td>
<td>Psychoanalytic w/ some cognitive-behavioral</td>
<td>yes</td>
<td>Psychoanalytic training</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M.Ed. counseling</td>
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<td>22</td>
<td>16</td>
<td>M.Ed. counseling</td>
<td>Christian; eclectic; cognitive-behavioral; family systems</td>
<td>yes</td>
<td>Conference workshops</td>
<td>Pieces in different courses</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Now in doctoral program</td>
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<tr>
<td>Elm</td>
<td>M</td>
<td>30</td>
<td>22</td>
<td>B.A. psychology</td>
<td>Jungian; psychodynamic; family systems; eclectic</td>
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<td>reading</td>
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<td>8</td>
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<tr>
<td>Fir</td>
<td>M</td>
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<td>reading</td>
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<td>Oak</td>
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<td>24</td>
<td>23</td>
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<td>yes</td>
<td>Working w/folks in recovery; recovery lit.</td>
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<tr>
<td></td>
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<td>Family systems Gestalt Rogerian</td>
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<td>Palm</td>
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<td>Spruce</td>
<td>F</td>
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<td>Ed.S. counseling</td>
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<td>Willow</td>
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<td>18</td>
<td>12</td>
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<td>Substance abuse training &amp; literature</td>
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</table>

LPC – Licensed Professional Counselor

LMFT – Licensed Marriage and Family Therapist

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Descriptions of Participants and Individual Case Analyses

Mr. Ash (Participant #1)

Mr. Ash reported that he has worked as a counselor for 27 years and been a licensed professional counselor for 17 years. He was also a licensed marriage and family therapist and has certification from the American Association of Sex Educators, Counselors, and Therapists (ASSECT) as a sex counselor. He reported that he has a bachelor’s degree in psychology, a master’s degree in counseling, and an Ed. D. in college and agency counseling. Mr. Ash stated that his theoretical orientation was, for the most part, psychoanalytic, but he also used cognitive-behavioral techniques in his work. He is currently in private practice.

### Ash Themes

<table>
<thead>
<tr>
<th>In Psychoanalytic Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oedipal Period</td>
</tr>
<tr>
<td>Trauma</td>
</tr>
<tr>
<td>Self-Concept</td>
</tr>
<tr>
<td>Self-Destructive</td>
</tr>
<tr>
<td>Bad Relationships</td>
</tr>
<tr>
<td>Shame Can Be Polarized</td>
</tr>
<tr>
<td>Anxiety, Depression, &amp; Trauma</td>
</tr>
<tr>
<td>Never Self-Disclosing</td>
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</tbody>
</table>

Sub-themes in italics

The predominant themes with *(related sub-themes)* that emerged during Mr. Ash’s interviews were: In Psychoanalytic Terms *(Oedipal Period, Trauma, Self-Concept)*; Self-Destructive *(Bad Relationships, Shame Can Be Polarized)*; Anxiety, Depression, & Trauma; and Never Self-Disclosing.

**In Psychoanalytic Terms**

This theme consists of Mr. Ash’s interpretation of how shame is viewed “in psychoanalytic terms.” When shame develops and what factors contribute to its development are discussed. In addition, a discussion about the impact that shame has on a
person's self-concept is undertaken. The following sub-themes are presented: Oedipal Period; Trauma; and Self-Concept.

**Oedipal Period**

The notion that shame develops at an early stage of development in an individual is presented in this section. Mr. Ash contended that shame is the result of a disturbance during the "Oedipal period."

In psychoanalytic terms, I would say it (shame) begins to develop, in the Oedipal period, around the ages of 4, 5, and 6. I think when there is a significant disturbance in the development at that time, there's oftentimes an exaggerated superego which leads to a sense of shame.

He proposed that in order for shame to be of an intense and chronic nature, it would develop during this critical Oedipal stage. "I think it's likely that if you're really going to feel a strong sense of shame, it will come from the significance of the early development."

**Trauma**

The view that trauma contributes to the development of shame is presented in this sub-theme. Mr. Ash suggested that trauma, particularly sexual abuse, is linked to the development of shame.

(B)ecause of the orientation that I take, especially when there's such a disturbance in the early period, whether it's poor parenting or whether it's some kind of trauma or especially sexual abuse. I think sexual abuse and rape ... have a significant impact for many people and the concept of shame.

The trauma, he maintained, impacts the person's self-concept, which, in turn, affects their actions, producing self-destructive behavior. "They end up feeling like a shameful person,
and I think they go on doing damage to themselves, oftentimes, becoming promiscuous and getting into bad relationships ."

**Self-Concept**

This sub-theme discusses the factors that contribute to shame and the negative impact that shame has on a person’s “self-concept.” Mr. Ash discussed that lack of adequate gratification in early childhood results in the message that one is not a worthy person. "(T)hen you get frustrated because there’s not enough gratification so what it teaches you at a deep, unconscious level is that you don’t deserve good things in life." He talked about how approval or disapproval from one’s parents shapes a person’s identity.

I think another significant part of it is whether or not you receive approval from your main caregivers, usually your parents. If you’re growing up and your parents give you the concept that you’re a good person, you’re okay, that’s going to create a self-esteem and a self-concept that says “I am a good person.”

He purported that significant damage results unless children receive acceptance and approval from their caregivers. "(T)he come into the world not knowing who you are and what you are, and you get a sense that you’re a shameful person and that you’re a bad person, I think that’s going to have a significant effect on your development.”

**Self-Destructive**

This theme discusses how shame contributes to an individual’s “self-destructive” behavior that may begin in childhood, but is unconsciously re-enacted and extends into adulthood. The idea that shame is present when behaviors at either end of the continuum are exhibited is put forth. The following sub-themes are included in this section: Bad Relationships and Shame Can Be Polarized.
Mr. Ash talked about the impact of a shamed individual’s self-concept on how he acts. 
“If there’s a disturbance during that period of development and they develop a strong sense of shame, I think it’s going to have a significant impact on how they view themselves and on how they operate in the world.” He remarked that feelings of worthlessness about oneself induce one to act in shameful ways. “Significantly, especially at an unconscious level. I think people who feel an awful lot of shame are self-destructive.” He went on to describe the kinds of self-destructive behaviors they would engage in and how their behavior reflects the lack of worth they feel. 

If you feel a lot of shame, you don’t feel like you deserve good things in your life so you’re going to unconsciously put yourself in a position where you don’t get good things, relationships, jobs, healthy experiences, friends, things like that.

**Bad Relationships**

Mr. Ash talked about how people with unresolved issues tend to repeat early situations or relationships with the unconscious hope that things would turn out differently, more positively, but usually the outcome is confirmation of the original problem.

In psychoanalytic terms, as you know, we believe that if there’s something that’s unresolved in the early period, unconsciously, you’ll try to recreate that over and over and over again throughout your life to try to get it right, not really recognizing that every time you do it, it just reinforces the same concept, the same fixation, or the same problem that you had.

Mr. Ash proposed that out of an identity of inadequacy and a sense of being a person who ruins everything, an individual repeats self-destructive behaviors.
People get into bad relationships over and over again because of other things, but I think shame is a significant part of it. I think a lot of it comes from the idea of “I’m not worthy. I don’t deserve this...”

**Shame Can Be Polarized**

Mr. Ash stated that shame tends to present itself at the extreme ends of a continuum of behavior.

I think shame ... can be polarized, too, so someone who feels a lot of shame can present as a kind of person we would typically expect, the person who is just kind of withdrawn and guilty ... or they can present on the opposite side, where they pretend to be confident and healthy and positive, but that becomes their defense.

He further said that chronic shame would not be present in more moderate behavior. “What you would not see is something in the middle, something appropriate, something along the continuum. You would see one end of the pole or the other.”

**Anxiety, Depression, & Trauma**

This theme discusses specific disorders that Mr. Ash expressed were associated with shame, namely, anxiety, depression, and trauma. In addition, he noted that shame was related to sexual abuse survivors and to those with sexual dysfunctions. Mr. Ash declared that there was a link between shame and anxiety and shame and depression. He surmised that shame and excessive anxiety were linked. “I would say that and psychoanalytic theory says that anxiety is oftentimes based on guilt so a lot of anxiety, excessive anxiety, would probably be connected to shame, but I think that depression would, too.” He said that shame is associated with depression because loss contributes to depression, and shame-prone individuals often put themselves in situations where they end of failing or losing.
“Depression is oftentimes based on loss and hurt, but I think it can also be based on, somewhat based on people who have shame, too, because they put themselves in situations where ... they end up losing, and that’s what creates depression in the long run.”

Mr. Ash maintained that shame is also connected to posttraumatic stress disorder because the person blames herself for the incident. He also implied that shame is associated with sexual abuse. “(P)osttraumatic stress disorder. .... I could see someone who had experienced a trauma, especially a rape, and then having the reaction later on because they feel like such a shameful person. They blame themselves for the experience.”

He asserted that shame is associated with sexual dysfunction. “(O)ftentimes sexual dysfunction will come as a result of excessive shame about who they are.”

Never Self-Disclosing

This theme talks about the issue of counselors sharing personal information with clients. Mr. Ash talked about the impact of self-disclosure on therapy and his personal guideline for sharing information about himself with clients. He also talked about the role that counselors play in inducing clients to ask personal questions, the possibility of sabotaging therapy through self-disclosure, and counselors’ motivation for revealing information about themselves. The topic of self-disclosure emerged when Mr. Ash was asked, “How can a counselor most effectively deal with his own shame when it emerges in counseling sessions?” He stated that if a counselor experienced shame in a counseling session that he should absolutely not reveal that to the client. “Also, never self-disclosing. I mean that can be really destructive where you feel some sense of shame, and then you tell the patient you feel shameful. I think that just destroys the whole therapy.”
Mr. Ash went on to say that it was okay for counselors to reveal superficial kinds of information to clients. “I think there are some things that you can disclose at a very superficial level that can be helpful for the therapy.” He explained that self-disclosure is not appropriate because the focus should be on the client, not the counselor. “I don’t think it’s ever appropriate to disclose deep personal issues or struggles that the therapist has because the purpose of therapy is to deal with the patient, not with the therapist.”

Mr. Ash talked about the guideline that he used for disclosing information about himself. He would disclose public kinds of information.

I use a guideline -- to think of it in terms of things that are public ... I think anything deeper and more personal is not appropriate for the therapy session because I think that can generate a lot of issues inside the patient, and that can really destroy the therapy.

Mr. Ash alleged that a counselor revealing personal information about himself to a client indicated that the counselor had some unresolved issues that he was using the counseling session to resolve.

I think once you start talking about your own personal issues, first of all, what it says to me is you haven’t dealt with your own issues, and then I would ask, “Why are you talking about them? Are you using this as your therapy session instead of helping the patient?

Mr. Ash insisted that a counselor should ask himself why the client is asking him personal questions. He maintained that a client may be feeling anxiety and therefore tries to redirect the therapy by asking the counselor questions. “Why is the patient asking me that question? Is the patient trying to divert and pull away from the issues that we’re talking
about? Is it creating too much anxiety for him or her?” He further contended that the
counselor should examine himself as to how he may be promoting this type of personal
questioning. “I think, as a psychodynamic therapist, one of the things you have to ask
yourself is, ‘What did I do to encourage that question?’”

Mr. Ash remarked that a counselor should be cautious as to why a client is eliciting
personal information from the counselor because it may be a way to derail therapy. “You
have to be careful because there’s always a reason why they do that, and oftentimes it’s a
way of sabotaging the therapy.”

Ash Summary

This section included the following themes: In Psychoanalytic Terms; Self-
Destructive; Anxiety, Depression, & Trauma; and Never Self-Disclosing. Mr. Ash
provided a fairly detailed explanation of how he looked at the construct of shame from a
psychoanalytic approach. Some of the more interesting ideas concerned the contribution
that trauma makes to the development of shame, behavior at either end of the continuum as
an indicator of the presence of shame in an individual, and shame’s association to anxiety,
depression, and posttraumatic stress disorder. Of particular note was the discourse on self-
disclosure.

Interpretation

Mr. Ash appeared to be knowledgeable about not only psychoanalytic theory but other
theories as well. He talked briefly about how shame would be viewed in cognitive-
behavioral theory as well as Rogerian theory. Having a solid knowledge base seemed
important to him as evidenced by statements he made about the importance to him of
understanding the different areas of counseling. His ability to integrate his understanding of
psychoanalytic theory and apply it to the construct of shame indicated a high level of intelligence. He demonstrated insight into the cases that he discussed. His ability to articulate his insights and the complex concepts associated with psychoanalytic theory into an understandable explanation is probably extremely helpful to his clients. He, in essence, provides them with an alternative perspective in which to view their behavior, a view that is objective and nonjudgmental. He fulfills the role of educator quite competently.

Although Mr. Ash appeared to be very aware of how to identify the presence of shame in his clients, he expressed that perhaps counselors could “embarrass” clients, but he could not really see counselors shaming clients. However, the literature indicates that unintended shaming is a normal part of the counseling process and that many therapeutic impasses result from unacknowledged shame experiences. Failure by the counselor to respond to a sensitive self-disclosure in a way that injures the client or failure on the part of the counselor to acknowledge a risk that the client takes results in the client experiencing shame. The client may express anger that masks the painful experience of shame or she or he may become withdrawn and less likely to disclose or take another risk. Failure to acknowledge the shame prevents counselors from restoring the relationship with the client.

Psychoanalytic theory, the approach that Mr. Ash identified as his primary framework, is one that may induce shame in a client because it connotes pathology, that there is something wrong with the client. In psychoanalysis, an emotionally safe, superior position is adopted by the analyst while the patient is relegated to a shameful, inferior one. In addition, Mr. Ash’s rigorous view of self-disclosure may reinforce the client who experiences shame. The counselor’s silence and lack of sharing similar experiences could convey to the client that the counselor has never experienced an episode of shame,
confirming the client's already ingrained sense of inadequacy as a human being, abnormalcy, and sense of isolation.

Mr. Cypress (Participant #2)

Mr. Cypress was a licensed professional counselor and a licensed marriage and family therapist. He reported that he has a master's degree and Ed.S. in counseling and is about halfway through a doctoral program in organizational leadership. He has worked in the counseling field for 22 years and has been licensed for 16 years. He described himself as eclectic, but he identified family systems and cognitive-behavioral theory, in addition to a Christian worldview, as his primary frameworks. He is currently in private practice.

Cypress Themes

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Sub-themes in italics

During the interviews with Mr. Cypress, the following predominant themes with (related sub-themes) emerged: Multiple Views of Shame (Guilt/Shame, Parental Influence, Reset the Scene, Self-Talk); A Christian Worldview; In Touch With Their Own Stuff; Disorders; and REBT Model.

Multiple Views of Shame

The title of this theme indicates the complexity of the construct of shame. This theme discusses many aspects of shame, many different ways of looking at the construct of shame. In this section the relationship and the distinction between shame and guilt are discussed. The importance of the of an individual's early relationships in his or her family
of origin and how those relationships influence relationships in adulthood are talked about. Also, Mr. Cypress discussed the repetition of shame experiences with the unconscious hope of a different outcome. Finally, a discussion about how self-talk in adulthood continues the negative messages from childhood takes place. This section contains the following sub-themes: Guilt/Shame; Relational Dynamics; Reset the Scene; and Self-Talk.

**Guilt/Shame**

Mr. Cypress discussed the distinction between shame and guilt. He said that guilt is connected to a person's actions; whereas, shame is linked to a person's perception of herself. “Guilt has more to do with what a person does or doesn’t do; it’s an act of commission and acts of omission. Shame is a more pervasive concept ... It has a greater impact on who you are, and so it goes deeper.” He also expressed that he often saw guilt and shame appear together. “Again, I see the two being hand and glove because what I do or don’t do often affects how I look at myself.”

**Parental Influence**

Mr. Cypress talked about the impact that “parental influence” during one’s childhood has on the development of shame in an individual. He suggested that parents play a significant role in their child’s development that extends into adulthood. He remarked that the individual who has experienced abuse in childhood is apt to reconstruct those interactions in her or his adult relationships.

(P)arental influence is an important construct to look at. I find that the more dysfunctional or more outright abusive a person’s growing up experience was, the greater the tendency to recreate that dynamic in their own adult relationships.
He asserted that a child internalizes negative messages when she or he hears them repeatedly.

(If you hear the same message over ... and over again, well, sooner or later what do we begin to equate with it? Truth. It’s all I’m hearing. Well, imagine how buried some people feel growing up, when all they hear is negativity and blaming and all that, and what happens, is after awhile, people internalize it.

*Reset the Scene*

Mr. Cypress proposed that people who were shamed growing up repeat shame-based relationships as a way of trying to change the outcome.

If they were shamed a lot, then you see shame-based relationships happening. It’s usually because people are looking for closure. They want to reset the scene, roll the cameras, and they’re hoping for the happy ending they never got, but yet it just keeps recycling through until they can understand what it is that’s going on.

He contended that internalized shame is expressed through self-destructive behavior and relationship problems. “Shame is an internal process. It’s usually a cognitive process, and that cognitive pain, if it’s an unhealthy sense of shame or guilt, does externalize itself in different ways, either self-defeating behavior or relational conflict.”

*Self-Talk*

Mr. Cypress maintained that people continue the criticism from childhood into adulthood through their own internal dialogue. Like I said, they may be long out of that environment, but they, in essence, have picked up the microphone, and now they’re continuing to record with their own self-talk because everything is filtered through “Well, I guess I really am no good ...
He proposed that self-talk presented an opportunity for intervention. “That’s where you often engage people, at least adults, in therapy because they’ve internalized this stuff for years, and you’re helping them say, “Wait a minute. Where’s that coming from?” Mr. Cypress claimed that “a good three-fourths of the people I see are struggling with shame issues.”

A Christian Worldview

This theme developed primarily from the following protocol item, “Tell me about the theoretical framework or frameworks that guide your counseling practice,” but a Christian worldview was discussed at various times throughout the interview. In this theme, the importance of examining all aspects, including the spiritual aspect, of a person is discussed, as well as the trend of the mental health profession toward including the spiritual element in assessment and treatment. How shame is viewed in a Christian worldview and how religion can contribute to both engendering shame and healing shame in individuals is examined. Finally, a discussion about the value of a shared worldview between counselor and client is presented.

Mr. Cypress stated, “(T)his is a Christian practice. All the people are licensed ... but all the practitioners counsel by being willing to include the faith aspect in the process.” He affirmed that the counselors in his practice “look at the whole person in terms of who the person is physically, emotionally, mentally, and spiritually...” He claimed that in the past, “traditional psychotherapy” has ignored the “spiritual component,” but declared that things are changing. “When they rewrote, revised the DSM IV, they included spiritual problems in there so the field of psychology and psychiatry are beginning to recognize the impact, the influence of spirituality.” He stated, “I think a Christian therapist has a very real...
opportunity to deal with shame issues in people because I think this orientation addresses
shame and addresses guilt.”

Mr. Cypress discussed how shame is viewed in a Christian worldview. He purported
that one’s self-worth should derive from the value that God grants each person rather than
one’s performance and what other people think about that performance. “Well, from a
Christian worldview, the Christian therapist would say, “You have value because God
created you. You have value regardless of what others say about you or do to you.”

He talked about the role that religion and church communities sometimes play in
instilling shame in individuals. “Frankly, people get some of their, I think, misguided
concepts of shame or self-concept from faulty theology.” He suggested that well-meaning
people sometimes give advice that is shaming. “Oh, people will come in sometimes
struggling in some aspect of life, struggling with depression, and they are told, probably by
well-intentioned people, ‘Pray a little bit more. Go to church a little bit more often.’”

Mr. Cypress said that people might feel ashamed of feeling depressed. “People of faith
often say to themselves, ‘I’m not allowed to be depressed. People of faith aren’t depressed.
We’re supposed to have faith and rise above it.’” He talked about how he would intervene
to counteract this belief and spoke about figures in the Bible who displayed symptoms of
depression.

Well, anyone who’s read the Book of Psalms would look at it and say, “There are
times that David looked clinically depressed.” Elijah, the prophet, was in the
wilderness, and he said, “I wish my life was over.” I mean these are people who
experienced depression so you don’t avoid it. You address it directly.
When Mr. Cypress was asked, “What are some of the characteristics and values that are important in a counselor,” a shared worldview is one of the characteristics that he talked about. He purported that counseling is more effective when the counselor and the client share the same worldview and value system. “I find also that people tend to get the most help when they’re in a counseling process with someone who fits into their worldview and into their value system because it’s like okay that’s settled.” He stressed that a shared worldview facilitated the counseling process by establishing a relationship fairly quickly. “Any therapist and any client that have compatibility there is going to foster probably a more rapid connection in a counseling process.” He emphasized the value of establishing the counselor-client relationship quickly in the therapy process partly because of the reality of the managed care system. “(Y)ou’re in a managed care environment, you have to figure out a way to connect with them quicker to maximize the time you do have.”

In Touch With Their Own Stuff

This theme developed from the question “What are some of the characteristics and values that are important in a counselor?” This section discusses the value of knowing oneself as an important counselor characteristic. Mr. Cypress explored some pitfalls caused by lack of self-knowledge that counselors encounter that greatly limit the effectiveness of counseling. He also talked about the value of discussion with colleagues as a way of keeping a check on one’s practice.

Mr. Cypress asserted that counselors should be aware of their own issues so that they do not use therapy sessions to work on their own problems. “I think the best counselors are the ones most in touch with their own stuff and they’re not trying to use the counseling process to continue to sort out their own stuff.” He talked about the possibility of a
counselor confusing her issue with the client’s issue. "(T)he better you know yourself, the better you’re going to be aware of ‘Okay, this is not their issue; this is my issue.’” He mentioned that “just as real as transference is, countertransference can be just as strong. ... But if they’re not in tune with that, then they’re just going to sort of be reacting to it, which can lead to problems.” Mr. Cypress suggested that if counselors do not know what their needs are, they might use counseling to meet these needs. “I think a counselor has to be aware of his or her own needs and not use the counseling room to fulfill those needs.”

Mr. Cypress talked about the value of counselors’ accountability to others. He contended that it was especially important, in fact, ethically necessary for a counselor to get help with unresolved issues because of the likelihood of having those unresolved issues impact negatively upon the counseling that clients were receiving. “Again it’s incumbent upon, I think, the therapist to be tuned into their own issues and to seek outside people to be accountable to.” He also said that ethics demand that counselors get help for unresolved issues so that they do not bring them into their sessions. “It’s good for counselors to be accountable as well, and ethical practice would say, ‘If you have unresolved issues, get help and resolution within yourself so ethically you don’t bring it into the session.’”

Disorders

This theme discusses the role that shame plays in specific psychological disorders. Mr. Cypress proposed that several disorders were linked to shame. He suggested that depression is connected to shame and has to do with “how we internalize our external events.” He also claimed that addictive disorders are associated with shame.

Again, it’s how I think addictive disorders can be because people are looking for a way to self-medicate, find relief for their pain or their emotional need. I’m not just
putting substance abuse there. Food can be a comfort thing if I feel like I’m never loved. I’m looking to feel good.

He maintained that anxiety disorders are linked to shame because the individual might think she will be harshly criticized when she is around others, which causes her to feel anxious. “Certainly some of the anxiety disorders are. If I’m around people that I think I’m going to get blasted every time I’m around them, I can see where that might produce a little bit of anxiety, to be around people ...”

Mr. Cypress expressed that shame is connected to abuse, dissociative disorders, and personality disorders. “If the shame is tied into abuse, and abuse is severe enough, you can see some dissociation. ... I think it can contribute to personality disorders.” Finally, he purported that shame and guilt could play a part in many psychological problems, and for that reason, he said that shame should be addressed in counseling programs.

(S)hame, guilt can play a role in a number of psychological issues that people confront. It may be in combination with other things going on, but I think certainly, it has a role, again, even more why it ought to be addressed at the academic training level as well.

REBT Model

This theme discusses Mr. Cypress’s view of rational-emotive behavioral therapy (REBT) and its application to shame. Mr. Cypress maintained that one’s thoughts, feelings, behaviors, and relationships have their source in one’s core beliefs.

I buy into the REBT model ... that our core beliefs do impact our thinking, and our thinking interacts with the emotions that we’re feeling, and our affect does influence our behavior, and our behavior definitely impacts our relationships.
He discussed that people's problems are symptoms that indicate deeper issues. He proposed that people usually seek counseling because of problems in their relationships with others.

Counselors deal with people when problems manifest, and problems manifest usually at the relational level, marriages, siblings, with your kids, co-workers. I think a person's core values and beliefs impact their thinking. If their core values and beliefs are not healthy, then it's going to eventually work itself all the way up to the relational level.

He elaborated further on the path of shame-based thoughts. The thoughts influence the feelings, which in turn, impact on behaviors that subsequently affect relationships.

Those shame-based thoughts are going to produce some anxiety, some depression, and that depression is going to result in certain behaviors, difficulty in concentration, difficulty functioning at work, greater conflict or avoidance or withdrawal or isolation behaviors, and in turn, are going to impact relationships.

Cypress Summary

This section covered the themes of Multiple Views of Shame, A Christian Worldview, In Touch With Their Own Stuff, Disorders, and REBT Model. Of particular note was the notion that shame-based relationships that are formed in childhood in families tend to be repeated in adulthood in failed unconscious attempts to bring about a better outcome. Mr. Cypress explored the role that religion plays in both instilling and healing shame in individuals. He looked at the importance of counselors' knowing themselves in order to provide more effective counseling and examined how a core belief of inadequacy as a human being negatively impacts thoughts, emotions, behaviors, and relationships. The association between shame and psychological disorders was also a topic of discussion.
Interpretation

Mr. Cypress exhibited an understanding of how shame would be viewed in a Rational Emotive Behavioral Therapy (REBT) approach. His description of his interpretation of REBT seemed simplistic, however, he did preface his explanation with the admonition that he was “being a little bit simplistic” and “a little bit reductionist.” His interpretation of REBT was hierarchical. The image that occurred in my mind as he was talking was that of a marching band with rows of thoughts, feelings, behaviors, and relationships, in that order, marching in lockstep behind the drum major of core beliefs and values. As he discussed some case examples, he referred to this simplistic model perhaps as a way of clarifying what was going on with clients.

His knowledge of Biblical Scriptures enabled him to draw on this Western tradition of wisdom that could help him to elucidate shame for his clients. Because his practice was known in the community for its Christian orientation, his clients, for the most part, would be familiar and feel comfortable with, as well as comforted by his Christian-oriented interpretation. Mr. Cypress expressed his view that a Christian worldview dealt with the issues of shame and guilt. He seemed to equate shame with self-concept because he used the words interchangeably. His view was that people who held the perspective that God granted worth to each human being were able to transcend the typical view that self-concept equals one’s performance plus what others think of that performance. He also was able to be critical of religion and church communities by discussing how they both contributed to instilling shame in people. He made a connection between counselors and clients sharing a common worldview and values to the ability to establish a trusting counselor-client relationship quickly.
Mr. Cypress’s eclectic and spiritual approaches correspond well to a more pluralistic view of the construct of shame. His REBT approach resonates with an interpretivist view “that experience is not just cognitive, but also includes emotions (Glesne & Peshkin, 1992, p. 19). His understanding of the power that family of origin relationships wielded helped him to understand how entrenched shame is and how it influences people to repeat self-destructive behaviors. He clearly had an understanding of the impact of shame on individuals. He was able to identify it in clients, and used REBT techniques to treat shame in clients.

**Mr. Elm (Participant #3)**

Mr. Elm reported that he has worked as a counselor for about 30 years and has a bachelor’s and master’s degrees in psychology and a doctoral degree in counseling. He stated that he also has had training in family systems work, hypnotherapy, and Jungian analysis. He has been licensed as a professional counselor for 22 years. He was also a licensed marriage and family therapist. He identified himself as eclectic in his approach to counseling but stated that Jungian analysis was the bedrock of how he thinks about things. Mr. Elm had an interest in the construct of shame and had done a good bit of reading about it. In fact, he was, at the time of the first interview, preparing to present a program on shame.

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Sub-themes in italics

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Based on the interviews with Mr. Elm, the predominant themes with (related sub-themes) that emerged were: Understand Our Own Nature (*Through the Process Themselves, Triggering Shame*); Multiple Views of Shame (*Shame Becomes Internalized, Identity & Affirmation, Connection, When We’re Young, A Drop Into the Experience*); Affect Theory; and A Mirroring Process.

**Understand Our Own Nature**

This theme discusses the value of counselors knowing themselves. To “understand our own nature” helps counselors to separate their own issues from clients’ issues and pay attention to the countertransference process. He also talked about the value of knowing one’s penchant in counseling. The importance of counselors going through the counseling process themselves and understanding the way they interact with clients were discussed. The sub-themes are: *Through the Process Themselves* and *Triggering Shame*.

Mr. Elm was an advocate for counselors knowing themselves. He stated that the better counselors know themselves, the better they can distinguish between their own issues and those of their clients. Also, he asserted, the threat of the therapy becoming confused and enmeshed would be diminished.

The more we understand our own nature and our own psychology, the better we’re able to differentiate and discriminate what’s mine and what belongs to the client ... but if I don’t know myself well enough, this is going to be one big muddy mess.

He also recommended that counselors remain in touch with the zeal that brought them into the counseling field.

With the environment of dealing with insurances and all those kind of things, the soul can kind of get taken out of this whole process so I think it’s just really
important to know where your passion is that brought you in here and do things to cultivate that, nurture it along the way.

**Through the Process Themselves**

Mr. Elm maintained that counselors going through therapy themselves would enhance their understanding and respect for their clients' position.

(It)'s very, very important for a person who’s sitting as a psychotherapist to have been through the process themselves because you ask an awful lot of people when they come and sit in your office and begin to bare their soul, and there's a certain reverence, a certain way of being present with that, that I think is very important.

Mr. Elm asserted that unless a counselor had worked on her own shame issues, it would be challenging for her to identify it in her clients. "I think if you haven’t recognized or explored the experience of shame in one’s own life, it makes it very difficult to really understand or recognize it in anybody else’s." He insisted that the danger of unintentionally shaming one’s clients exists if a counselor has not worked through her own shame issues.

(We) need to be doing our own work. Otherwise, we are going to be inadvertently, unconsciously shaming our clients, not recognizing when somebody is stuck in some experience and some mood, to understand really why that persists.

**Triggering Shame**

Mr. Elm stressed that being able to recognize shame in clients and having an awareness of one’s own manner is valuable in identifying ways in which one might be inducing shame in clients. “That’s why I think it’s very important to begin to recognize in what way do I know this (shame) and to develop some understanding really and awareness
of one’s own manner.” He stated that an awareness of shame helps a counselor to attend to subtle changes in clients that might indicate the presence of shame.

So whether I say something inducing it or triggering some experience of shame, ... some offhanded comment or some lack of thinking through something that I just talked about or making some joke or responding in some ways to some joke that’s really self-effacing that a client makes.

Multiple Views of Shame

This theme discusses the many perspectives that Mr. Elm used in looking at shame. The effect that shame has on how people see the world and themselves and the view that some personality types are more susceptible to shame were discussed. He talked about the impact that shame has on one’s identity and the role that lack of support plays in the development of shame. A discussion about how shame severs the connection between people took place. He also talked about children’s susceptibility to shame and the necessity to go through the experience in order for the healing of shame to take place.

The sub-themes in this section are: Shame Becomes Internalized; Identity & Affirmation; Connection; When We’re Young; and A Drop Into the Experience.

Shame Becomes Internalized

Mr. Elm discussed the impact of internalized shame on an individual. “When shame becomes internalized, it begins to infect or affect so many parts of one’s own experience. It can have a real censoring and suppressing effect on a person’s kind of life energies.” He declared that it tends to restrict a person’s life in major ways, and the individual tends to repeat shame-bound relationships and experiences.
It can become a filter through which one views almost every aspect of one’s own self and their life. ... it becomes very limiting ... people tend to repeat these experiences or these relationships which become shame-bound or shame-binding in some way...

**Identity & Affirmation**

Mr. Elm contended that a lack of support or nurturance in the environment could contribute to one’s sense of identity developing into shame. He remarked that without a supportive individual in the environment to reflect one’s value and integrity, a person would tend to absorb criticism and disapproval. Mr. Elm asserted that shame could become one’s identity. “It also becomes an affect with which someone identifies themselves. It can become a sense of one’s identity, a certain sense of unworthiness.” He proposed that this identification with shame tends to occur when there is a lack of support and nurturance in the environment. “(W)hen somebody is told that they’re pretty worthless, that they really are stupid or this or that over a period of time, and there’s no other place where some other possibility of self is available for affirmation or redemption in some way, they are going to believe that.”

**Connection**

Mr. Elm proposed that shame occurs in an individual as a result of disappointing another person. “I think it develops when we experience something where there’s a certain sense of we disappointed somebody, we feel we’ve failed somebody, we’ve done something wrong.” He stated that the failure of meeting another’s expectations becomes a judgment of the self, rather than a specific act. “Rather than one’s actions or the incident being the thing that becomes the thing that’s criticized or judged in some way. The judgment that becomes one’s personhood.”
Mr. Elm suggested that shame occurs when a connection with another person is broken. He insisted that when that happens, one experiences shame, which tends to become chronic when there is no supportive person in the environment with whom one feels safe revealing that experience.

What also happens is that the connection, that interpersonal bridge, ... when that’s broken then it becomes very damaging because one’s left with these little islands, ... of one’s own feeling, and there’s no place to go to figure out where I went wrong ...

He claimed that when there is no one in the environment to validate one’s feelings of shame as a normal part of human experience, then shame becomes part of oneself. “There’s no adequate mirror or available mirror so it becomes internalized, and that’s when I see that it does so much damage.” Mr. Elm stated that these breaks in relationships are experienced physically and begin early in one’s life. “(I)t’s (shame) an experience, a physiological experience of some sense of relationship, a very early bond that’s forming, break. ... Those things happen really from very, very early in life all the way through our lives.”

When We’re Young

Mr. Elm conjectured that shame would probably originate in childhood. “My hunch would be that we would probably be much more susceptible to those deep shaming experiences when we’re young.” He purported that shame could develop at any time in one’s life. “I could imagine situations across a lifespan where one would have a difficult time with shame.” He went on to say that children are probably more predisposed to shame than adults. “In the course of a lifetime, I just think that we’re most influenced by it in our childhood.”
A Drop Into the Experience

Mr. Elm emphasized that a client needs to do more than just talk about shame in order for healing to take place. He asserted that “there is a certain sense of the need for whatever emotion that is carried in the body, whatever that energy is, to be released, to be expressed.” He talked about how this is an experience that most people want to sidestep. “I mean most of us want to avoid the messiness of that, ourselves.” He stressed that “at some point there needs to be a drop into the experience.”

Affect Theory

This theme discusses the role that shame plays in affect theory. A discourse on how shame interrupts other affects and how it occurs first in the body takes place. Mr. Elm also talked about the role that reflection plays in the process of shame. Mr. Elm discussed self-mirroring and self-disclosure.

Mr. Elm spoke about his interpretation of affect theory. He stated that biology is involved in affect, and certain physiological responses occur when there is a specific stimulus. “(A)ffect is a biological process. It’s part of our physiological wiring, and there are certain very set responses that take place in response to a specific stimulus.” He asserted that reflection is a necessary part of the development of chronic shame. “Shame really depends upon the ability in some ways to reflect upon what has just happened.” In addition, he claimed that the ability to make connections plays a role in the development of shame. “For humans, shame takes on even greater meaning because of the layers of association, this library of experience that builds up as we experience shame.” He alleged that shame serves to interrupt the positive affects. “There is a process, a biological process of interruption that is the affect of shame.” He insisted that both body and mind are
involved in the shame experience, that the experience begins in the body before it enters a person’s awareness.

When something happens that is shaming, there’s this combination of both body and mind. ... So if something happens, I feel that interruption. I go through the physiological responses of head dropping, eyes down, stuttering, get clumsy, and I begin to rethink of all other times I felt this way.

A Mirroring Process

This theme discusses the processes of self-disclosure and mirroring. Mr. Elm talked about counselors revealing their emotional experiences as a way of evoking the client’s emotional experience. A discussion about the helpfulness of a counselor using self-disclosure occurred.

Mr. Elm advocated the sharing of emotional experience in a session with clients in order to elicit the client’s feelings, which he called “essentially a mirroring process.”

... I say, “Right now as we sit here, I’m just aware of my head just wanting to drop and feeling this bad feeling inside, I feel like I’m feeling some shame; in some way I’ve been scolded ... Does that mean anything to you? Do you relate to that?...

Mr. Elm discussed his use of self-disclosure to help clients.

My clients ask me at times. “What do you do in situations like that?”... if they haven’t had the experience at home of seeing ... how somebody else copes with a particular situation or experience or affect, ... there are times when sharing how I responded to or what did I do when I had that. It’s very, very helpful because it gives them another model, something else to begin to identify with.
He suggested that a counselor should be inquisitive about clients asking personal questions. “Are they trying to get away from themselves? Is this some of just trying to get to know me better, of somehow moving the relationship to more personal dimensions?” He indicated that he would share with the client that he had experienced shame.

I would say, “This is what shame feels like. It moves you in some way to the outside edge of town. You feel like you’re an outsider, the fish out of water, the only one that brings this sense of vulnerability and this awful experience of a spotlight being right on parts of oneself that one wants most hidden. So what you’re describing to me makes perfect sense. That is the experience of shame.”

Mr. Elm declared that he used self-disclosure with great care and in a thoughtful and planned way. “As therapists, our reason for being with people is very, very different so when people ask me a question that involves some self-disclosure, I do self-disclose, but very intentionally.”

Elm Summary

This section included the following themes: Understand Our Own Nature; Multiple Views of Shame; Affect Theory; and A Mirroring Process. The impact of shame on an individual’s identity and the importance of counselors knowing themselves were discussed. An exploration of how shame is viewed in affect theory and a discourse on self-disclosure and mirroring were conducted. The role that lack of support and nurturance in the environment plays in the development of shame and how shame severs the connection between people were topics of discussion.
Interpretation

Mr. Elm displayed a presence in the interviews that revealed great sensitivity, empathy, and genuineness, particularly when he discussed individual cases. He displayed openness when he used himself as an example of how a counselor inadvertently shames a client. In describing his interactions with clients, he exhibited a keen sensitivity to nuance of speech and gesture in clients as well as himself, and an ability to be self-critical without being self-denigrating. He showed concern for his clients' confidentiality when he stipulated that he did not want the individual cases that he used as examples presented in my dissertation. He suggested that a sensitive sharing of what an experience of shame feels like shows that a counselor not only understands what a client experiences, but that it normalizes the experience and elevates it because the therapist is sharing that he, too, has had this very human experience. Mr. Elm discussed shame in a way that was different from the other participants. He seemed to include himself as a participant in the human family who experiences shame. He appeared to be one who was well-acquainted with the experience of shame.

Ms. Fig (Participant #4)

Ms. Fig reported that she has a master's degree in learning disabilities and an Ed. S. degree in counseling. She served as a learning disabilities specialist for seven years, and then was a stay-at-home mom for 8 years after which she returned to school for her degree in counseling. She worked 2 years as a counselor before becoming licensed. She has been a licensed professional counselor for 10 years and a licensed marriage and family therapist for 8 years. Ms. Fig is in her sixth year of private practice and described her counseling approach as eclectic.
Multiple Views of Shame

From the Outside
Insidious/Control
Self-Esteem /Identity
Shame/Guilt

Guilt
Developing
They Wouldn’t Use That Word
Short Treatment
For Almost Every Diagnosis

Sub-themes in italics

During the interviews with Ms. Fig, the predominant themes with (related sub-themes) were presented: Multiple Views of Shame (From the Outside; Insidious/Control; Self-Esteem /Identity; Shame/Guilt); Guilt; Developmentally; They Wouldn’t Use That Word; Short Treatment; and For Almost Every Diagnosis.

Multiple Views of Shame

This theme presents several of Ms. Fig’s views of shame. She talked about the qualities of shame and the effects that shame has on self-esteem, development, and identity formation. A discussion about the distinctions between shame and guilt follows.

From the Outside

Ms. Fig proposed that shame was externally imposed and inhibited growth in an individual. “I see shame as something somebody puts onto somebody else, that’s not reality-based and has no meaning for them and is not helpful for them, and it gets people really stuck.” She maintained that shame results when someone repeatedly blames an individual. “Shame—someone else tries to put guilt over them over and over and over again, and I think it becomes then shame-based where it’s not something that’s reality-based.” Because shame is imposed externally, Ms. Fig claimed that getting outside assistance was valuable in addressing experiences of shame. “I think to fully work through
a construct like shame, I think that you probably need some help. Once again, since it comes from the outside, I think that having help from the outside helps.”

**Insidious/Control**

Ms. Fig suggested that shame is a powerful, sinister, devastating, and enveloping feeling that is always harmful and needs to be removed from people’s lives. “I think that shame is insidious and is overwhelming. I think it’s not helpful for anyone, and I think that shame needs to be blasted out of people’s souls and people’s hearts.” She asserted that shame encased the soul in crushing sadness. “Shame is just, you know, a cocoon and you feel sad and overwhelmed. It’s a spirit, soul kind of thing, to me.” She contended that shame is something that is menacing, mean, all-encompassing and occurs within an individual. “I mean shame is internal, too, but shame is like an insidious, nasty virus kind of thing. It’s just pervasive.” Ms. Fig purported that the external imposition of shame on individuals left them with no control or choices to make.

(I)t’s (shame) truly usually something that’s put on somebody. You know, they have shame because they did something that they weren’t really in charge of, being able to control; they really didn’t have choices usually, with shame, is the way that I see it.

**Self-Esteem/Developing/Identity**

Ms. Fig asserted that shame has a negative impact on self-esteem, that shame becomes one’s identity. “Not a positive function, but a function. I think it (shame) inhibits people and lowers self-esteem, stops communication.” She further claimed that shame develops into an inherent element of a person’s self-concept. “Then they take it on as an intrinsic part of who they are and feel bad because they don’t talk about it.”
Ms Fig maintained that shame impacts identity formation negatively because this culture, in general, and more specifically, many families do not provide a supportive environment in which individuals can talk about shame and sort out who they are.

People really don’t talk about shameful things—that they’re not able to sort that out, and that’s what you do when you are going through identity issues, sort out, what’s you and what’s somebody else ... You’re not able to do that with shame.

Shame/ Guilt

Ms. Fig defined guilt as actions or behaviors that the conscience judges and from which one can grow and develop, while shame is something inflicted on an individual by someone else, something that one does not choose and thwarts development. “I see guilt as something that your conscience is telling you that you’re doing right or wrong. Shame—I don’t think you’re actually looking at it as a choice. It’s something that’s put on you by someone else.” She claimed that shame inhibits one’s growth whereas guilt advances one’s development. “(I)t’s (shame) not something that you really grow from or work from; whereas, guilt is something that you can grow from and work from.”

Guilt

This theme focuses on Ms. Fig’s ideas about the construct of guilt, its close connection to conscience and its association with resentment. Ms. Fig talked about guilt’s role in cultivating a conscience. She also declared that women feel more comfortable in expressing guilt than anger. She alleged that they mask their anger by cloaking it in the language of guilt.
(G)uilt does go strongly for developing a conscience, but I think that women tend to use guilt a lot as a crutch, as an escape. You know, “I feel guilty about this” ... when actually they’re probably pretty resentful, but it’s okay to feel guilty.

Ms. Fig discussed the hand and glove relationship of guilt and resentment. She affirmed that addressing one’s resentment aids an individual in dealing with one’s guilt. “One thing with guilt is that I see it as a coin, and however much guilt you have, if you flip that coin over, you have the same amount of resentment.” She emphasized the positive role guilt plays in motivating people to make changes and identify their boundaries and limits. “I think it’s (guilt) important because they can identify what they regret and make changes. With guilt, their conscience is ... letting them know that they’ve crossed over a line for themselves ... “

**Developing**

This theme explores how and when shame develops in an individual. Ms. Fig averred that shame developed in an individual because it had been imposed upon them, particularly when abuse had been inflicted upon them. “I think it (shame) develops because other people have pressed them to feel shame. ... emotional abuse, things like that. I think that people use it as a tool and try to push people into feeling shame ...” She averred that shame thwarts one’s development. “... (Shame) really intrudes on your developing who you are ... then they’re going to be stuck at a stage that’s inappropriate for their age. They are not going to have done the tasks that they need to do ...”

She asserted that shame develops in early childhood. “Well, developmentally, what does Erikson say, ‘shame and doubt’ ... It’s like when you’re 3 to 5 or something, toilet-training time.” She acknowledged that shame could develop later than childhood but
maintained that children have a susceptibility to shame. She asserted that each stage of
development presented an opportunity for the rise of shame. “I think that it (shame) can
develop from then on, but I think that children can have a propensity at that point. ... I
mean I think that you can turn a lot of those developmental tasks into shame-based
thinking.” She said that guilt emerged later than shame in development. “I think that that’s
what makes it so core. That’s way before guilt. I mean real guilt doesn’t really happen until
6 to 9 years old ...”

**They Wouldn’t Use That Word**

This theme presents Ms. Fig’s observation that “shame” is not a word that is
commonly used by her clients, that they use other words that indicate the presence of
shame.

They wouldn’t use that word. ... (G)uilt is more just a word that people use a lot ...
“shame” is a real powerful word, and I don’t think that people really will come in
initially using a word like that unless they’ve heard somebody else say it to them ...

Ms. Fig stated, “(T)hey talk about guilt, but they won’t talk much about shameful
things.” She asserted that clients use the terms of “guilt” and “shame” interchangeably and
talked about the value of uncovering what they mean.

I think that they’re (guilt and shame) two separate entities, but I think that they get
confused. I think that people interchange words and don’t really necessarily define
the word in the same way that maybe I would so it’s important to clarify when
someone uses one of those words, what they’re actually talking about.
She talked about assessing for shame by attending to the language that clients use.

Well, words that they use, situations that they give that you could anticipate that that may be a piece of it, ... to see that they may use words like “guilt,” or “sad,” “hurt,” “abused,” and you just would try to figure out if that’s a piece of it ...

Short Treatment

This theme explores the notion that shame would be much more likely to be addressed in long-term treatment as opposed to the short-term treatment that Ms. Fig normally provides. Ms. Fig said that, of her clientele, she observed shame in “20 or 30 per cent which is pretty much when you consider 3 to 6 sessions. She went on to say, “(I)f you had people who their treatment modality incorporated 20 or more sessions, that should be very high, the percentage that would use shame or guilt as a piece of counseling ...” She avowed that shame would be addressed in a long-term model of counseling. “I would say it would be close to a 100% if you were on a long-term model kind of thing; whereas, on a short-term model, ... you’re not going there to ‘so how did your mother treat you?’” She declared that with short-term treatment, presenting problems may be the only issues that there is time for. “When people come in for short treatment, they may come and they may be feeling shame, but what they really want to address is ... their conflict with a kid ... you just don’t go necessarily more places ...”

For Almost Every Diagnosis

This theme presents specific diagnoses or problems that Ms. Fig associates with shame and her view that shame could play a role in almost any diagnosis. Ms. Fig stated, “I do find that shame and guilt are really important when you’re dealing with codependency issues, when you deal with substance abuse issues, when you deal with domestic violence,
when you deal with incest and physical abuse, molestation.” Ms. Fig noted the connection
between shame and trauma, shame and anxiety disorders, and shame and depression. “I
think that frequently when people have been traumatized that they may have a sense of
shame ... Sometimes some anxiety disorders, certainly some depression, difficulty adjusting
because they may not be quite as resilient.” She went on to say that shame could play a role
in almost any disorder. “I see that it could be for almost every diagnosis, have a bearing on
that diagnosis in a particular client.”

**Fig Summary**

This section covered the following themes: Multiple Views of Shame; Developmentally; They Wouldn’t Use That Word; Short Treatment; and For Almost Every Diagnosis. Different characteristics of shame were discussed, as well as the impact of
shame on identity and development. A discourse on clients’ use of the word “shame” and a
discourse on the connection between shame and a variety of psychological disorders were
presented. Ms. Fig also talked about the distinction between shame and guilt and discussed
the relationship between guilt and resentment.

**Interpretation**

Although Ms. Fig could recall having no training about the construct of shame or
seeing anything in the literature, she had some definite ideas about it. Her thinking about
the construct of shame seems to have come from her clinical experience and perhaps from
reading in the general counseling field. It is clear that whether or not she received any
training about the construct of shame, she had constructed for herself a theory about shame.
From her statements about people not having a supportive environment in which to talk
about shame, one could surmise that she would attempt to provide a safe place in which to
talk about shame in therapy sessions. However, because she normally provides short-term treatment, she would most likely address shame only if the client presented it as an issue.

**Mr. Fir (Participant # 5)**

Mr. Fir has been working as a counselor for over 25 years. In addition to being a licensed professional counselor, he is also a licensed marriage and family therapist. He reported that his formal education included a master’s degree in counseling, a specialist degree in marriage and family counseling, and an Ed.D. in counseling. Mr. Fir believed in being trained in many different theories. His approach, he stated, was influenced primarily by family systems theory, particularly by the work of Virginia Satir, and by Elisabeth Kubler-Ross, who focused on issues of loss and transition. He had worked in the public arena ten years before he became licensed and then went into private practice in which he is currently engaged.

**Fir Themes**

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Sub-themes in italics

The predominant themes with (related sub-themes) that emerged in Mr. Fir’s interviews were: Multiple Views of Shame (Identity/Project My Image Onto Other People, Shame/Guilt, Our First Schools Are Our Families); It’s a Requirement (They’re Not Good Enough); The Mind, Body, & Spirit (Psychological & Emotional); We Start to Shame Our Clients; It’s Always There; Addressed (In Practice, Counseling Courses).
Multiple Views of Shame

This theme presents a definition of shame that Mr. Fir reported came from Claudia Black, who has written many books about chemical dependency. A discussion about how Virginia Satir, a noted family therapist, reportedly conceptualizes the impact of an individual’s negative self-thoughts on relationships takes place.

Identity /Project My Image Onto Other People

Mr. Fir said that he agreed with Claudia Black’s definition of shame. “Claudia Black says, ‘Shame is defined as feeling bad about who I am.’ So who I am is my identity.” He asserted that shame is one’s internal self-concept. “How I conceptualize about it is that shame is the internal, that is, how I feel about myself.” He also agreed with Satir’s reported formulation of how thoughts affect one’s relationships with others.

Satir would say it this way, “How I think about myself, if it’s negative, affects how I think about other people, which we would call projection. If I have a negative concept, it’s likely that I’m going to find frequently negativity, limitations, shortcomings in others and sort of project my image onto other people. ...

Shame/ Guilt

Mr. Fir stated that there are distinctions between shame and guilt but also recognized that they usually show up together, guilt as the external expression of the shame within an individual. He claimed that guilt is related to actions or behaviors; whereas, shame is connected to one’s identity, feeling bad about whom one is. “Guilt is feeling bad about something that I’ve done. Shame is feeling bad about who I am so it goes to the person’s identity, to their self-concept.” He also purported that there was a relationship between guilt and shame and that they probably existed together. “(I)f the person is expressing guilt,
they also have unresolved issues of shame. I think more typically you will find them
together.” He saw the person’s expression of guilt as an indicator the shame that the person
feels inside. “But guilt is more the external expression of what’s going on internally. The
shame would be more internal.”

Our First Schools Are Our Families

Mr. Fir declared that shame develops in one’s family of origin, and asserted that
parents do not receive the training that would help them to rear children. “I think our first
schools are our families. (P)arents do the best they can do, but in all fairness to them, they
don’t get any training.” He believed that families sometimes unintentionally convey to their
members that they are loved only if the live up to the family’s expectations. This suggests
that if a child fails to live up to her parents’ expectations, she would tend to feel inadequate
and unlovable, characteristics associated with shame. “Many families, without realizing it,
practice conditional loving; ‘I will love you if you make good grades.’” He further asserted
that people operate in their created families as they were taught to operate in their families
of origin. This implies that people unintentionally contribute to their children’s
development of shame by parenting like their own parents. “People do what they know.
That’s what’s been taught to them. That’s what they’ve experienced.”

It’s a Requirement

Mr. Fir stated that addressing shame is essential in counseling, that counseling cannot
be nearly as effective unless shame is addressed. “Again, my position is that it’s essential to
deal with that issue. It’s not an elective; it’s a requirement in order to do effective work
with clients.” He asserted that shame keeps people stuck, repeating the same destructive
behaviors. Therefore, he remarked that it was an absolute necessity that shame be
addressed in counseling. "I think it's essential. ... I think shame functions to keep people stuck in what they're in, when people will just keep repeating the same patterns over and over and over again."

**They're Not Good Enough**

Mr. Fir emphasized that people seek counseling because of shame, because they feel inadequate in some way. He noted research that supported his opinion.

I think the research shows that the reason, using meta-analysis ... these literally hundreds, if not thousands of studies, what they found out is this-- most people go to therapy because they feel, for one reason or another, they’re not good enough, and therein, that’s shame, that’s my definition of shame, actually.

**The Mind, Body, and Spirit**

Mr. Fir maintained that there was a link between shame and most psychological and emotional problems.

**Psychological & Emotional**

When asked if there was a connection between shame and psychological disorders, Mr. Fir stated that there was a link between shame and the way people think as well as shame and emotions. "In terms of psychological, if that means mind or how we think or our beliefs, yes, and for other theories that support emotions, I would say yes also." He discussed the systems perspective of human behavior, the idea that if an individual changes her emotions, then the mind is affected and visa versa. "It (shame) would create emotional disturbance as well, ... because even though we separate the mind, body, and spirit, they're actually not." He proposed that from a systems perspective, when one part changes, the
other parts change as well. “If you change one part, you’re affecting the other parts, which is also what systems people talk about.”

An association between shame and most compulsive and addictive behaviors was noted by Mr. Fir. He also asserted that shame is linked to depression and anxiety. “Like compulsive overeating, for example. Like chronic overachieving. We’re back into sort of the compulsions or addictions, and most of those, if not all, are shame-based.” He said that shame is connected to depression. “I think many times depression has to do with how I see and how I feel about myself, sort of that chronic sadness, worthlessness.” He declared that shame is related to anxiety. “I think the other thing as to how it (shame) will manifest is ...as anxiety ...” Mr. Fir said that shame was involved in most disorders that are not physical or biological. “I would bet you in any of the nonbiological ... any of the nonmedical, nonphysical, I bet you shame is inherent in the struggle.”

We Start to Shame Our Clients

Mr. Fir suggested that counselors could shame their clients unintentionally with countertransference operating in the session or on the other end, with clients transferring feelings about their parents to counselors. He claimed that the pathological or medical model of counseling is inherently shaming because it indicates to clients that there is something wrong with them.

One of Mr. Fir’s assertions was that counselors inadvertently shame clients. “I think therapists actually shame people without meaning to.” He said that the shaming occurs as a result of a reaction to negative feedback from clients.
And so if we start to shame our clients, first of all, I think we’re starting to get into countertransference stuff probably. You know, if you’re not a good client, then I’m not a good therapist so I don’t like that and now I don’t like you.

He further proposed that perhaps clients expect to be shamed by counselors because counselors serve in some ways as surrogate parents, who may have shamed them.

“(C)lients actually expect to be shamed by their therapist because I think there is a part of therapy that actually is a reparenting process.” He also emphasized that the medical or pathology model in which people’s problems are pathologized are shaming to clients. “I think the pathology model can be shaming. You know, there’s something wrong with you; you’re sick.”

It’s Always There

Mr. Fir stated that he saw shame in varying degrees in all his clients. He said that he assessed for shame by observing clients’ nonverbal behaviors and attending to the issues they bring into the session. He also remarked that he paid attention to the symptoms they presented and how they talked about themselves.

Mr. Fir said that all of his clients have experienced shame to some extent and that he tries to be attuned to the presence of shame in them. “Always. 100%. ... I think it’s always there. I think from client to client, it really can vary substantially in degree or intensity.”

Mr. Fir remarked that he assessed for shame in his clients. “Nonverbally, by how they present, whether they actually make eye contact, actually make connection with you.” He stated that he was attentive to his clients’ body language, presenting issues, and how they behaved toward themselves.
The body will tend to give out information about if the person doesn't feel good about her or himself. ... their presenting issues and the symptoms, like depression or anxiety, compulsive behavior, or ... how they behave in the session, particularly how they act toward themselves when they report what goes on.

Another statement by Mr. Fir indicated that he shies away from using the word “shame” to identify shame in his clients because of his concern that his clients will attach a label to themselves. “I acknowledge it without naming it, without labeling it.” Instead he maintained that he explores feelings by asking open-ended questions. “I do emotions as opposed to labels like diagnostic kind of stuff like ... ‘You are bipolar; you are depressed’ ... Opposed to that, it’s ... ‘What are you feeling?’”

Addressed

In Practice

Mr. Fir declared that the construct of shame emerged in the counseling field via the chemical dependency arena. “I think a better understanding of focusing on that construct came out of the work around chemical dependency issues ... There’s lots of shame for the addictive person and for significant others of the addictive person.” He purported that counselors in the field are well acquainted with the construct of shame and address shame experiences with their clients. “(P)eople who are actually meeting with clients, doing therapy day to day, yes, this is very much a topic that is considered in in-service training, in supervision.”

He asserted that academicians are less likely to be familiar with the construct of shame because they do not practice counseling, and therefore, do not see it in clients. “(M)aybe because most academicians don’t actually practice ... it has more to do with actually being
in the sessions. He remarked that practicing counselors usually do not do research and have it published in the counseling literature. “A lot of practitioners also don’t write or do research.” Mr. Fir said that he learned about shame from seeing it and exploring it with his clients. “I would say my clients have been my best teachers about the concept, the reality, and the importance of addressing issues of shame in therapy.” He said that he also read about it in the chemical dependency literature and attended workshops. “It was through reading and workshops ... that I became more consciously aware of the construct of shame and actually confronting that in therapy.”

**Counseling Courses**

Mr. Fir affirmed that the construct of shame was addressed in family counseling classes, particularly in discussions about families in which chemical dependency was a problem. He stated that in other counseling courses shame was not addressed. Mr. Fir stressed that the construct of shame should be focused on in graduate counseling classes, and that greater emphasis should be placed upon the person of the counselor, what is going on with the counselor during sessions. He suggested that a counselor should be aware of what her or his own shame issues are. He also proposed that rigid boundaries result in a counselor who is less effective.

Another statement made by Mr. Fir indicated that the construct of shame was not covered in the general counseling courses in his graduate programs, but was presented in the family counseling courses. “The concept of shame was brought up, particularly in the courses having to do specifically with family therapy. ... particularly when you’re dealing with chemically dependent families. ... in other courses, more standard kind of counseling courses, no.”
He stated that the construct of shame should be emphasized in graduate counseling programs. “I think it (shame) should be in the central part of any graduate training program, and I don’t think it can be overemphasized.” Mr. Fir recommended that the person of the counselor should be the focus of training and supervision. “I think through formal focus in formal training and certainly in supervision, and supervision really needs to focus on the counselor as opposed to the client.” Mr. Fir averred that working on one’s own shame issues is essential in order to be a good therapist. “How do we deal with our own issues of shame, I think, is integral to being an effective helper.”

**Fir Summary**

This section covered the following themes: Multiple Views of Shame; It’s a Requirement; The Mind, Body, & Spirit; We Start to Shame Our Clients; It’s Always There; and Addressed. A discussion about the impact of shame on identity and behavior and a discourse on the distinction between shame and guilt were presented. Mr. Fir talked about the psychological disorders associated with shame and the attention that the construct of shame receives in the counseling field. Other topics of discussion included why people seek counseling and how counselors sometimes inadvertently shame clients.

**Interpretation**

Mr. Fir had strong opinions about the value of the construct of shame. The populations (HIV-infected persons, gays, lesbians, addicts) that he saw in his practice probably influenced his view of shame. He appeared to assess for shame with every client and saw shame in all his clients in varying degrees. He deemed the construct of shame to be an essential counseling construct and asserted that counseling would be much less effective, if shame were not addressed. His understanding of shame was that it was closely linked to
one’s self-concept, that it impacted negatively on one’s behavior and relationships, and that it developed during childhood in families. He also held strong views about the lack of training about parenting and building healthy relationships. Without such training, he asserted that poor parenting that encourages the development of shame, continues from generation to generation. In addition, he seemed to feel that shame is being addressed by practitioners because they are seeing it in their clients daily whereas shame is not being addressed in the literature because academicians, the ones who do the research and writing, are not quite as aware of its presence. Personally, I find it hard to criticize Mr. Fir because he so enthusiastically embraced the construct of shame that I also earnestly maintain, but his endorsement of the construct seemed rather exuberant particularly when he talked about the meta-analysis on shame and the thousands of studies stating that the reason people seek counseling is because they feel inadequate.

Ms. Gum (Participant #6)

Ms. Gum was a licensed professional counselor, with a master’s degree in counseling. She was also a substance abuse specialist. She was certified to teach English, French, and public speaking. She had also been in two doctoral programs, one in school administration and one in gerontology. She began her work career as a teacher and also served as a school counselor. She identified her approach as eclectic. She has been in the counseling field for about 30 years and been licensed for 17 years. She is currently in private practice.

Gum Themes

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Sub-themes in italics
The predominant themes with *(related sub-themes)* that emerged from the interviews with Ms. Gum were: Multiple Views of Shame *(Shame/Guilt; In Early Childhood)*; Therapists; The Underpinnings of Counseling; and Clients.

**Multiple Views of Shame**

This theme presents Ms. Gum’s different ideas about her perspective of shame. A discussion about shame becoming addictive as well as a discourse on locus of control occurred. She talked about the distinction between shame and guilt and the development of shame in childhood.

Ms. Gum said that shame is “equivalent to cancer of the soul.” She stated, “Some clients get addicted to the shame. They don’t want to let it go because then in some ways, they would have no reason for not changing.” She suggested that the healing of shame come from outside assistance, either earthly or heavenly. “Shame I know means you’ve done something terrible. You cannot change it, and the only way it’s going to get better is if somebody rescues you or somehow you’re given grace ...” She proposed that shame can be self-initiated. “(S)hame also can be self-inflicted by not living up to your own expectations. ...Mainly it’s that they’re not living up to what they think according to their culture and experiences ...” She talked about the power of shame and how it informs people of their imperfection. “Shame is an emotion like guilt, especially because it affects our sense of guilt by letting us know that we are imperfect. Shame is extremely powerful.”

**Shame/Guilt**

Several distinctions between shame and guilt were made by Ms. Gum. She associated guilt with actions and shame with self-concept. “Guilt is a lot of times through action, what you do. Shame is who you are and what you lack.” She talked about shame having no
usefulness whatsoever. "I don’t think shame is useful at any point in time." She contended that guilt served a purpose. She proposed that guilt fosters responsibility. "I need to feel guilt. Sometimes, if I didn’t have guilt, I wouldn’t get out of bed, and get up and go to work or clean the house. It’s taking responsibility." She discussed the external nature of shame and the internal nature of guilt. "Shame, you know, you can’t fix it; somebody else has got to do it so it’s external locus of control. Now, guilt is, if you want to get clinical, we can say internal locus of control."

Ms. Gum also noted the vulnerability of people with shame. "And it (shame) makes them very vulnerable because they cannot get their own reward by themselves. They need it from outside of themselves. Locus of control type." She also stated that shame and guilt fuse because people confuse the two terms. "I guess (shame and guilt) merge because people can’t tell the difference. You have to define it for each one." She asserted that guilt could be positive. "I see guilt in its purest form as good because you take a look at your behavior. You take responsibility, and then you make a positive change. It’s in your court. You get to decide." She suggested that when clients use the word “guilty,” they might mean “angry.”

A lot of times I suggest to clients to substitute the word “angry” for guilt. "I feel guilty that I’m not looking forward to my mother-in-law coming for Christmas. I’ll say, "Why don’t you try, ‘I’m angry,’ and then let’s talk about that.

In Early Childhood

One suggestion made by Ms. Gum was that the development of shame in early childhood is related to a child’s lack of defined boundaries as a factor in her letting in shame from the environment.
(Shame develops) in early childhood. I go back and talk about it. It begins so early.

"You’re going to be the death of me." ... Because, in my opinion, the external locus of control allows that shame is dumped or acquired as a child or either absorbed ...

She went on to talk about children carrying feelings such as shame that their parents did not acknowledge. Again, she contended that because children’s boundaries are permeable, they are susceptible to absorbing their parents’ feelings.

Carrying shame is another thing ... That’s when your parents did not own their feelings ... a child will take on those feelings, and a child can handle their feelings; however, they can’t handle their feelings and their parents, especially when they sell out to their parents’ reality, and ... "You’re such a bad girl." ... children don’t really have the ability to put up firm boundaries until at least 9 or 10.

Therapists

She alleged that therapists who have not explored their own experiences of shame are prone to bringing them into therapy either through avoidance or projection.

(E)specially young therapists, and sometimes old therapists who have never dealt with their core issues will bring their matters of shame into the therapy session either by avoiding issues that are right in front of them or by creating issues that may be some projection of the therapist.

Ms. Gum went on to say, "(A) lot of therapists don’t do their own unfinished business, and they don’t want to go there." She said that there are some counselors who use therapy sessions with their clients to work through their own issues. "There are good counselors who work through their issues; there are counselors that use their therapy to get themselves well." Ms. Gum asserted,
If anyone, especially a client says something that agitates you or you ponder on more than 15 seconds, it's your issue, not the client's, and you have to get into the back room and do your business, unfinished business so that you can clarify what is going on with you so you don't dump it on the client.

She discussed the possibility that counselors could unintentionally shame their clients. I think one of the main places it's (counselors inadvertently shaming their clients) been done is in the substance abuse field. “Oh my goodness. You’ve gone off the wagon again. You’ve had a slip. If you would just don't drink and go to the meetings, it would be all right. There’s something wrong with you ...

She expressed strongly that there had been problems in the substance abuse field with counselors having dual relationships with clients and shaming clients. “(T)here’s almost like a lot of emotional incest in the substance abuse field because the therapist would go to the meetings and then be a therapist with the people, just shame clients, badger clients into seeing me, and that has done a lot of real harm to clients.”

The Underpinnings of Most of Counseling

The notion that shame is the basis of most counseling was discussed by Ms. Gum. “I think the issue of shame is the underpinnings of most of counseling, or the lack of shame, and the defenses of shame.” Ms. Gum argued that shame could conceivably be linked to every psychological disorder and problem. “(Everything in the DSM-IV plus everything else) could have an element of shame, yes.” She reiterated, “I imagine you could put it on every single one, attention deficit to leaning to having an illness that costs the family.”
She mentioned a variety of specific disorders and problems. "Well, I think that it can be in anxiety; I think it can also in depression." She went on, "And beyond that, I mean if you're getting into those obsessive, compulsive, anxiety, they just sort of overlap."

Ms. Gum talked specifically about the connection between shame and sexual abuse. "The client has to learn to separate the shame that her body responded to the sexual abuse positively from the fact that her body was responding naturally, and the shame is not hers." She mentioned codependence and sex addiction. "I do think that shame is the undercoating of codependence, which then leads into love and sex addiction." She also talked about self-help people in the addictions field shaming those who took medication for depression. "Although a person who's clinically depressed and has been self-medicating and also has alcohol dependence diagnosis has been shamed by some self-help people by ‘Don’t drink and go to meetings. I did it the hard way.’"

Clients

Ms. Gum affirmed that most, if not all, of her clients have shame issues. "That’s a very hard question because I truly believe that most of my clients come in with a big shame issue." She further asserted that all of her clients have had something about themselves for which they are ashamed. "I think that if you do enough therapy with enough people, they have some part of their character that feels ashamed." She reiterated, "100% (of clients have shame). Everybody has an ugly side of their rock; it’s got to be on the ground somewhere." She talked about how clients exhibited that they may be experiencing shame in the session. "Simply by the way they talk and their body language and if they don’t give you good eye contact. If I establish a rapport, they’ll tell me ..."
She discussed how clients talk about shame in sessions.

(When clients have a sense of shame, they say), “I feel bad about myself.” Oh yeah. And “I’m depressed,” or “I’m anxious,” and “I’m not living up to what I think I ought to do,” or “I’m just a bad person ...”

**Gum Summary**

The following themes were covered in this section: Multiple Views of Shame; Therapists; The Underpinnings of Most Counseling; and Clients. A discussion about Ms. Gum’s view of shame and the distinctions between guilt and shame took place. When and how shame develops was discussed. Ms. Gum talked about how important it is for counselors to know themselves, particularly their issues around shame. A discourse on how clients express shame was presented.

**Interpretation**

Ms. Gum definitely seemed to think that shame was an important construct that counselors should attend to, as reflected in her statements that “100%” of her clients have shame issues and that everything in the DSM-IV plus everything else “could have an element of shame.” She predicted that if counselors did not pay attention to their own shame issues, that they would show up in their counseling sessions, either in the form of avoiding their clients’ shame experiences or projecting their own shame issues onto their clients. From my perspective, it was clear that she had a good deal of interest in the construct of shame and had done some reading and attended workshops on it. Her basic understanding of shame was that it was something evil, “equivalent to cancer of the soul.” She talked briefly about both the positive and negative role that religion could play either in fostering shame or in healing it. She appeared to have some negative feelings about things
that had occurred in the substance abuse field, for example, when she talked about how “some self-help people” shamed individuals and when she asserted that “one of the main places” shaming has been done “in the substance abuse field.”

**Ms. Hickory (Participant #7)**

Ms. Hickory was a licensed professional counselor and a licensed marriage and family therapist. She taught school for a number of years, obtained a master’s degree in teaching emotionally disturbed children. While she was still working as a teacher for emotionally disturbed children, she went back to school for her master’s degree in counseling and became a school counselor. She continued her education in the counseling doctoral program, became licensed, retired from the school system, and opened her practice. A couple of years later she obtained her Ed.D. She has been a counselor for 12 years and licensed for 8 years. Ms. Macon’s primary framework was cognitive-behavioral theory, but she also used techniques from other approaches. She is currently in private practice.

**Hickory Themes**

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From the interviews with Ms. Hickory, the following predominant themes with (related sub-themes) emerged: Externally Imposed; Multiple Views of Shame (Intensive/Pervasive, Childhood, A Useful Shame/Identity/Conscience); and Attention (A Charismatic Spokesperson; Counseling Programs/Materials/Counselors; and What You Expect To See).
Externally Imposed

In this section, Ms. Hickory presents her definition of shame and her concern that a definition of shame was not provided to her by the researcher. The distinctions between shame and guilt are discussed. Throughout the two interviews Ms. Hickory repeatedly referred to her definition of shame. "I think that feelings of shame are externally imposed, that someone outside of me has made me feel that I have fallen short in some way, that I am inadequate in some way." The aspect of its being something that is externally imposed upon an individual was cited in many of her responses. "(S)hame develops when the individual perceives disapproval from someone else because I’m defining it as something that’s externally imposed."

Ms. Hickory stated that she would have been more comfortable if I had provided a definition of shame based on the literature. "I think I would have been more comfortable with a literature-based definition, to which I could have responded positively or negatively, supplementing it with my own ideas." She expressed concern about the results of this study because she thought that it might seem that the participants are agreeing when they really are not because they all are defining shame in different ways.

Every question in your interview has a different meaning to each subject, because of the unique meaning each of us attaches to the word “shame.” You may find that this will make summarizing results or drawing conclusions a more daunting task. She questioned whether shame should be defined so broadly as feeling inadequate. "Are we saying that feeling inadequate is the same as shame? I don’t know. If we were going to define it that broadly, then maybe." Ms. Hickory argued that vocabulary was a problem. "I
do think that a lot of what we're talking about is terminology, that the construct you're
talking about, you may call it shame. I may call it something else.”

Ms. Hickory talked about distinctions between shame and guilt. She stated, “Shame, to
me, is the feeling that one has fallen short or failed in some profound way. Guilt, to me, is
more connected with an act of commission or omission, an action, something that I have
done or not done.” She asserted that, with guilt, individuals feel they can make amends. “I
think guilt is more likely to make them feel that they have to do something to make up for
it.” She also maintained that shame was something that is learned and externally imposed
on a person by others whereas guilt was an intrinsic part of a person. “I think shame is
something that’s learned and comes from the environment, that guilt probably is something
that all nonpathological personalities feels. ... (S)hame is externally imposed, and guilt is
internal.”

Multiple Views of Shame

This theme presents several of Ms. Hickory’s views, including her view of how and
when shame tends to develop in an individual. She spoke also about the lack of connection
between shame and any psychological disorders. The impact that shame could have on
identity and conscience, as well as the useful role shame plays in deterring deleterious
behavior is discussed. This section contains the following sub-themes: Intensive/Pervasive;
Childhood; and A Useful Shame/Identity/Conscience.

Intensive/Pervasive

Ms. Hickory claimed that destructive shame occurs only if it is of some duration,
frequency, and intensity. “... I would think that it would have to be intensive, pervasive,
over a long period of time, these feelings would have to be imposed in order for them to
have any great effect on the person." When asked, "Are there specific psychological disorders connected to shame," she replied, "I wouldn't see a specific psychological disorder arising because of shame imposed from someone else. I wouldn't see that."

**Childhood**

Ms. Hickory surmised that shame is more likely to happen during childhood but conceded that it could occur at any time during one's life. "It can happen at any point, but I would conjecture would be more likely to begin in childhood or adolescence ... The person who could never please the parent." She further declared that if an individual had absorbed shame at an early age, it would be a problem to free himself of it. "Probably ... more likely to happen with children and young people and then carried over into adult life, and once that feeling has been inculcated, it'd be very difficult to get rid of it."

**A Useful Shame/Identity/Conscience**

Ms. Hickory speculated that shame could impact a person's behavior, identity, and conscience.

(W)hat I conjectured was that the more active person feeling shame would struggle to overcome those feelings. ... I think she'll always be struggling to prove herself if she's one type of person or she will just give up and think that she isn't worth anyone's attention if she takes a more passive approach.

Ms. Hickory proposed that shame could serve a useful purpose in deterring detrimental behavior. "(I)f I'm a child and I steal something at the store and I receive the strong disapproval of my parent ... I might experience a useful shame. A useful shame would be a deterrent to repeating a harmful act or something that would be hurtful to me or to someone else." Ms. Hickory presumed that shame could have an impact on identity formation as
well as the development of conscience. “If I perceive that other people are disapproving of me ... not just of my act but of me, then, yeah, I think it could well affect your identity formation, how you view yourself.” Ms. Hickory postulated that shame would affect development of one’s conscience. “Well, theoretically, because our conscience tends to develop... in response to the rules of the world ... I guess if could and would have an effect on the development of conscience, theoretically.”

Attention

In this theme, Ms. Hickory discussed the amount of attention shame receives in the counseling field. Attention given to shame in counselor education programs and in the literature was discussed. Ms. Hickory talked about her lack of encountering shame in her clients or coming across it as a topic of discussion with colleagues.

A Charismatic Spokesperson

Ms. Hickory conjectured that the reason that the construct of shame had not received much attention in the counseling field was because it did not have a compelling representative or simply because it was not a legitimate construct and did not deserve more attention.

Perhaps because it hasn’t had a charismatic spokesperson. ... other theories and concepts in counseling, there’s usually a name that you connect with ... like Glasser.

Either that or it just isn’t that valid or it doesn’t deserve any more attention ...

Counseling Programs/Materials/Counselors

Ms. Hickory said that she could not recall the construct of shame being taught in her graduate programs. She went on to say that one is usually exposed to the ideas that the faculty members are championing. “Absolutely none. But you’ve got to remember that that
was 10 years ago. And you tend ... to be exposed to the ones that your faculty are espousing." She stated that there is so much material to cover in counseling programs that it’s difficult to cover every concept. “It’s very hard in counselor ed. to—there’s so much that needs to be covered, that it’s very difficult to cover every issue, every aspect.” She also asserted that the construct of shame was one that was perhaps currently the fad. “I think it’s (the construct of shame) a little trendy.”

Ms. Hickory stated that shame is not a construct that she has seen in the literature. “I will say I do read counseling materials, and in the period since I’ve seen you, I haven’t seen any articles on shame.” Mr. Hickory also had said that the construct of shame has not emerged in her several conversations about cases with other counselors. “...I’ve had many discussions with counselors and counselor ed. people since the time I was in school. That issue has never come up. Never.”

*What You Expect To See*

Ms. Hickory talked about what she saw in her own practice with clients. She claimed that she had not seen clients who experienced chronic shame in her practice. “... I’m trying to think of an example of someone who was experiencing shame according to my definition of shame, something that had really been externally imposed. I can’t think of one at the moment.” She said that if the client talked about feeling hopeless and inadequate, she would make the assessment of depression. “If someone comes in and talks about feeling hopeless and inadequate and whatever your other word was, I’m thinking this person is depressed because they would be standard symptoms of depression.” She also would not be inclined to talk about a client’s childhood. “Because therapy has to be brief, I’m not likely to go back and dig into childhood experiences.”
Ms. Hickory asserted that counselors who subscribe to the construct of shame might promote a victim attitude in their clients.

“(W)hat you’re describing is the out that many people use, “I am a victim. I am a victim because of the shame that was imposed on me when I was a child growing up.” And I do not encourage the victim stance for people.

She implied that a counselor would be more likely to see shame in a client if that was her expectation. “I think it’s important to keep emphasizing you see what—I don’t want to say you see what you want to see. ... You see what you expect to see, in a sense.”

**Hickory Summary**

The themes that were covered in this section included Externally Imposed, Multiple Views of Shame, and Attention. Of particular note was Ms. Hickory’s definition of shame as well as her concern that shame would be defined differently by participants, making it difficult to draw conclusions about the construct of shame. Her view of how and when shame develops in an individual and her thoughts about the useful role that shame plays were topics of discourse. Why shame does not receive much attention in the counseling field was another interesting idea that was discussed.

**Interpretation**

Ms. Hickory seemed to strongly dismiss the construct of shame as an important counseling construct, or, indeed, as a construct at all. Her thinking seemed fairly concrete as demonstrated by her reasoning that shame is not an issue for her clients because they do not use the word “shame.” She did, at times, particularly toward the end of the second interview, acknowledge that semantics or vocabulary was a factor in her dismissal of the construct of shame. She seemed quite attached to her definition of shame, that it is
“externally imposed.” Her discomfort in my not providing a definition for shame further supported her desire for precision and exactness. The definition or lack of definition for shame seemed to be a problem for her. Although she used the word “inadequate” at two different times when she was defining shame, Ms. Hickory later questioned that shame should be defined as broadly as “feeling inadequate.” Although she questioned the reality of a construct called shame, she stated that shame probably had an impact on behavior, identity, and the development of conscience. Her assertions about the influence shame has over these aspects of human beings were most likely tentative because she could not quite bring herself to believe that such a construct as “shame” exists. She also seemed concerned that the construct of shame could be used in a way that is not helpful to clients, perhaps as a way of not taking responsibility or ownership of their lives or problems.

Mr. Maple (Participant #8)

Mr. Maple reported that he has a bachelor’s degree and a master’s degree in psychology, and an Ed.S. degree in counseling. He also has had extensive training in a variety of therapies and techniques, including psychosynthesis, hypnotherapy, altered states of consciousness, and outdoor survival skills. He has had training in working with drug abuse, alcoholism, and sex abuse perpetrators and victims. In addition to being a licensed professional counselor, Mr. Maple was a licensed marriage and family therapist and a diplomate in clinical hypnotherapy by the National Board of Certified Clinical Hypnotherapists. He has been in the field of counseling for over 28 years, and has been licensed for 10 years.
Maple Themes

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Sub-themes in italics

The predominant themes with (related sub-themes) presented in Mr. Maple’s interviews were: Abuse; Psychosynthesis; Self-Development; Multiple Views of Shame; Psychological Problems; Socialization; and It’s Not That Common (Clients, Counselors, Managed Care, Training).

Abuse

This theme presents the connection between trauma, particularly sexual abuse suffered at an early age, and shame. Mr. Maple also talked about the connection between childhood sexual abuse and mental disorders. Perspectives on substance abuse and shame were explored.

Mr. Maple proposed that shame resulted from trauma or abuse, physical, emotional, but often sexual abuse, usually inflicted at an early age. “I think whenever there’s abuse, whether that’s sexual, physical, verbal, or mental, shame is the unholy byproduct of abuse of some kind.” He maintained that children tend to take responsibility for what happens to them and believe that they are the cause of the abuse and feel ashamed. “Children, the way the psyche develops, we take responsibility for, we assume we are the reason for, the cause of what’s outside of us. ... ‘I’m the cause of or it’s my fault that I was molested or abused, and I’m ashamed about that.’”
Mr. Maple claimed that when children are repeatedly blamed or shamed for what happens in the outside world, they are inclined to internalize the shame and feel that there is something wrong or bad about them. “Feeling responsible for the negative energies in the outside world and also at the level of introjection, I think that introjections, the blaming and shaming from the outside gets internalized.” He asserted that shame is an issue when there has been abuse of any kind. “I will say unequivocally that whenever I have ever worked with abuse victims, physical, sexual, mental, emotional, then if I have the time to do a true therapy, there will be a journey into the dynamics of shame.”

Mr. Maple contended that shame was linked with those who had suffered sexual abuse as a child or grown up in families where alcoholism was present. “We look at wounds to ego, and the lack of development or the perversions of capacity that result from often sexual abuse, but equally substance abuse, alcoholism. ... these are the two great woundings that occur.” He stressed that in his work with sexual abuse survivors, shame has been an issue that he has addressed. “Shame is so key to the experience of survivors of childhood sexual abuse. .... With these clients, the issue of shame, it’s always one of the steps of the journey of healing and of redemption.”

Because sexual abuse is so pervasive, he said that all counselors would have sex abuse survivors as clients. “Anybody in counseling is going to run in to survivors of sexual abuse because it’s so pervasive.” He further purported that the trauma of sexual abuse is linked to several mental disorders. “I have been startled to discover how pervasive early childhood abuse is and how it underlies so much of the major mental disorders, anxiety disorders, depression, recurrent depressions, panic disorders, eating disorders.”
Psychosynthesis

This theme discusses psychosynthesis, the lens through which Mr. Maple viewed the construct of shame. He also talked about techniques that he taught his clients to help them connect with their inner source of wisdom. “(O)ne of the primary goals of psychosynthesis is to align the personality with this function that we call the higher self…” He suggested that through this connection, inner conflicts could be resolved or transformed.

(0)nly through the effort to align with this center of love and will inside can we remediate ... conflicts, the necessary and inevitable conflicts in ego or identity formation and actualize the unique talents and the universal resources that exist in us.

Mr. Maple used a variety of methods to work with the unconscious mind; he also taught these techniques to his clients. “My job as a psychosynthesis practitioner is to use all these techniques and methods and experiences and retreats and whatever else to help the individual get in touch with their own wisdom.” His goal was to have the client identify with a deeper or higher consciousness than that of her or his own ego. Through this identification, inner conflicts can be worked out.

The challenge in my counseling practice is ... to orient that primary identity of a client to the deeper reaches of consciousness ... I employ: hypnotherapeutic techniques; mental imagery; visualization techniques; symbolic art; Mandela art; psychodramatic work ...

He emphasized that he did not promise resolution of trauma effects but rather taught a toolset that could be used by clients to get through crises and problems that emerge in life. “I need to teach them an approach to the ongoing living of their lives and not promise the resolution of those trauma effects because it’s a lifelong process.”

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Self-Development

This theme explores self-development, the reason that Mr. Maple reported he had for becoming involved in the counseling field. "The journey to self-discovery, self-development was primary and continues to be. I was interested in knowing who I am and what powers and resources I could develop about myself." He said that what he saw as the self-growth component of counseling attracted him to the field. "Practitioners are more or less trained in the universe of personal growth work and so I wanted that developmental process for myself so that took me on a path which ultimately led to counseling and psychotherapy." He discussed the value of knowing oneself and insisted that knowledge of oneself is connected to the development of empathy and the lack of self-knowledge and empathy is linked to the greater likelihood of a counselor shaming one's clients.

To be an excellent counselor, one has to be constantly working on oneself. ... If I have unresolved issues, ... it is highly more likely that I am going to be shaming people I interact with. ... Without self-knowledge, there can be no empathy or compassion. Without empathy and compassion, shame increasingly raises its ugly head in counseling or in human affairs.

Multiple Views Of Shame

This theme presents several of Mr. Maple's views on shame. A discussion about what contributes to the development of shame and what shame feels like takes place. Mr. Maple also talked about the impact that shame has on identity. He contended that shame is the internalization, at an unconscious level, of criticisms at an early age. "It is the incorporation at center of the negative values and judgments and criticisms that a child grows up with early, and get enfolded into the operating program of the personality at the level of the
unconscious." He stated, "Shame for me is self-doubt. ... betrayal, in early childhood, result(s) in self-doubt, in the lack of development of a strong center, in the development of self-esteem."

Mr. Maple thought that shame results from wounds to the ego without adequate support or nurturance in the environment. "Well, at a process level, I think shame is the result of the wounding of a normal ego development without nurturance and support on the outside to understand life experiences." He suggested that shame is alienating and confusing and results in a lack of self-love. "One begins to feel different from and separated from people around her or him. There's a wounding of the capacity for self-love. The result of the wounding is self-doubt. I think, 'I don't understand what's going on.'"

Mr. Maple stated that there was nothing positive about shame. He also asserted that shame is just beginning to emerge as a construct in the counseling field. "Shame, for me, is a shadow on the soul, a shadow on the self. It isn't anything that I would encourage or foster or try to celebrate or use. ... I think it's in its infancy in the counseling field.

Identity

Mr. Maple declared that those who suffer from toxic shame feel that they are bad and do not deserve to exist. "(T)he message of shame is that "I am no good, and I have no right to be here." ... I think shame has a tremendously negative impact on identity formation."

He said that shamed individuals feel unworthy and behave in self-destructive ways that support their notion of unworthiness.

Shame, for me, is a fundamental state of unworthiness, somehow. I am unworthy. I don't deserve to live, or my being in the world is a problem for other people. These
are fundamental identities. So then I do things in the world, and that’s evidence that I
am unworthy because I overeat, because I’m morbidly obese, because whatever ...
He alleged that shame is connected with the fear of not fitting in. He also proposed that
shame occurs when there is a discrepancy between what one believes about oneself and
what others believe about oneself. “There’s a fear of not fitting in, of not being a part of the
pack ... The greater the difference between my self-concept and what I want you to buy
probably describes shame ...”

Psychological Problems

The connection between shame and psychological problems is presented in this theme.

Although Mr. Maple insisted that the construct of shame couldn’t be applied to all
disorders, he went on to name a large array of disorders with which shame is linked.

I don’t think shame is a broad brush that we can slap on all psychological problems.

... I think shame plays a larger role in some disorders than in others—avoidant
disorder, probably adjustment disorders, social aversion disorder, to be sure, post-
traumatic stress disorder, generalized anxiety disorder, probably all the mood
disorders that aren’t biologically based ...

Mr. Maple also mentioned that addictions are associated with shame.

All addictions are an attempt at ... self-medication, self-nurturance. Why is one
needing that? Because one is at odds with one’s self, and why is that? Because the
developmental process has been messed with. ... Low or no self-esteem, no or low
self-confidence, poor self-concept, I think underlies addiction.
Socialization

The role that shame plays in the socialization process is explored in this theme. A discussion about how the lack of love and nurturance contributes to the presence of shame takes place. Mr. Maple maintained that shame is part of the socialization process for all human beings, and the culture has rules in order to regulate the primitive instincts. “The ego and the instincts and the primitive nature wants expression, and there’s a cultural socialization process ... In the boundary there between primitive instinct and enculturation, there are feelings of shame or being ashamed. “I am different than.”

Mr. Maple averred that the absence of love and nurturance in the environment is a breeding ground for shame. “The deep debilitating experience of shame occurs when love is absent in the process.” He suggested that the natural impulse to achieve becomes twisted, as do the primitive instincts when an individual is not supported. He stated that the result is perversion and secrets because the individual connects shame to these impulses.

In the absence of that nurturance and loving support, ... there is a wounding of the instinctive and natural impulses, and along with shame, then comes deviance and secrets and perversion of a natural process of unfoldment because the primitive instincts need and will be expressed somehow ...

It’s Not That Common

This theme included a discussion of a variety of factors that contribute to shame not being addressed in the counseling field and counselor education. Mr. Maple talked about the reasons that clients and counselors do not talk about shame. The role that managed care and training play in the paucity of attention paid to shame is explored.
**Clients**

Mr. Maple thought that most clients are not familiar with the constructs of guilt and shame, and, therefore, do not talk about them. They might be able to verbalize that they feel guilty, but most likely do not know what shame is or whether or not they feel it.

(There aren’t a lot of clients who have the kind of sophistication ... they can probably talk about “I feel guilty,” but they probably don’t know that they feel shame. ... Do clients come in and say, “I’m filled with shame?” No.

He also said that he does not see shame and low self-esteem in clients all the time, nor did he think that shame underlies all mental problems. “I don’t think shame underlies all mental illness. I think it’s a subset. ... As a percentage of my whole caseload, it’s not that common.”

**Counselors**

Mr. Maple suggested that counselors who have not dealt with their own shame issues tend to either avoid the shame that their clients experience or use the session to work on their own shame issues.

I think if I am a counselor and I am filled with or have a lot of shame, ... I may not go anywhere near shame, ... we can overfocus on those issues with our clients, luxuriating in the sympathy with those issues...

He said that unless a counselor is sensitive to issues of shame and guilt, she or he probably would not see them in a client. He suggested that time constraints may prevent a counselor from addressing shame.

(Neither of them show up unless I’m sensitive to them. ... I think clinically we have to make the discrimination about what to go after, given the extreme constraints we
have in this work of time and depth. If I'm only going to have three sessions with somebody, ... I may well see an issue of shame, but I may not get to it because there may well be so many other dynamics that are on top of that ...

**Managed Care**

Mr. Maple asserted that the insurance industry does not encourage in-depth counseling which shame requires. He implied that the hard work of exploring shame might also encourage clients to steer clear of that issue. “I don’t get the privilege of working real deeply with many people because of managed care and because of the cost of counseling and because it’s hard work…”

Mr. Maple talked about managed care that follows a medical model that looks at identifying symptoms and then eliminating them, and is concerned with keeping costs down. “(A)s you know, the insurance industry moves against working in depth. ... The insurance industry is based on the medical model ...What we are commissioned to identify are symptoms and we are only commissioned to help diminish symptoms.”

**Training**

Mr. Maple said that he did not recall the construct of shame having ever been mentioned in his graduate programs. “Certainly not in the academic field, certainly not in coursework. .... Guilt and shame.” Mr. Maple stated that he did not think that counselors are prepared to work at a deep level with only academic training under their belts.

Academic training is so broad in scope. It really only scratches the surface of anything. ... maybe only touch and maybe not ever hear about shame, certainly not explore that deeply. I don’t think anybody is prepared to work at any significant level of depth rolling out of academic training or even after supervision.
Mr. Maple further proposed that academic programs have so much to cover in their programs that they are not able to emphasize a single construct such as shame. “In the academic setting, there’s so much to cover is such a short period of time. It can’t afford to get specialized in anything.”

Although Mr. Maple said that he had had no education about the construct of shame in his graduate counseling program, he had had training about the construct of shame in psychosynthesis training and in training on sexual abuse.

I did some training in working with the issue of sex abuse, and the construct of shame came up in that as well. I had infinitely more training in psychosynthesis than I ever had in the specifics of sex abuse work, but shame is primary to that field.

He also asserted that there is literature and training now on shame in the Adult Children of Alcoholics (ACOA) field as well as in the sexual abuse arena. “The world of adult children of alcoholics, the ACOA world, I think is more popularizing these concepts and through workbooks and workshops helping people look at some of these deeper structures.”

**Maple Summary**

The following themes were presented: Abuse; Psychosynthesis; Self-Development; Multiple Views of Shame; Psychological Problems; Socialization; and It’s Not That Common. The connection between trauma, particularly sexual abuse, and shame was discussed. Psychosynthesis, the importance of counselors’ self-knowledge, and the connection between shame and some psychological problems were topics of discussion. Mr. Maple talked about factors that contribute to the development of shame and the relationship between shame and identity. A discourse on the dearth of attention given to shame in the counseling field was the final subject of discourse in this section.
Interpretation

Mr. Maple seemed as though he had done quite a bit of thinking about the construct of shame. His understanding of the construct included a well-worked out theory of its origins, the factors that contributed to its development, and its impact on human beings. He seemed to be aware of the presence of shame in his clients, but at the same time recognized its depth and the time constraints that often prevented the exploration of shame. His spiritual counseling approach appeared to be humanistic, that is, one of its tenets was that each human being possessed the inner wisdom to guide her or his life. His knowledge, in-depth training, and experience with many tools and techniques that help connect people with their inner source of wisdom provided an appropriate treatment to shame which has been described in the literature as “a sickness of the soul.” Mr. Maple’s approach pushes people to transcend themselves and become grounded in the ultimate source of reality.

Mr. Oak (Participant #9)

Mr. Oak has been a counselor for about 24 years, and a licensed professional counselor for 23 years. He was also a licensed marriage and family therapist. He has a master’s degree in rehabilitation and a year of intensive training in family systems. Mr. Oak described his framework as eclectic, and said he used chiefly family systems, Gestalt, and Rogerian theories. He is currently in private practice.
The following predominant themes with *(related sub-themes)* emerged during the interviews: Multiple Views of Shame *(Hide Their Sense of Shame, Fundamentally Inadequate, and A Way of Helping to Understand)*; When Kids Aren’t Connected *(Repeated Assaults and Trauma & Poor Bonding)*; Trauma/Shame/Disorders; and An Index of Awareness.

**Multiple Views of Shame**

This theme addresses the views Mr. Oak espoused on the construct of shame. It includes a discussion of the impact that shame has on individuals and their efforts to hide their sense of shame. He also talked about a connection between shame and identity as well as the distinctions between shame and guilt. The usefulness of the construct of shame in helping him understand human behavior was discussed. The following sub-themes are presented: *Hide Their Sense of Shame; Fundamentally Inadequate, and A Way of Helping to Understand.*

**Hide Their Sense of Shame**

Mr. Oak talked about shame as a sense of “badness” or “wrongness” and that people try to hide this sense of themselves by acquiring a variety of defenses.
It (shame) incorporates some sense of incompleteness, badness, wrongness, and folks will do whatever they need to do in order not to feel that way. ... (T)hey begin to develop defenses about that that may prove to be very dysfunctional as they move into adulthood. Those may range from macho acting out to obesity to sexual acting out to sexual avoidance.

He discussed the enormous energy that people expend in trying to mask their sense of shame and protect themselves from experiencing shame.

(I)t takes an incredible amount of energy for most folks to hide their sense of shame, ... most folks spend an awful lot of time and energy protecting that, creating personas and creating artificial parts of themselves ... They spend an awful lot of time defending themselves against experiencing shame.

He also maintained that shame is used, in this culture, to instill a sense of conscience, although he asserted that it was not a healthy sense of conscience.

I think there’s an attempt in our culture to use shame as a way of developing a sense of conscience. I don’t think that it produces a healthy sense of conscience. I think it produces a fear-based, shame-based sense of conscience.

**Fundamentally Inadequate**

A connection between shame and identity was discussed by Mr. Oak. He suggested that shame becomes one’s identity because the individual feels that he is wrong, bad, and incomplete.

Again as kids are shamed about themselves, about the behavior and about themselves, that they develop a sense of themselves as being inadequate,
fundamentally inadequate and bad and therefore begin to develop a persona, an identity based on that, often seen in body concept.

Mr. Oak said that shame is a feeling about oneself whereas guilt is about one's actions. "I view shame as a sense of oneself since guilt I view as sort of a reaction or a feeling tone about one's behavior, and shame as a pervasive feeling about oneself."

A Way of Helping to Understand

The helpfulness of the construct of shame was discussed by Mr. Oak. "I think it's a way of helping to understand and organize ideas about behavior." He proposed that shame is a principle that exists in all cultures and delineates boundaries and establishes rules for behavior. "I think shame is often used in most cultures as a way of protecting the boundaries of that culture. When folks step outside the boundaries ... then the group or culture shames that individual for his or her behavior."

When Kids Aren't Connected

This theme explores repeated denigration, poor bonding in families, and trauma as factors in the development of shame in individuals. The following sub-themes are presented: Repeated Assaults; and Trauma & Poor Bonding

Repeated Assaults

The development of shame in an individual was a topic of discourse. Mr. Oak stated, "I think shame develops in an individual as a result of repeated assaults upon their humanness and their worth and value. Pervasive, long-standing, repeated sort of experiences of being demeaned."
**Trauma & Poor Bonding**

The notion that clients experience shame when they grow up in families where there was abuse, trauma, or poor bonding was discussed by Mr. Oak.

Clients who were raised in families where either abuse or trauma took place or poor bonding, ... often experience a sense of something being dreadfully wrong with them ... kids, they don’t have cognition to understand the dynamics so how they incorporate it ... they’re bad in some way which generates a sense of intense shame.

Mr. Oak suggested that lack of bonding is a type of emotional trauma. “Again, it’s that form of emotional kind of trauma ... when kids aren’t connected and bonded with someone in their environment.” He alleged that when children are not connected to their parents in a close way, they feel that there is something wrong with them. “They begin at a pretty early age, I believe, to realize that there’s something wrong with them and begin to act that out and attempt to protect themselves in some way with that.” He further proclaimed, “Almost all of the people in my practice have some degree of difficulty with attachment, poor processes around bonding and attachment.”

**Trauma/Shame/Disorders**

A discussion about the links between trauma and shame and trauma and mental disorders takes place in this section. Mr. Oak also talks about the connection between extensive trauma and chronic shame and the percentage of his clients who have a history of trauma.

He proclaimed that he thought all psychological disorders have some association with shame. “I think they’re all connected to shame in some way, all of them. ... Most of the
DSM, with the exception of schizophrenia and bipolar ... have their origins in trauma.” He purported that shame is part of the trauma process.

Part of that trauma process is the induction of shame. ... They’re (disorders) all manifestations of trauma, pretty much, except for the adjustment disorders ... Take PTSD and take DID, take a lot of the anxiety disorders, a lot of the mood disorders; I think they’re really related to trauma. ...

A distinction between a single traumatic event and trauma of some duration was made by Mr. Oak. It is long-term trauma that produces enduring shame. “It would be like simple trauma vs. extensive trauma ... A trauma that’s ... contained; it’s simpler to work with versus folks who were raped every week for 5 years when they were growing up.” He said that “10 per cent. ... as much as 20 per cent” of his clients have a history of trauma. He also linked shame to sexuality, specifically male sexuality. “I don’t know any male that doesn’t grow up in America hardly who doesn’t have a sense of shame about their sexual needs or desires or abilities in some ways.”

Talk About Shame

This theme includes a discussion about Mr. Oak’s clients’ use of the word “shame” and their confusion between shame and guilt. He talked about the distinction he saw in the exploration of shame by people in recovery from addictions and those who were not in a recovery program. Another topic that is discussed is why shame is not addressed in counseling.

Clients

A discussion by Mr. Oak about how his clients talk about shame follows.

My clients talk about shame often, they don’t use that word but they use situations
and feeling tones that indicate that’s what they’re talking about. ... They talk about
feeling bad at their core, or feeling dirty, feeling like damaged goods.

He went on to say that clients often confuse guilt and shame. “I think clients often use
those words (guilt & shame) interchangeably. Mr. Oak maintained that becoming
painstakingly honest is part of the chemical dependency recovery program that encourages
people to talk about shameful experiences. “They (recovery folks) learn a process of pretty
rigorous honesty as a part of their program ... and really do often talk about things that
people don’t normally talk about ...”

He proposed that counselors must attend closely to clients’ body language and what
they express and be patient.

For folks not in recovery, it’s just a real patient process of just tracking them. If folks
kind of make allusions to things and slide away from it, or their nonverbal behavior
indicates that they’re struggling with something, just be patient and continue to elicit
gently some responses from them ... it often leaks out in behaviors connected with
body image and connected sometimes with abuse, self-abuse, self-harm.

He contended that clients are not eager to deal with the experience of shame because it is
agonizing. “I don’t think many clients are willing to wade into that stuff (shame). I think
you really have to hold their feet to the fire in some ways for them to address that.”

Counselors

Mr. Oak talked about several factors that contribute to counselors not addressing shame.

I think there are several reasons. One is that counselors are fairly uncomfortable
dealing with shame. It’s a pretty amorphous concept, and it’s really a core kind of
issue, and if you’re trying to deal with folks from a more surface cognitive-

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behavioral type place ... it’s not something one would deal with. ... I think that there is some discomfort with that as a topic because it sounds like old religiosity kind of stuff, ... concepts of shame and sin ... I don’t hear of anyone coming through training processes even now talking about any kind of direct instruction or practice addressing conceptual models of shame. ...

He claimed that he and his colleagues did not discuss shame much. “We (my colleagues and I) never really talked about it much. You know, it’s mentioned from time to time, but no one had ever talked about what you do with that, how you conceptualize it.”

An Index of Awareness

The critical role that counselors’ awareness of shame plays in whether shame is addressed in counseling is discussed in this section. How Mr. Oak identifies the presence of shame in clients is discussed. “I think having an index of awareness about it is part of the most helpful piece I know ...”

Mr. Oak maintained that in order for a counselor to address issues of shame in his clients, he would need to attend to his own shame issues. “(T)he counselor or therapist doesn’t pay attention to his or her issues around shame, it’s going to be really hard to address those with clients whose tendencies, are, I think, to avoid them.”

Attending to verbal and nonverbal behaviors in a client as a way to begin to assess for shame was presented. Mr. Oak proposed that the way a person is talking about a particular experience is an indicator that shame is present.

There’s a lot of stuttering and stammering about the behavior. There are a lot of pauses, a lot of struggle for the right words. Those are often clues for me that the person is talking about some sense of shame for them.
He stated that certain nonverbal behaviors could indicate shame in a client. "Mostly by nonverbals, though often folks will tell me they’re ashamed of their behavior. ... they talk about it with their bodies. There’s a lot of eye averting. It’s difficult to make eye contact."

**Oak Summary**

The following themes were covered: Multiple Views of Shame; When Kids Aren’t Connected; Trauma/Shame/Disorders; Talk About Shame; and An Index of Awareness. The distinction between shame and guilt, as well as the connection between shame and trauma were topics of discussion. Mr. Oak discussed how clients talk about shame and why counselors do not address shame in counseling. The association between shame and psychological disorders was a focus of discourse.

**Interpretation**

Mr. Oak seemed familiar with the construct of shame and talked fluidly about his perspective of shame. It is a construct that he apparently used in assessment, as evidenced by his discussion of identifying shame by attending to both verbal and nonverbal language. He seemed to incorporate the construct of shame in his case conceptualization, as demonstrated by his recognizing that shame is closely connected to a sense of self and impacts on one’s behavior and relationships. He had a strong sense of the devastating effect that shame had on one’s identity, which then translated into mental disorders. The notion that shame becomes a sense of an inadequate self served to explain to Mr. Oak why clients continue to repeat relationships and situations in which they experience shame. He was able to discern that shame was present even though clients did not use the word “shame.” In fact, he demonstrated insight into the prospect that clients’ behaviors serve as defenses that hide their shame.
Mr. Oak articulately clearly his thoughts as to why both counselors and clients do not address shame in counseling. He expressed an understanding of a counselor’s inability to recognize shame in clients if she or he did not recognize shame in herself or himself. He especially cited the discomfort and pain that arises when shame is addressed that perhaps human beings naturally want to avoid. His experience of working with clients with a history of trauma and folks recovering from substance abuse seemed to confirm, for him, the importance of shame as a counseling construct.

**Ms. Palm (Participant #10)**

Ms. Palm reported that she has a master’s degree, an Ed.S. degree, and a doctorate in counseling. She has worked as a counselor for about 21 years and has been a licensed professional counselor for about 17 years. In addition to being a licensed professional counselor, she was also a licensed marriage and family therapist. Ms. Palm talked about her extensive training in family therapy, training in transpersonal psychology, and chemical dependency training. She called herself a “heart-centered” therapist and identified her primary frameworks as systems theory, transpersonal psychology, and cognitive-behavioral theory. She is currently in private practice.

**Palm Themes**

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Sub-themes in italics

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The predominant themes with (related sub-themes) from the interviews were presented: Multiple Views of Shame (Language, It's Usually One Extreme Or the Other; Guilt/Shame; A Lot of the People...Have a Huge Shame History); You Have to Know Yourself; and Attention.

**Multiple Views of Shame**

In this section, shame’s link to identity, the development of shame at an early age, and the sense of alienation connected to shame are discussed. Ms. Palm also talked about the prevalence of shame in her clients and the association between shame and abuse. She spoke about the language that people use to inflict shame on others and on oneself. The impact that shame has on behavior and the distinction between shame and guilt were also topics of discussion.

Ms. Palm proposed that shame is connected to an individual’s identity. “I think that a lot of people who carry shame feel that it’s not like an emotion, it’s like who they are. It’s like their personality. It’s that they are ashamed of being alive.” She declared that self-esteem begins at a young age. “I mean I think that people’s self-worth develops from when they’re really little.” She discussed further how she views shame.

It’s in talking to people about where their suffering is; there’s often shame, scapegoating kind of issues in their family or in their work environment or in their educational experiences ... shame and the shunning about what was wrong with them, and then their believing that it’s about them.

Ms. Palm stated, “I think it’s a major issue for most people. I think maybe 80% of people who walk through the door have horrendous shame issues.” She contended that
shame was linked with abuse and trauma, that often people blamed themselves not only for the event, but also for not speaking up about it at the time.

People with abuse histories, so people who might have PTSD. “How could I let that happen to me?” ... just a lot of shame about not being able to make it stop or why didn’t they go to the authorities so that’s where I probably see it the most

She talked about a lack of support and nurturance as being forms of abuse that can stunt the growth process. “(A) lot of times people think that abuse is only overt—hitting, yelling, screaming, but a lack of nurturing, a lack of compassion, a lack of caring is also very detrimental to a developmental process.”

**Language**

She equated language that people use, particularly toward children, to poison.

The image that comes to me about shame is sort of the language ... that people use in talking to children or students or other people is sort of like the old images of whaling. ... They zap you with the harpoon, and the whale doesn’t die, but the whale is poisoned, and that’s my construct, in my mind, of shame, that it comes out of language and sort of body stuff, and then it’s like a poison that runs in the blood.

She talked more about how denigrating language plays a role in shaming people. “The language of shame is putting people down. We see that in spouse abuse, right? It’s the language. Shame, to me, implies that someone is putting someone else down for what they’re doing ...” She talked about how shame could be identified in a client through his language. “It’s the negative self-hatred and the language of how they talk about themselves. A lot of drippy self-hatred – ‘Stupidity. An idiot.’”
**It’s Usually One Extreme Or the Other**

Shame’s impacts on behavior was discussed. Ms. Palm asserted that behavior at either end of the continuum indicated the presence of shame, either aggressive behavior or submissive behavior. “My experience of it is that it can go in one of two ways. Either they become incredibly passive and submissive or they become aggressive, not assertive, but aggressive. It’s usually one extreme or the other.”

**Guilt/Shame**

Ms. Palm purported that the distinction between shame and guilt is that guilt is about one’s actions whereas shame is about one’s identity.

My sense of a difference is that guilt is a feeling of regret of something that you’ve done or haven’t done, but shame is more of a core belief, a person feels more like it’s really who they are versus a result of behavior or something.

She asserted that although shame and guilt coalesce, guilt is what is most often presented. “I think they merge. They usually come up -- it all depends, but it usually initially gets presented as guilt.”

**A Lot of the People ... Have a Huge Shame History**

An association between shame and addictions was addressed by Ms. Palm. “I work with it a lot with people with addictions, and a lot of them have been shamed. A lot of the people that I work with have a huge shame history.” She contended “that internalization of being bad or wrong or not very smart” was linked to addictions. She stated that there was a connection between shame and eating disorders. “I mean the people that I see with extreme eating disorders; the shame is just phenomenal ...” She asserted that shame was connected...
to obsessive-compulsive disorder (OCD). “People who are obsessive-compulsive. Often they had parents who shamed them if they didn’t put their shoes in the right order.”

Ms. Palm remarked that people with a history of sexual abuse felt that they were responsible for what happened to them and feel ashamed. “(T)he women and the men that I’ve worked with, actually, who have a sexual abuse history, feel like it was their fault that they didn’t say “no” when they were seven ...” Ms. Palm talked about an association between shame and some religions.

(T)here’s tremendous shaming in religion about what you should do and shouldn’t do. ... It’s about shame as a primary construct in some religions or at least how it’s presented.

She also discussed the link between shame and certain ethnic groups and cultures.

I also think that shame is, in family systems, we study ethnicity and in some ethnic cultures, shame is a discipline tool. ... It’s the culture. I grew up with German parents, very shaming. The whole fear theory of childrearing was all shame focused, and I think that was an ethnic process. I’m sure there’s other cultures. I know certainly Asian, certainly Korean and Vietnamese, it’s all shame based.

You Have to Know Yourself

Counselors going through their own therapy and attention that shame receives in the counseling field were topics of discussion under this theme. Ms. Palm contended that a good therapist should know herself or himself because what she or he is doing in counseling is helping clients explore their own processes.

I think that to be a really good therapist you have to know yourself and that if it’s a person who’s unwilling to look at themselves and their own process, that’s what you
try to help other people with, that you’re going to have to practice what you preach.

Ms. Palm suggested that counselors should go through therapy themselves. “Well, personally, I think that anyone who’s going to be a counselor or a therapist needs to do their own clinical work ...” She further recommended that counselors-in-training do some internal exploration. “I’m saying that I think that grad schools need to teach that each person, if they’re going to be a therapist, that you have to do a little introspection and to do your own work around shame ...”

**Attention**

This theme discusses the attention that is paid to the construct of shame in the counseling field. Ms. Palm said that she could not recall having any instruction or discussion on the construct of shame in her master’s or doctoral programs. “I graduated 12 years ago, and at that time absolutely not, so I don’t really know what people are teaching today.” She remarked that shame is given attention in the addictions field and in family therapy. “I think that the attention given, certainly in the addictions field, is very important. I think we do that a lot. Certainly in my work with addictions and family therapy ...”

She also stated that she has seen shame discussed as a part of eating disorders. “I think that shame is often a piece that you see with eating disorders ... I’ve seen it written about ...” Ms. Palm claimed that shame had been emphasized in a transpersonal program that she done some extensive training in. “(I)n 94 ... I started an extensive training program with Stan Grof, who’s one of the founders of transpersonal psychology in California. We talk a lot about shame and guilt and projection and introjects.”
Palm Summary

The following themes were covered in this section: Multiple Views of Shame; You Have to Know Yourself; and Attention. Discussion of Ms. Palm’s many thoughts about shame included its close connection to one’s identity, its prevalence among her clients, its relationship to language, its association with a lack of support in the environment, and its link to various psychological disorders and problems. Her comments also focused on the value of counselor’s self-knowledge and the importance of introspection in counselors.

Interpretation

Ms. Palm’s realization of the prevalence of shame in her clients and her recognition of an association between shame and abuse revealed that she had given the construct of shame much consideration. She appeared to be well aware of shame in her clients as substantiated by her remarks that “a lot of the people I work with have a huge shame history ... maybe 80% of people ...” She used her sensitivity to language to identify shame in her clients, particularly the way they talk about themselves, generally, in a demeaning manner. She had a broad view of shame that included not only shame suffered by individuals, but shame associated with groups of people such as certain cultural and religious groups and people with disabilities. In addition, she talked about shame used as a way of social control and as a method of discipline. Ms. Palm’s discernment regarding the construct of shame is demonstrated by her cognizance of shame’s close association with one’s identity, its connection to abuse, and the role that lack of support and nurturance in the environment contribute to shame.
Ms. Spruce

Ms. Spruce reported that she has a master's and Ed.S. degrees in counseling and is in her third year of a doctoral counselor education program. In addition to being a licensed professional counselor, she is a licensed marriage and family therapist. She also has a certification for chemical dependency from a nearby university. She has been working as a counselor for approximately 10 years. She worked as a counselor a couple of years before becoming licensed. Prior to that time she had been a teacher and worked in human relations, writing training manuals and conducting training among other things. The primary approaches that guided her practice were a systems perspective, attachment theory, and a developmental approach.

Spruce Themes (Participant #11)

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Sub-themes in italics

The predominant themes with (related sub-themes) from the interviews were presented:

Multiple Views of Shame (Shame/Feeling Guilty, When Children Are Small, They Go to Great Extents to Hide It); The Actual Word Isn’t Used; and The Counselor.

Multiple Views of Shame

This theme includes views of shame such as: shame from a developmental perspective; shame from an attachment theory perspective; shame as incongruence; and shame as a positive experience. Ms. Spruce talked about the distinction between shame and guilt and also about people’s desire to hide shame. The differences between shame and other emotions were discussed. Ms. Spruce commented on her view of shame from a
developmental perspective. She asserted that shame might contribute to keeping an individual fixed at some stage of development. “From a developmental perspective, ... I would say that usually there was some crisis or problem that the issue of shame might be involved in the crisis or problem that is keeping them at that particular level or keeping them stuck.” She maintained that all people experience shame, and that how an individual deals with it influences how well they can endure the shame, value themselves, and progress developmentally.

I think everybody has experienced shame ... Developmentally, how the person is able to handle some of these other situations impact how well they’re able to tolerate it and accept themselves and do what they need to do and move on later in life.

She talked about how she looked at shame from an attachment theory perspective. “In attachment theory, I would say around that loss would be feelings of helplessness or guilt or shame that they weren’t able to change a certain course of events.”

Ms. Spruce conjectured that shame is defined as “a feeling of the incongruence between what you expect of yourself and what others expect of you and what your actions are.” She proposed that shame motivated people to seek counseling. “I’d say it plays a big use maybe initiating therapy to begin with or at least as a motivator in coming into therapy or as they’re going through the process.” She affirmed that shame had a positive function by motivating people to make changes. “(W)hen they do something that they are experiencing feelings of shame, it is sort of a trigger for ‘okay, how do I change or what needs to be different?’ I think it can trigger good.” She surmised that shame was “one of those core feelings that can be really long-lasting” as she compared it with other emotions.
"whereas something like joy, those are sporadic times, even anger, those are sporadic things..."

**Shame/Feeling Guilty**

Ms. Spruce proposed that shame could develop through association whereas guilt implies some participation in an act.

I think shame, you don't actually have to have been the person that created the situation ... yet just by association, you can be ashamed. ... I think feeling guilty about something implies that in least some aspects you participated in something.

**When Children Are Small**

Ms. Spruce proposed that shame was part of the socialization process and connected to rule violation.

I think probably we socialize it into everybody shortly after birth. When there are rules and we don't follow the rules, ... then we feel bad. I think shame and a probably a very young fear of abandonment and loss, "If I'm bad, Mommy won't love me or Daddy won't love me."

She reiterated that shame begins early in life. "When you're talking about the expectations of others, you're probably talking about—some of those things start at a very early age, with parents in the home when children are small ..."

**They Go to Great Extents to Hide It**

Ms. Spruce asserted that shame influences an individual's behavior. "I think it impacts their actions. If someone is ashamed of some action that they're doing, or an addiction, those different things they go to great extents to hide it from other people and often from themselves." She went on to say that shame was associated with being accepted, with
fitting in. "(I)n attachment theory from that fear of not being accepted or liked, wanting to be part of the group, if found out, if somebody found out."

**The Actual Word Isn’t Used**

Ms. Spruce stated that although she did not use the word “shame,” shame was nonetheless present in her clients. “I don’t think I use the word as a word, but I think ... there whether or not I label it.” Ms. Spruce conjectured as to why the term “shame” is not used. She speculated that “shame” was a disparaging term. “Maybe it’s got that derogatory thing from ‘You should be ashamed of yourself’ or something like that.” She surmised that shame is such a potent emotion, that it requires delicate handling and deep respect. “It’s not that it’s not addressed. Maybe that it’s so powerful an emotion that if somebody is coming to that level, you treat it with more respect or more delicately.”

Ms. Spruce remarked that in her discussions with colleagues, the word “shame” was not used.

It might be that somebody would be more willing to say “Oh, that person is borderline rather than say “That person’s really ashamed of themselves.” ... I’m just saying with your talking professionally with somebody else, that kind of conversation would be more likely to occur than using the word “shame,” again from my experience.

Ms. Spruce avowed that clients did not use the word “shame,” but instead other phrases that indicated that shame was present. “No, that’s the thing. I don’t hear that word very often. I hear, ‘It’s all my fault,’ or ‘I should have done something different,’ or ‘I wish I had,’ where they feel like that they have regrets.” She asserted that a high percentage of her clientele had shame issues. “I’d say during therapy between initiating it or sort of
coming out over the course of therapy, probably a high percentage, maybe 90%, maybe even higher as far as coming in with it.”

**The Counselor**

Ms. Spruce asserted that a counselor should “understand that you can’t fix a client or a family, that they’re the ones who actually do the work. You’re sort of like a helping hand in the whole process.” She discussed that being empathic, compassionate, nonjudgmental, and genuine were important counselor characteristics. “I think you have to have a lot of empathy and compassion for people and not be judgmental, especially when you’re working with people who think differently than you, and I think you have to be yourself.” She added, “I think it’s important for counselors to be able to—you have to be able to lead a balanced life yourself.” She suggested that therapists who have not dealt with their own issues would tend to avoid addressing them with their clients. “If a therapist hasn’t done enough of their own work, some of the topics may be too sensitive for them to be able to really handle it or to be able to really handle whatever the issue is appropriately.” She asserted that it is important for counselors to know themselves.

Ms. Spruce talked about how a counselor who does not understand a client, who asserts his own agenda rather than the client’s, who lacks of awareness of transference and countertransference issues, and who suffers from burn-out could contribute to inadvertently shaming a client.

I think it (shame) happens or can happen when a counselor isn’t really grasping what the person is trying to tell them ... if the counselor’s own agenda is taking precedence over what the patient needs, and if there’s some bad transference-countertransference going on, and if the counselor is really burnt out and really doesn’t care.
She also thought shame could arise in session when boundaries between counselor and client became blurred or when a counselor gives a client an inappropriate diagnosis.

Like the boundaries or whatever got so blurred, or the therapists, themselves, were so directive or gave them a diagnosis that really doesn’t fit, and they’re recreating their childhood all over again.

She discussed that, if a counselor experienced shame in a session, he should process it later with someone.

They need to process it, but they can’t process in the room. They need to ... set it aside for the moment if they feel like it’s going to affect what you’re saying completely, whatever to the client, maybe move away from the subject ...

Ms. Spruce discussed the value of counselors knowing themselves and suggested that they go through counseling themselves. “I think counselors or if anyone is in a program where they’re training to be counselors, I feel like they really better know themselves and worked on their own issues and had some counseling themselves.” She stressed that counselors “should have gone through some form of therapy themselves and really understand how their own personal culture and family background and history impacts who they are and how they think.”

Spruce Summary

The following themes were covered in this section: Multiple Views of Shame; The Actual Word Isn’t Used; and The Counselor. A discussion of shame from different perspectives included views of shame from a developmental perspective and an attachment theory approach. Other interesting ideas consisted of the notion that shame motivates people to seek counseling, that shame has a positive function, that shame is longer-lasting.
than other emotions, and that people take great pains to hide their shame. The absence of the word “shame” in counseling sessions was talked about. Lastly counselor attributes were discussed.

**Interpretation**

Ms. Spruce appeared interested in the construct of shame. Her understanding of shame included her recognition of people’s desire to hide it and its role as a motivating factor in people coming to counseling. She was able to discern its presence in clients without them using the word “shame.” She had the ability to articulate how and when shame develops and to express that it played a role in the socialization process. She had discerned that counselors could shame clients and verbalized how that could occur. The strong opinions that Ms. Spruce expressed about the qualities that a counselor should possess indicated that she had given thought to the counselor’s role and how it could impact the presence of shame in the session.

**Ms. Willow (Participant #12)**

Ms. Willow reported that she has a master’s degree and an Ed. S. degree in counseling. In addition to being a licensed professional counselor and a licensed marriage and family therapist, she was a certified clinical hypnotherapist. She has been licensed for 12 years and has been a counselor for 18 years. She began her counseling career with a structural family therapy framework, but has moved to a more solution-focused framework. She identified herself as having an eclectic approach but also stated that, at present, she uses primarily cognitive-behavioral theory and solution-focused therapy. She is currently in private practice.
### Willow Themes

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Sub-themes in italics

This section includes the following themes with *(related sub-themes)*: Multiple Views of Shame *(Pervasive, Likely To Develop in Childhood, Guilt/Shame, Construct of Shame)*; Behavior; It Gets Overlooked *(They Orchestrate Their Behavior; A Vague Term)*; How Else Would I Recognize It; Core Beliefs Are Connected to Shame; and Counselors *(The Message That It’s Their Fault, Not Willing to Deal With It)*.

#### Multiple Views Of Shame

In this section, a discussion about several of Ms. Willow’s views of shame takes place. Ms. Willow talked about the distinctions between shame and guilt and spoke about how the construct of shame is helpful to her in understanding clients’ behavior. The distinguishing qualities of shame and the variation in its intensity among individuals are discussed. This theme includes the following sub-themes: *Pervasive; Likely To Develop in Childhood; Guilt/Shame;* and *Construct of Shame.*

**Pervasive**

The pervasiveness of shame in client’s lives was discussed by Ms. Willow. "(F)or some people it really colors their entire life.” She also noted their lack of awareness of shame. “I think it’s very pervasive. I think people are often unaware of the extent of how
ashamed they feel.” Ms. Willow identified pervasiveness and permanence as the distinguishing characteristics of shame as compared to other emotions. “I guess it’s (shame) more pervasive than some emotions. ... Shame, in my mind, is not something that tends to come and go as some other emotions. I would say it’s more permanent.”

She talked about the presence of shame in many clients, but stressed that it is not pervasive or intense in all clients. “For some people, it’s there, but it’s much less intense. ... I’m thinking of the more extreme cases, but now that I think of it here, it probably exists in other people I’m working with, but it’s just not so extreme.”

**Likely to Develop in Childhood**

Ms. Willow said that shame developed from external sources, primarily parental or family disapproval. “Certainly parental influence, societal influence, disapproval from lots of different sources. I don’t think we’re born feeling shame. I think that comes through our external contacts.” She stated that shame could certainly develop later in life. “I think it’s more likely to develop in childhood, but I certainly think it could develop later on.” She further contended that shame establishes itself in an individual in the family of origin, and the shamed person is inclined to repeat those relationships and experiences later on. “Probably more that it began in the family of origin and then repeats itself. I would say that’s the more common, more commonly what you see.”

**Guilt/Shame**

Distinctions between shame and guilt were discussed. Shame, Ms. Willow remarked, was pervasive and connected to one’s identity, whereas, guilt was focused on a particular incident. “I think of shame as more pervasive. I think of guilt as usually more connected to
specific events. ... I think shame comes more from the core and comes more from very deep beliefs about oneself.'

**Construct of Shame**

She talked about the ways that the construct of shame is useful to her in her counseling practice.

It was helpful to realize that some of the people I see—why they may be behaving the way they are, why they’re having so much difficulty changing, why some people may actually drop out of therapy—thinking about things that sometimes are unspoken in terms of what the client is willing to talk about ...

She contended that the construct of shame is useful. “I think it (the construct of shame) was very helpful in ...how it may be affecting not only people’s lives but how it may be affecting the counseling session.”

**Behavior**

Ms. Willow emphasized that shame “absolutely” affects people’s behaviors. “Sometimes their whole lives are organized around not feeling okay.” She noted that for some people, shame resulted in their being helpful all the time.

You have sometimes the client who is always cheerful and always trying to be helpful to other people and always thinking of other people first. What you realize is that all that behavior is organized around not feeling acceptable, not feeling okay.

She pointed out that for some people, shame generated hostility and acting out behavior. For others, it produced dependence. “You’ve got other clients who, I think, because they don’t feel worthy or they don’t feel lovable, competent, they’re acting out, doing negative things all the time. They’re hostile or they’re dependent ...” When asked, “Do you think
shame can be useful,” Ms. Willow remarked that it could be useful as far as alerting people to behaviors that they may want to change. “I’m sure there are times when people being ashamed is probably a useful thing for behavior that they’ve done. ... in terms of realizing that maybe certain behaviors are not appropriate.”

It Gets Overlooked

A discussion about the word “shame” not being used by her clients or by her was presented in this section. Clients hiding shame and the vagueness of the term “shame” were discussed. The theme, It Gets Overlooked, contains the following sub-themes: They Orchestrate Their Behavior and A Vague Term.

They Orchestrate Their Behavior

Ms. Willow contended that most clients do not talk about shame. “I don’t think most people come in and actually say, ‘I’m ashamed.’ ... It’s there, and sometimes it’s very obvious, but I don’t think people typically come in and say that.” She stated that often denial and lack of awareness of shame played a part in clients not discussing shame. “A lot of times I think they are denying the fact that they feel shame or maybe aren’t even aware of the fact that that’s what’s going on.” In fact, Ms. Willow declared that clients typically behaved in ways to keep shame hidden. “I think it gets overlooked because people don’t usually come in and verbalize that and because they orchestrate their behavior to hide those feelings.”

A Vague Term

Ms. Willow expressed that she did not usually use the word “shame” with clients in her counseling sessions. “It’s not a word I happen to use.” She declared that she did not use the word “shame” because it is defined in a variety of ways.
(I)t's kind of a vague term. ... each client would have a different definition ... using
words like ... "you don’t feel competent" or "you don’t feel like you’re good enough"
are probably more concrete for people than saying "you feel ashamed" ...

She asserted that in her counseling, she tries to stay more positively focused by
emphasizing clients' strengths. "I think probably another reason why I don’t use that
terminology, I really try to stay very positively focused, and I really try to focus more on
strengths, focus more on solutions ..."

**How Else Would I Recognize It?**

Included in this theme is a discussion about identifying and addressing shame in
clients, as well as a comment on the percentage of clients in her practice who have shame
issues. Observing clients’ behaviors and language and examining their core beliefs were
discussed as ways that Ms. Willow used to assess for shame.

Ms. Willow talked about the frequency in which she saw shame as an issue to be
addressed in counseling. "I would say probably at least 25%.” She discussed that there
were a variety of ways that she identified shame in clients, their sense of hopelessness, their
resistance, or their hostility. “How else would I recognize it? ... You could call it a form of
‘I try and try and try, and nothing ever gets better.’ It could come in the form of resistance.
It could come in the form of hostility." She assessed for shame by examining clients’
beliefs about themselves. “To try to elicit from people if there are some beliefs about
themselves that they are operating on, that they may or may not be aware of ...”

Ms. Willow said that she might introduce and explain core beliefs, particularly beliefs
about being inadequate or unlovable, as a way to probe to see if these beliefs fit for clients.
“'I also talk about the fact that sometimes we may not feel worthy or we may not feel
lovable, but they’re not aware that that’s what’s going on with them. Sometimes it’s very conscious, but sometimes it’s not even in their own awareness…"

**Core Beliefs Are Connected to Shame**

This theme explores where shame is addressed in the counseling field and how shame is viewed in cognitive behavioral theory. The impact of insurance companies on counseling is talked about.

Ms. Willow could not remember shame being addressed in her graduate programs. “As I said, I don’t recall in my program having that (shame) come up at all.” She recalled that shame had been discussed in the addictions field. “My experience has been, for the most part, that outside of the addictions field, you don’t hear very much about shame.” She asserted that although the construct of shame was not dealt with in the general counseling field, it was spoken to in the addictions field. “I think you probably see that word (shame) used more in chemical dependency kind of context …” She maintained that although cognitive behavioral training did not deal directly with shame, that it addressed it through the concept of core beliefs.

It was the cognitive behavioral training that I’ve been through in the last couple of years. Again I don’t recall them using the word “shame,” but I think they addressed the issue. …. I think the core beliefs are connected to shame.

Ms. Willow stated that shame is not the focus of professional training these days. Because of insurance companies, the focus is more on short-term treatment, reducing symptoms quickly.

A lot of it these days it’s driven by third-party payers and meeting those needs, and having clients in and out as quickly as possible so people are focusing on strategies
that are quick, strategies that work. They’re not focusing on long-term issues so much.

She stated that shame, an issue that requires longer-term counseling, should be addressed somewhere. "(T)he big push by insurance companies to do solution-focused therapy, shame is just not going to come up at all in that kind of outlook, but it does need to be addressed somewhere."

**Counselors**

This theme discusses how counselors may inadvertently shame clients. Another topic of discussion is counselors who have not worked on their own shame issues. The two sub-themes in this section are: *The Message That It’s Their Fault* and *Not Willing to Deal With It*.

**The Message That It’s Their Fault**

Ms. Willow talked about how counselors could shame clients. One way was by the counselor expressing impatience when the client does not change as quickly as she would like. The shaming message is that “you are an inadequate client.”

By getting frustrated with people when they don’t change, when they don’t get better, when they keep doing what they’ve come in for. ... giving them the message that it’s their fault that this isn’t working.

She remarked that another way that counselors could shame clients is by asking them things that they don’t think they can do. When they do not do the homework, the counselor could again give a message of disapproval that is shaming to the client. “I think by asking people to do things that maybe they can’t do or think they can’t do, and then when they come back in, and you ask them why they didn’t do it ...”
*Not Willing to Deal With It*

Ms. Willow discussed that if counselors had not dealt with their own shame issues, they would tend to avoid their clients’ shame issues. “Well, I would guess if there are areas that a counselor is not willing to deal with related to shame that they probably wouldn’t get dealt with in a counseling session.” She also indicated that the counselor’s avoidance of shame issues would be inadvertent. “I would imagine a lot of it would be unintentional if that would happen, if you were to avoid an issue.”

**Willow Summary**

This section covered the following themes: Multiple Views of Shame; Behavior; It Gets Overlooked; How Else Would I Recognize It; Core Beliefs Are Connected to Shame; and Counselors. Of particular note were comments that alluded to the lack of awareness of shame or the lack of attention that shame receives. Ms. Willow talked about how people are often unaware of the extent of shame in their lives or if they do recognize shame, they tend to try to hide it. She talked about how she does not use the word “shame” because it is too ambiguous and also because she wants to stay more positively focused. A discussion about the push by insurance companies to do brief solution-focused therapy that precludes addressing core issues like shame took place. The tendency for counselors who have not dealt with their own shame issues to avoid the shame issues of their clients was discussed. Commentaries on ways to identify shame in clients and the usefulness of shame as a construct were presented.

**Interpretation**

Ms. Willow displayed awareness that shame is present in many of her clients and recognized shame’s variation and intensity among clients. Her recognition of the
permanence of shame relative to other emotions and the development of shame in childhood in the family of origin showed that she had given thought to the topic of shame. Her identification of how the construct of shame fosters an understanding of the difficulty of changing behavior appeared to have promoted greater tolerance for repetitive behavior in clients, a recognition that change is incremental. It brings to mind Shakespeare's comment, "What wound did ever heal but by degrees?" (Othello, Act ii, Sc.3). Her comments seemed to indicate a struggle between brief solution-focused therapy and long-term counseling. She acknowledged that shame would not be addressed in the therapy to which she subscribed, brief solution-focused therapy, but recognized the need for shame to be addressed somewhere.

Chapter Summary

The findings and within-case analysis of this exploratory study were described in this chapter. Following an overview of the analytical procedure, a section was devoted to each of the twelve participants. Statements related in content were clustered into themes. Those themes that were selected for discussion were those that occurred most frequently in the text. Each analysis was followed by researcher interpretation. The next step in data reduction will be presented in Chapter Five. Themes and sub-themes across the twelve participants will be clustered according to content.
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<td><strong>Be Accountable To</strong></td>
<td><strong>Through Process Themselves</strong></td>
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<td><strong>Jumping On the Pile</strong></td>
<td><strong>Shame Becomes Internalized</strong></td>
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<td><strong>Drop Into Experience</strong></td>
<td><strong>Guilt</strong></td>
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<td><strong>They Wouldn't Use That Word</strong></td>
<td><strong>It's Always There Without Labeling It</strong></td>
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<td><strong>Addressed (In Practice Counseling Courses)</strong></td>
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<td>TABLE 4.3 THEMES/SUBTHEMES</td>
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<td><strong>HICKORY #7</strong></td>
<td><strong>MAPLE #8</strong></td>
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<td><strong>Psychosynthesis</strong></td>
<td><strong>In Touch w/ Wisdom</strong></td>
<td><strong>Socialization</strong></td>
<td><strong>When Kids Aren’t Connected</strong></td>
<td><strong>Repeated Assaults, Trauma</strong></td>
<td><strong>Focus on People’s Strengths, Core Beliefs</strong></td>
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<td><strong>Childhood</strong></td>
<td><strong>When Children Are Small</strong></td>
<td><strong>When Children Are Small</strong></td>
<td><strong>Likely to Develop in Childhood</strong></td>
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<td><strong>A Useful Shame</strong></td>
<td><strong>Identity</strong></td>
<td><strong>Identity</strong></td>
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<td><strong>Identity/Conscience</strong></td>
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<td><strong>Disapproval</strong></td>
<td><strong>Poor Bonding</strong></td>
<td><strong>One Extreme or Other</strong></td>
<td><strong>Behavior</strong></td>
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<td><strong>Abuse (Sex, Substance)</strong></td>
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<td><strong>Psychological Problems</strong></td>
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<td><strong>Mult. Views of Shame</strong></td>
<td><strong>Multiple Views of Shame</strong></td>
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<td><strong>Externally Imposed</strong></td>
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<td><strong>Intensive/Pervasive</strong></td>
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<td><strong>Shame/Guilt</strong></td>
<td><strong>Shame/Guilt</strong></td>
<td><strong>Guilt/Shame</strong></td>
<td><strong>Shame/Feeling Guilty</strong></td>
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<td><strong>Self-Development</strong></td>
<td><strong>An Index of Awareness</strong></td>
<td><strong>You Have to Know Yourself</strong></td>
<td><strong>The Counselor/They Better Know Themselves</strong></td>
<td><strong>Counselors (Message It’s Their Fault, Not Willing to Deal w/It)</strong></td>
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<td><strong>Hide Their Shame</strong></td>
<td><strong>Great Extents To Hide The Word Isn’t Used</strong></td>
<td><strong>How Else Would I Recognize It (Beliefs About Themselves)</strong></td>
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<tr>
<td><strong>Mostly by Nonverbals</strong></td>
<td><strong>It’s Not That Common (Clients, Cnslrs, Managed Care, Trng)</strong></td>
<td><strong>A Lot of the People Have a Huge Shame History</strong></td>
<td><strong>It Gets Overlooked They Orchestrate Behavior, A Vague Term</strong></td>
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<td><strong>Talk About Shame Clients, Counselors</strong></td>
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<td><strong>Attention, What You Expect. Programs, Materials, Counselors, Charismatic Spokesprsn</strong></td>
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<td><strong>Language</strong></td>
<td><strong>Attention</strong></td>
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<td><strong>Attention</strong></td>
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<td><strong>3rd Party Payers</strong></td>
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CHAPTER FIVE
Cross-Case Analyses

Chapter Four presented the analysis of each participant, including themes with (related sub-themes) and researcher interpretation. Chapter Five presents the next step in data reduction: cross-case analysis of themes.

Overview of Analytical Procedure

In order to conduct the cross-case analyses, I examined all themes and sub-themes that emerged from within-case analysis of each of the twelve participants. Cross-case analyses for this study explore themes found to occur across participants (cases) and unique to certain cases. The within-case themes were clustered according to content. To qualify, the themes had to be present in at least half of the cases. Although at least six participants talked at length about the cross case themes, there were a variety of perspectives presented that were supported by fewer than six participants. In the previous chapter, within-case themes (except for Multiple Views) were presented in the participants' own words; in this chapter, cross-case theme titles are in my words.

The following themes emerged from this reduction process: Multiple Definitions (present in twelve); Hidden Nature of Shame (present in eight); Theories (present in six); Self-Knowledge (present in ten); Identity & Shame/Guilt (present in twelve); Childhood/Relationships (present in eleven); and Disorders & Problems (present in eight). The following Table (Table 5.1) illustrates the reduction of within-case themes and sub-themes (italicized in table) into the seven cross case themes.
<table>
<thead>
<tr>
<th>Participant</th>
<th>Multiple Definitions</th>
<th>Hidden Nature of Shame</th>
<th>Theories</th>
<th>Self-Knowledge</th>
<th>Identity &amp; Shame/Guilt</th>
<th>Childhood/Relationships</th>
<th>Disorders &amp; Problems</th>
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</thead>
<tbody>
<tr>
<td>Ash</td>
<td>Defect in ego; deeper embarrassment; overdeveloped superego</td>
<td>In Psychoanalytic Terms</td>
<td>Never Self-Disclosing</td>
<td>Self-Concept</td>
<td>Oedipal Period Trauma Selfdestructive Bad Relationships ShmePolarized</td>
<td>Anxiety, Depression, Trauma</td>
<td></td>
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<tr>
<td>Cypress</td>
<td>Fear of Rejection; inadequate as a person</td>
<td>Christian ShareWorldview REBT Model Self-Talk</td>
<td>In Touch With Their Own Stuff Accountable</td>
<td>Guilt/Shame</td>
<td>Parental Influence Reset Scene</td>
<td>Disorders</td>
<td></td>
</tr>
<tr>
<td>Elm</td>
<td>Internalized sense of violating something about oneself; Failure to live up to expectations</td>
<td>Affect Theory</td>
<td>Understand Nature Through the Process Triggering Shame A Mirroring Process</td>
<td>Identity &amp; Affirmation</td>
<td>When We’re Young Connection</td>
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<tr>
<td>Fig</td>
<td>Something someone puts on someone else; insidious, overwhelming</td>
<td>They Wouldn’t Use That Word Short Treatment</td>
<td>Developmentally</td>
<td>Self-Esteem Devel/Identity Shame/Guilt Guilt</td>
<td>Almost Every Diagnosis Short Treatment</td>
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<tr>
<td>Fir</td>
<td>Feeling bad about who I am; goes to person’s identity</td>
<td>Addressed In Practice Counseling Courses Without Labeling It</td>
<td>We Start to Shame Our Clients</td>
<td>Identity Shame/Guilt</td>
<td>First Schools Our Families Project My Image onto Other People</td>
<td>It’s a Requirement Not Good Enough Mind, Body, Spirit Psychol.&amp;Emot. Always There</td>
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<td>Gum</td>
<td>Who you are &amp; what you lack; an emotion;</td>
<td></td>
<td>Therapists</td>
<td>Shame/Guilt</td>
<td>In Early Childhood</td>
<td>Underpinnings of Counseling, Clients</td>
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<tr>
<td>Hickory</td>
<td>Feeling that one has fallen short in a profound way; external</td>
<td>Attention Programs, Materials, Counsels, What You Expect, Spokesperson</td>
<td>Useful Shame/Identity Conscience Shame/Guilt</td>
<td>Childhood Disapproval</td>
<td></td>
<td>Abuse (Sex, Substance) Psychological Problems</td>
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<tr>
<td>Maple</td>
<td>Incorporation of criticisms that a child grows up with; self-doubt; linked with identity</td>
<td>It’s Not That Common (Clients, Counselors, Managed Care, Training)</td>
<td>Psychosynthesis In Touch w/Wisdom</td>
<td>Self-Development</td>
<td>Identity Socialization</td>
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<td>Oak</td>
<td>Intense sense of one’s badness, wrongness; internalized sense of self</td>
<td>Hidetheir Shame Mostly by Normerhals Talk About Shame Cts./Counselors</td>
<td>An Index of Awareness</td>
<td>Identity Shame/Guilt</td>
<td>Kids Aren’t Connected Repeat Assaults Trauma, Poor Bonding</td>
<td>Trauma/Shame Disorders Extensive Trauma</td>
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<tr>
<td>Palm</td>
<td>Scapegoating issues; shaming</td>
<td>Attention</td>
<td>To Know Yourself Own Work</td>
<td>Guilt/Shame</td>
<td>Language</td>
<td>People Have a Huge Shame Hx. One Extreme</td>
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<td>Spruce</td>
<td>Involved in crisis; keeps people stuck; by association</td>
<td>They Go to Great Extents to Hide It The Word Isn’t Used It’s All My Fault</td>
<td>Counselor They BetterKnow Themselves</td>
<td>Shame/Feeling Guilty</td>
<td>Children Are Small</td>
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<tr>
<td>Willow</td>
<td>Core beliefs of “I’m not lovable; I’m not capable; I’m not good enough”</td>
<td>It Gets Overlooked (Clients, Counselors) 3rd Party Payers How I Recognize It Beliefs About Themselves</td>
<td>Focus Strengths Core Beliefs</td>
<td>Counselors Message It’s Their Fault, Not Willing to Deal with</td>
<td>Guilt/Shame Pervasive</td>
<td>Likely to Develop in Childhood</td>
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</table>
Cross-Case Themes

These seven themes are arranged into two groupings. The first grouping is theoretical in nature and is associated with the counselors' perspectives and the counseling field in general. It includes Multiple Definitions (12), The Hidden Nature of Shame (8), Theories (6), and Self-Knowledge (10). I am presenting this grouping of themes in the order of importance as seen by me, not necessarily as those themes that were talked about most by the greatest number of participants. I will explain further the rationale for this particular order under each theme as it is presented. The second grouping of themes that emerged was less abstract and more closely connected to clients and includes: Identity & Shame/Guilt (12); Childhood/Relationships (11); and Disorders & Problems (8). The number of participants (from most to least) who discussed these themes at length corresponds to the importance that I attach to each theme so they are presented in that order.

Theoretical Grouping

Theme: Multiple Definitions

This theme consists of the initial definitions and descriptions of shame from all participants. This is the first theme to be discussed because it goes to the heart of this study. There is no one single definition of shame. Rather, there seems to be layers of meaning attached to the construct of shame. While this study seeks clarity around the construct of shame, it also welcomes the richness of diversity. This study asks, "What is the understanding that licensed counselors have of the construct of shame?" This theme answers that there are multiple understandings of the construct of shame. Having said that, it happens that even in this theme of variable definitions, certain elements were shared among participants. Initially, when asked about their understanding or view of shame,
participants responded with many divergent definitions and views of shame. The following definitions represent the variety of views of shame that participants offered.

Ash – “I see shame as a deeper level of embarrassment and just a real defect in the ego development around the time, and the superego development, around the time of the phallic period, 4 to 6, thinking in Freudian terms. I think of it as overdevelopment of the superego and somehow getting messages that ‘I’m not good enough as a person,’ and that ‘when I do things, I am to blame,’ and I have a strong sense of judging myself and certainly judging in a very negative way.”

Cypress – “Shame, I think, deals more with the concept of the fear of rejection. A lot of times when people fail, you know, they experience rejection ... I think shame has more to do with rejection issues, a pervading sense that you as a person, not just what you do as a person, but you as a person, are inadequate or no good or not of value so I deal with shame issues all the time.”

Elm – “Shame is more of an internalized sense of having, not just having violated some kind of social, societal rule, but somehow violated something about oneself, failing to live up to something that somebody else or that we kind of really were expected to do or expected ourselves to do so it’s a much more generalized response to a sense of our own transgression or failing.”

Fir – “Shame is feeling bad about who I am so it goes to the person’s identity, to their self-concept.”

Fig – “I see shame as something somebody puts onto somebody else, that’s not reality-based and has not meaning for them and is not helpful for them, and it gets people really stuck. ... I think that shame is insidious and is overwhelming.”
"Shame is who you are and what you lack. ... Shame is an emotion, like guilt, especially because it affects our sense of guilt by letting us know that we are imperfect. Shame is extremely powerful."

Hickory – “Shame, to me, is the feeling that one has fallen short or failed in some profound way. ... To me, I think that it is something that is imposed on the person. The person feels shame because of some external approval, or rather disapproval.”

Maple – “It (shame) is the incorporation at center of the negative values and judgments and criticisms that a child grows up with early, and get enfolded into the operating program of the personality at the level of the unconscious. Shame for me is self-doubt. ... It is an abnegation of the power and the richness and the authority of the self in life because the message is and the experiences, typically of betrayal, in early childhood, result in self-doubt, in the lack of development of a strong center, in the development of self-esteem. ... Shame is at a deeper level and has something to do with fundamental identity.

Oak – “(Shame is) an intense felt sense of one’s badness, wrongness and badness. ... Shame is a more pervasive internalized sense of self ...”

Palm – “(It’s (shame) not theoretical. It’s (shame) in talking to people about where their suffering is, there’s often shame, scapegoating kind of issues in their family or in their work environment or in their educational experiences, adults who were diagnosed with learning disabilities, or dyslexia, and the shame and the shunning about what was wrong with them, and then their believing that it’s about them.”

Spruce – “From a developmental perspective, ... I would say that usually there was some crisis or problem that the issue of shame might be involved in the crisis or problem that is keeping them at that particular level or keeping them stuck. ... I think shame, you don’t
actually have to have been the person that created the situation, and you may not have done anything that you particularly feel guilty about and yet just by association, you can be ashamed."

*Willow* -- "(S)ome core beliefs that people may have such as ‘I’m not lovable’ or ‘I’m not capable, I’m not good enough.’ ... I think in a lot of ways people really are not aware of how powerful those beliefs are."

Six participants included in their definitions some notion that shame is feeling bad about oneself. The following examples represent these participants’ concept of shame as a negative sense of one’s self. Mr. Ash stated that shame involves “getting messages that ‘I’m not good enough as a person ...’” and having “a strong sense of judging myself and certainly judging in a very negative way.” Mr. Cypress said that shame is feeling that “you as a person are inadequate or not good or not of value ...” Mr. Fir stated, “Shame is feeling bad about who I am so it goes to the person’s identity, to their self-concept.” Mr. Maple talked about self-doubt and a lack of self-esteem that also indicate a negative sense of the self. He stated, “Shame for me is self-doubt. ... It is an abnegation of the power and the richness and the authority of the self in life ... in the lack of development of a strong center, in the development of self-esteem.” Two participants discussed shame in terms of beliefs about the self. Ms. Willow said that shame is “some core beliefs that people may have such as ‘I’m not lovable’ or ‘I’m not capable, I’m not good enough.’” Ms. Palm talked about “the shame and the shunning about what was wrong with them, and then their believing that it’s about them.”

Two participants mentioned that shame is an “internalized sense.” Mr. Elm stated, “Shame is more of an internalized sense of having ... somehow violated something about
oneself...” Mr. Oak said, “Shame is a more pervasive internalized sense of self...” Two participants talked about shame being imposed from the outside in their initial discussions of the construct of shame. Ms. Fig stated, “I see shame as something somebody puts onto somebody else...” Ms. Hickory said, “To me, I think that it is something that is imposed on the person.” Two participants discussed that shame comes from disapproval or criticism, both which are externally imposed. Ms. Hickory said, “The person feels shame because of some external... disapproval.” Mr. Maple stated, “It (shame) is the incorporation at center of the negative values and judgments and criticisms that a child grows up with early...”

Two participants discussed that shame is failing in some way. Mr. Elm said, “Shame is ... failing to live up to something that somebody else or that we kind of really were expected to do or expected ourselves to do so it’s a much more generalized response to a sense of our own transgression or failing.” Ms. Hickory stated, “Shame, to me, is the feeling that one has fallen short or failed in some profound way.” There were a variety of other definitions and descriptions that participants offered about their understanding of shame. These included that shame was “a deeper level of embarrassment,” “a real defect in the ego development,” “overdevelopment of the superego,” “fear of rejection,” “insidious and overwhelming,” “an emotion,” “letting us know that we are imperfect,” “extremely powerful,” “where their suffering is, ... scapegoating kind of issues in their family or in their work environment or in their educational experiences,” “adults who were diagnosed with learning disabilities, or dyslexia,” “involved in the crisis ... that is keeping them ... stuck,” and shame “by association.”
Summary.

The most prominent thread that pulled many of these characterizations (10 of 12 participants) of shame together was that shame was viewed as a negative feeling or belief about oneself. The other views that were supported by more than one participant (usually two) included the following. Shame was seen as an internalized sense of self. Participants also remarked on their observations that shame was externally imposed upon individuals. Disapproval and criticism, as well as failure, were discussed in regard to shame. A variety of other definitions of shame were presented.

Interpretation.

The finding that there were multiple definitions of shame was expected. One of the aims of this study was an exploration of shame, precisely because it is a murky construct. The likely exposure of these participants to a variety of counseling theories, each of which looks at problems from a different perspective, predicted that their views of shame would probably vary depending on what theory they used to explain that construct of shame. Shame is a concept that is found in other disciplines such as theology, biology, anthropology, and sociology. Their concepts of shame might have very well come from these divergent areas of study. A purpose of this study was not only to see if there were common threads of shame that were found in different perspectives, but also to explore different views that can enrich a theory of shame.

Theme: Hidden Nature of Shame

This cross-case analysis theme is composed of sub-themes (See Table 5.1, p. 215) and the following within-case themes from eight participants: They Wouldn’t Use That Word; Short Treatment; Addressed; Attention; It’s Not That Common; Talk About Shame; They
Go to Great Extents to Hide It; The Word Isn’t Used; and It Gets Overlooked. This theme was placed as second in importance because of the participants’ view that shame is generally neglected in the counseling field and in counselor education. In this study, participants reported that clients and counselors tend not to use the word “shame.” Participants also indicated that insurance companies encourage short-term treatment, which is not appropriate to working through shame issues. There was some discussion about therapies that are not conducive to an exploration of shame. Most participants said that they had received or could remember receiving no education or training regarding the construct of shame in their graduate programs.

Nine participants remarked that clients did not use the word “shame” or that clients take great pains to hide their shame from both others and themselves. Some of the participants claimed that although clients did not use the word “shame,” it was clear to them that they were talking about the experience of shame. Speculation as to why clients did not use the word “shame” was presented.

Mr. Elm said, “Very rarely do I have somebody who comes in and says, ‘I’m just full of shame. I need to see you because I’m just struggling with this issue of shame.’” He purported that people are apt to try to conceal their shame.

I think shame is, in some ways, is something that we tend to hide. ... There’s a real disconnection with the self that happens with shame. I think that makes it very difficult for people to acknowledge or name what’s going on.”

Ms. Willow affirmed that clients do not usually articulate that they feel shame, but, to her, it is apparent that that is what they are experiencing. “They may feel it; they may think it, but in my experience, it’s not that often when they will actually verbalize it.”
Ms. Hickory asserted that her clients did not use the word “shame.” “Shame is not a word that my clients generally use. They might say they feel guilty about something, and maybe they’re saying the same thing. ... Guilt is more a part of the common vocabulary. Shame, perhaps, has more negative connotations.” Ms. Palm concurred that clients do not use the word “shame.” “I wouldn’t say that they necessarily use the word ‘shame.’ I’d say the clients usually use the word ‘guilt, embarrassment.’” Mr. Elm talked about guilt being easier and more acceptable to express than shame. “It’s carried as guilt on the outside because it’s easy—it’s far more respectful, respected to feel, I think, to be guilty than to be so shameful. It’s easier to say, ‘I’m a disappointment to you,’ than it is ‘I’m really a disappointment to myself’ ...”

Five participants maintained that either they themselves do not use the word “shame” or that in their discussions with other counselors, shame is not mentioned. Various rationales were offered for their decisions about not using the word “shame.” Ms. Spruce said, “I would say, ‘Where is that feeling coming from? It sounds like you feel this is all your fault. I don’t use the word ‘shame’. I think it’s more common to use ‘What would you have done differently? What do you regret?’” Ms. Willow remarked, “I can’t say that’s a word I use a lot. I personally don’t call it that with a client. No, maybe just feeling bad about yourself.” Ms. Hickory was the only participant to say that she did not see shame as an issue that her clients needed to address.

I think that it (shame) happens to everyone to a greater or lesser extent, but in my particular practice, I haven’t seen—I can’t think of anyone that I’ve seen who has had these feelings on her so pervasively, so intensively, that this is a focus of the counseling.
She also said, “I don’t see it (shame), and I freely admit, perhaps it’s because I don’t look
for it. I don’t go back and look at the client’s childhood. I don’t have time. It isn’t that it
wouldn’t be interesting.” When asked “Why do you think counselors are not giving more
attention to this (shame), in the counseling field,” Mr. Maple answered, “An awful lot of
counseling is support. An awful lot of counseling is talk therapy. Talk therapy, I don’t
think, and supportive therapy, ever, I mean it might get to ‘I’m ashamed,’ but working with
shame, to really explore that in a deep way is a specialty.”

Three participants commented on not using the label of “shame.” Mr. Fir said, “I don’t
say, ‘Oh, you are a blah blah blah obsessive compulsive. You are a depressed person. You
are generalized anxiety.’ I don’t get into that too much because I’m not big on labeling
people.” Mr. Maple remarked, “(S)hame as a label or as a title is not something I often
use.” Ms. Hickory stated,

I am not very label conscious. I wouldn’t use the DSM if I didn’t have to. ... It
may well be the same way with your, what you view as a construct of shame,
that I wouldn’t be likely to think of as a construct because I’m not much about
labeling.

Seven participants talked about the role that insurance companies play in discouraging
shame from being addressed in counseling practice. Mr. Cypress stated, “Some managed
care companies don’t even want you to deal with core issues. They say, ‘Well, when the
symptoms do begin, we’ll treat the symptoms again.” Ms. Palm said, “(S)ome of the
companies want you to do 6 or 8, but you really can’t do deep clinical work that way.
You’re doing band-aid therapy, and sometimes it’s appropriate.” Mr. Maple said,
“(T)hey’re (shame and guilt) subtle and deep and the insurance industry is into capping
costs so they’re looking for solution-oriented counseling. They’re not interested in
transformational counseling so it’s kept the work at these levels.”

Ms. Gum asserted, “We live in a very quick generation, instant success rather than building
and working hard to get to that place. ... They’re (insurance companies) putting on a band-
aid. It just goes back and fosters—actually, it costs them more money because it’s going to
come out in some physical related symptom.”

Five participants discussed that certain types of therapy are not conducive to the
exploration of shame. Ms. Fig stated, “Theoretically, I try to see people in a short of period
of time as I possibly can. ... I think that time and resources are so valuable for people right
now.” She noted that shame issues do not usually get addressed in short-term treatment.
“(Y)ou just don’t necessarily go more places than where—they’re really coming in for
service delivery.” Ms. Hickory said, “Shame can be an issue. In my counseling, however, I
would be very unlikely to identify it as such because in my counseling ... because of my
training and because of the constraints of time ...” Ms. Willow commented, “(S)olution-
focused therapy—shame is just not going to show up at all in that kind of outlook.”

The lack of education in graduate counseling programs appears to support the neglect
of shame in the counseling field. Ten counselors said that they had received or could
remember receiving no education or training regarding the construct of shame in their
graduate programs. When asked, “What kind of education or training have you had
regarding the construct or issue of shame,” Ms. Fig replied, “I don’t think I’ve had any, not
that I remember. ...Nothing in my formal training, no.” Mr. Oak replied, “None.” Mr. Ash
responded, “I wouldn’t say in any of the degree programs that we talked much about the
construct of shame. I can’t remember anything specific so obviously it didn’t stay with
me.” When asked, “Do you have any thoughts about why the construct of shame is not
given more attention ... in counselor education programs,” he replied, “(T)hey wouldn’t see
it as important to emphasize specifically because there is so many different constructs. ... I
would guess that there’s just so much material out there that they wouldn’t try to focus in
on one particular area.” Mr. Maple said, “In the academic setting, there’s so much to cover
in such a short period of time. It can’t afford to get specialized in anything.”

Other reasons for the lack of attention given to shame in the counseling field were put
forth. Mr. Elm said,

(I)t’s been an uphill struggle for psychology and counseling to kind of legitimize
itself as a field of study in science. ... I think we spent a lot of years looking at things
that we could kind of reconstruct in a laboratory and not so much looking at some of
the more subtle dynamics of what happens in human interactions that are much
harder to measure and objectify. Emotions are very difficult to kind of quantify ....

Ms. Hickory stated, “’Probably there just hasn’t been a persuasive (person). ... You can
never underestimate the importance of the person behind the theory or the person behind
the construct.”

Summary.

In this section, the lack of attention that the construct of shame receives in the
counseling field and in counselor education was discussed. A discourse about clients’
avoidance of the word “shame” as well as their unwillingness to discuss shame experiences
was presented. A discussion about the rationale for counselors’ avoidance of the word
“shame” was put forth. Participants also talked about the role that insurance companies and
counselor education plays in avoiding the construct of shame.
Interpretation.

On many levels the construct of shame appears to be avoided in the counseling field and in counselor education. Seemingly, clients, counselors, counselor educators, insurance companies, and the culture all tend to ignore shame. For example, most counselors in this study said that they had received no training about the construct of shame in graduate programs, but also stipulated that their graduate education had occurred ten to twenty or more years ago. At the same time that counselors were not using the word “shame,” almost all seemed to be aware of its presence and had given the construct much thought. Although these counselors had, for the most part, received no or little training about the construct of shame in their graduate programs, all of them articulated a definition of shame, a theory about how and when it develops, and distinguished between shame and guilt. The participants were able to verbalize what factors contributed to the development of shame and ideas about its treatment. Many participants talked about how shame was viewed through a particular theory and saw shame as a factor in many psychological disorders and problems.

The years of experience (an average of 22 years) that these participants had in the counseling field, the likelihood of them encountering clients with substance abuse or sex abuse histories where shame plays a more obvious role, their opportunities for further training, reading, and consultation with colleagues suggested the possibility that they would have come in contact with the construct of shame in the counseling field. Their discussion of the role that insurance companies and certain types of therapies play in the avoidance of shame in the counseling field suggested to me that there was some dissonance occurring...
within them, particularly with those who advocated short-term or solution-focused therapies.

**Theme: Theories**

This theme is presented as third in order of importance because views of shame most often stem from a particular theory or theories to which participants subscribe. Ten participants identified themselves as eclectic in approach. One described himself as using a combination of psychoanalytic and cognitive-behavioral approaches. One said that he used chiefly psychosynthesis but was trained in many disciplines. Those who did describe themselves as eclectic identified some primary approaches. One described his underlying worldview as Christian. One described her primary approach as cognitive-behavioral, and another said that the theory he used was chiefly that of Jung. Ten participants talked about including a cognitive-behavioral approach in the counseling they provided. One participant said that none of the theories address shame. Another counselor stated that he thought just about all the theories address shame, albeit indirectly.

Several participants articulated how shame is viewed in cognitive-behavioral theory. Ms. Hickory stated, “I think that, from a cognitive point of view, certainly you could get back to Ellis and then say it isn’t so much the event; it’s how the person feels about the event.” Ms. Willow said, “It was the cognitive-behavioral training ... they talk about automatic thought and what do those automatic thought go back to. They go back to the core beliefs, and I think the core beliefs are connected to shame.” Mr. Ash maintained that in cognitive-behavioral theory, shame is “just disturbed thinking patterns, that for some reason a person thinks of himself ... as a shameful person, and the cognitive-behavioral therapist would try to work at undoing that ...” Mr. Fir declared, “Remember that old RET
stuff which is very useful in confronting. You know, when people say ‘I’m not good enough.’ One way of approaching that is to dispute that irrational belief.”

Two participants discussed how shame is viewed from a humanistic perspective. Mr. Ash said, “Rogers would say that you just didn’t get the support and the empathy and the understanding that you needed so it taught you were a bad person.” Mr. Fir stated, “Rogers talked about it in unconditional positive regard as the antithesis of shaming people.”

Mr. Elm discussed Jungian theory and how shame is looked at in that theory.

(W)hat the psyche is reaching for is wholeness, and one’s symptoms really become more of a thwarted attempt really at some effort towards health as a way of trying to accommodate or to meet some situation, and we get stuck along the way.

He elaborated on how shame would be seen from a Jungian perspective.

I think with Jung, he looks at it (shame) as kind of a complex. He talks about feeling-tone complexes in the psyche. These get activated by, triggered in some way by different things in our experience. Shame, he would see as one of these feeling-tone complexes, that when it’s activated brings a certain way of feeling and thinking and responding to the world.

Mr. Maple talked about the theory of psychosynthesis. “Psychosynthesis is an orientation or an approach to human development and counseling and education which asserts fundamentally that there is a source of wisdom or guidance or inspiration inside each person that can guide and direct their lives.” He spoke about how shame is viewed from a psychosynthesis perspective. He proposed that shame is “an abnegation of the power and the richness and the authority of the self in life.”
Mr. Elm discussed the experience of shame through the perspective of affect theory. A key tenet of affect theory is that shame begins first in the body, before an individual has an awareness of it. “I think in practice, things really are that way, that we have an experience of it way before we’re able to articulate it or before it hits our consciousness.” He talked about how a counselor observes shame in clients by attending to their body language. The little responses and these subtle changes in a person’s physiology or movement or position of the body or their breathing. We’ll talk about those as being an edge, an edge, in the sense, that’s where the affect is beginning to break through. It’s not fully conscious ...

What the counselor does at that point is, “(G)o right for that and work with that and get the person to move more deeply into that so he’ll understand it a little bit more, ... access some of the shame.”

Mr. Ash discussed how shame is seen from a psychoanalytic perspective.

There’s a lot of talk about that (shame & guilt) because psychoanalytic theory really looks at shame as a very significant aspect of personality development, a very deep aspect of it. They look at it as a major disturbance. They look at it as someone who was really pressured in their self-esteem and self-concept. ... The ego just isn’t strong enough. The ego, of course, being the logical, rational, decision-making part of the personality, and it’s not strong enough to balance out the superego.

Mr. Cypress spoke about shame from the perspective of a Christian framework.

One of the ways we try to look at the difference is, and I think you can do this within the framework of the spiritual framework is try to understand the
difference between self-concept, self-worth, self-acceptance, and a sense of God-worth, God-concept.

He also talked about the benefits of counseling from a Christian perspective. “When you look at the whole person that way, it offers you the opportunity to delve into that area whereas other therapists may be a little bit reluctant to go there with a client.”

Two participants expressed almost diametrically opposed views about shame being addressed in counseling theories. Mr. Oak said, “In fact, most of them don’t mention shame. Like I don’t remember any literature in any of those basically that address the issue of shame.” Mr. Ross stated, “I think indirectly in almost all programs or all approaches to counseling, there is sort of imprisoned in that the notion of shame.”

Summary.

This section covers various theories that the participants discussed. How shame is viewed in cognitive-behavioral, humanistic, Jungian, psychosynthesis, affect theory, psychoanalytic and Christian frameworks was presented. Of particular note were the opinions of two participants. One stated that shame was addressed in all theories while the other participant said that none of the theories address shame.

Interpretation.

Counselors are exposed to a variety of theories in their academic training and ongoing professional development. Therefore, in a discussion of the participants’ perspective of shame, inclusion of a variety of theoretical frameworks would be expected.

Theme: Self-Knowledge

This theme emerged as fourth in importance because it is a more peripheral topic in the discussion of shame. This theme emerged from the clustering sub-themes (See Table 5.1, p.
215) and themes of nine participants. The themes included: Never Self-Disclosing; In Touch With Their Own Stuff; Understand Our Own Nature; We Start to Shame Our Clients; Therapists; Self-Development; An Index of Awareness; You Have to Know Yourself; and Counselors. All but one participant discussed self-knowledge as an extremely valuable attribute for a counselor to have.

Most of the remarks about self-knowledge occurred in response to two questions, “What are some of the characteristics and values that you think are important in a counselor?” and “What connection, if any, is there between counselors’ own shame issues and how they provide counseling to their clients with shame issues?” Mr. Maple remarked, “The journey to self-discovery, self-development was primary and continues to be. I was interested in knowing who I am and what powers and resources I could develop about myself. That’s always been my primary drive.” Mr. Oak said, “Well, it’s an old kind of saying in this field that you can’t take your client past where you are, and I think there’s some truth in that, that if a counselor or therapist doesn’t pay attention to his or her issues around shame, it’s going to be really hard to address those with clients whose tendencies, are, I think, to avoid them.” Ms. Fig confirmed Mr. Oak’s opinion. “I don’t think a counselor can take a client any further than they’ve been personally. I don’t think that you could help a client work through shame issues if you continue to have shame issues, at least not fully.”

Mr. Ash entered into a discussion of self-disclosure when he discussed how important it was for a counselor “to be aware, to know what the issues are, to recognize the shame you have.” He stressed that the counselor should not reveal that he is experiencing shame in the session or that he has shame issues. “I don’t think it’s ever appropriate to disclose
deep personal issues or struggles that the therapist has because the purpose of therapy is to
deal with the patient, not with the therapist.” Mr. Ash asserted that knowing oneself is a
valuable counselor attribute; he also emphasized that it is important not to share that
personal knowledge of oneself with a client.

Mr. Ash’s view radically differed from the perspective of two other participants who
talked about self-disclosure. Ms. Willow briefly mentioned how she might disclose
personal information.

(T)here definitely are times when I will say to people, “I know where you’re
coming from. I understand. I can relate to that. That’s something I struggle with
in my own life or have struggled with in my own life.”

Mr. Elm claimed that self-disclosure is “very, very helpful because it gives them another
model, something else to begin to identify with” because often “they haven’t had the
experience at home of seeing how somebody else moves through the world, how somebody
else copes with a particular situation or experience of affect.” He stressed that “it’s really
critical that we know ourselves” in order to use self-disclosure “in service of the client, you
know it’s for their benefit.”

Mr. Elm proposed lack of “awareness of one’s own manner” might result in “triggering
some experience of shame,” that “(i)t’s sort of jumping on the pile when somebody’s
down.” Mr. Elm implied that self-knowledge was a prerequisite to engage in “a mirroring
process” with the client in which he reflects the client’s feelings. He further maintained that
“the more you know yourself and the way of your own workings, one, you’re better able to
understand the experience of somebody else.”
Summary.

In this section, the importance of a counselor’s self-knowledge was discussed. Of significance was the opinion of several participants that a counselor cannot be effective in helping clients with their experiences of shame if they have not worked through some of their own shame experiences. A debate on self-disclosure was presented as well as a brief discourse on self-awareness.

Interpretation.

From my experience in three graduate programs, one in social work and two in counseling, self-knowledge is emphasized and viewed as a critical component for effective counseling. Often counselors are encouraged to go through the counseling process themselves because such self-exploration can increase their level of self-awareness (Corey, 1991). The likelihood that the participants, who are all veteran counselors, have probably heard or read about the importance of knowing oneself and the value of going through counseling oneself, is great. Their many years of providing counseling perhaps has confirmed the notion that one’s own issues can be triggered by those of clients. One particular question that prompted self-knowledge as a theme was “What connection, if any, is there between counselors’ own shame issues and how they provide counseling to their clients with shame issue? For these reasons, this theme could have been anticipated, however, the discourse on self-disclosure was not expected.

Clinical Grouping

Theme: Identity & Shame/Guilt

This theme is presented as the first theme to be discussed in this group of clinical themes because identity or shame/guilt emerged as a theme or sub-theme across all
participants and there was almost universal agreement that shame is about the feeling and believing of inadequacy, worthlessness, or wickedness of oneself. All 12 counselors agreed that shame plays a role in identity formation. Eleven participants talked about individuals believing or feeling that they are “not worthy,” “no good,” “worthless,” “not good enough,” “inadequate,” “bad,” or “something wrong with them.”

When asked, “Does shame play a role in identity formation,” these participants responded in the following ways. Ms. Palm replied, “I think a lot of people who carry shame feel that it’s not like an emotion, it’s like who they are. It’s like their personality. It’s that they are ashamed of being alive.” Mr. Maple answered, “I think in some stereotypic way, or archetypal way, the message of shame is that ‘I am no good, and I have no right to be here.’ ... I think shame has a tremendously negative impact on identity formation. He declared, “One way I might talk about shame is, if the self is a mirror, shame is a broken mirror. The pieces don’t fit together. There isn’t a sense of wholeness or goodness or integrity.” Mr. Ash responded, “If you see yourself, and that’s my concept of shame, that shame is really part of your self-identity, that you see yourself as a shameful person.”

When asked, “Is there a distinction between ‘shame’ and ‘guilt,’” nine counselors responded generally that shame is feeling bad about who you are as a person; it is who I am; it is self-esteem or self-concept whereas guilt is feeling bad about specific behaviors or actions, either having done something or having failed to do something. There were a few other distinctions between shame and guilt that were discussed.

Mr. Fir said, “Guilt is feeling bad about something that I’ve done. Shame is feeling bad about who I am so it goes to the person’s identity, to their self-concept. Ms. Gum stated,
“Guilt is a lot of times through action, what you do. Shame is who you are and what you lack.” Mr. Cypress declared,

I see guilt as people addressing behavior. Guilt, to me, usually has to do with what I did or what I didn’t do but maybe I should have, either acts of commission or acts of omission ... I think shame has a little bit more to do with how I perceive myself as a person, and so it’s a little deeper, I think.

Mr. Elm tended to see shame as a violation of oneself while guilt was much more specific.

Shame is more of an internalized sense of having, not just having violated some kind of social, societal rule, but somehow violated something about oneself ... it’s a much more generalized response to a sense of our own transgression or failing—when we feel guilty, we break a rule, much more specific, much more focused.

According to Ms. Fig, shame tends to make one passive and incommunicative, while guilt tends to encourage action. “I think shame is just so overwhelming and demobilizing that then they don’t tend to talk. They don’t tend to do what they need to do to self-care, whereas guilt sometimes will make people act.” Ms. Spruce talked about shame occurring because of an association with an event, whereas, guilt has to do with actual participation in the event. “I think shame ... You can be associated with a certain situation or something that happened even though you may not feel that you were responsible for some of the things that unfolded. I think feeling guilty about something implies that in least some aspects you participated in something.” Another distinction that was mentioned was that others externally impose shame whereas guilt is internal. Ms. Hickory said, “(S)hame is externally imposed, and guilt is internal. Ms. Fig talked about shame as “someone is taking on something as part of who they are that doesn’t belong there.”
Summary.

This theme discussed the unanimous agreement among the twelve participants that shame plays a role in identity formation and the almost unanimous agreement (11 of the 12 participants) who talked about shame as feeling “bad,” “inadequate,” or “worthless.” The distinction between shame and guilt was discussed as shame being associated with one’s identity and guilt as being related to one’s actions or behavior. This distinction was supported by nine participants. Other distinctions were also noted.

Interpretation.

The finding that identity is associated with shame and is related to feeling “inadequate,” “bad,” and “worthless” made sense because the participants are, after all, seasoned counselors who have probably had many opportunities to interface with shame through contact with clients and colleagues, training, or reading. Most of the participants had recognized that clients are more likely to talk about shame than guilt because, I presume, they recognized that shame is intimately connected to an individual’s sense of self. The finding that the major distinction between shame and guilt is that shame is associated with one’s identity while guilt is related to one’s actions or behavior was expected, also for the same reason. People can more easily talk about guilt because it is associated with specific actions and events outside oneself while shame is a part of who one is.

Theme: Childhood/Relationships

This theme emerged as second in this group because all participants said that shame usually originated in childhood. After identifying that shame is one’s identity in the previous theme, it is important to locate its source. This cross-case theme represents data
from ten participants. This theme was a blending of two clusters of within-case themes and sub-themes (See table 5.1, p. 215), namely, Childhood and Relationships. The following themes were clustered under the broad theme of Childhood/Relationships: Socialization; When Kids Aren’t Connected; and Self-Destructive. These two clusters of within-case themes, Childhood and Relationships, were combined into one cross-case analysis theme Childhood/Relationships because all 12 participants talked about shame developing from the relationship a child had with her primary caregivers, usually parents, in early childhood.

Ms. Spruce discussed that children were not only afraid of parental disapproval but also of losing their parents love and support altogether. She surmised that “we socialize it (shame) into everybody shortly after birth.” She suggested that “shame and a probably a very young fear of abandonment and loss” occurred “when we break a rule from the time we’re a little kid, when we don’t pick up our toys, then we feel bad.” She asserted that the message is “If I’m bad, Mommy won’t love me or Daddy won’t love me.”

Mr. Ash talked about the susceptibility of children to the early parental messages. “I think at that early age you’re so vulnerable so unless you receive approval, unless you receive acceptance from these people (your parents) for who you are as a person, I think that does significant damage.” Mr. Oak affirmed that. “(A)s kids are shamed about themselves, ... they develop a sense of themselves as being inadequate.” He went on to connect this sense of shame about oneself to relationships with others.

If I’m ashamed at a core level about myself and who I am and yet I want to connect with other human beings, then interpersonally what I’m going to do is I’m going to develop a single kind of sense of self and put that out there ...
somebody's dealing with a shadow kind of relationship with myself instead of my core self which is shame.

He continued to talk about what kind of relationships this shamed self would be involved in. "Those kind of relationships are often either overly engaged ..." or "they keep themselves at a distance."

Mr. Fir asserted that parents shame children as a way of controlling them. "Children come into the world shame-less, and then we train it into them. ... I think that we do that because we are afraid so it's fear that's connected to control, and one way to control people is to shame them." Ms. Gum suggested that children often feel responsible for the negative things that go on in the family and they feel ashamed. "I think you know that children think that they can do all sorts of powerful things, which they cannot. They can step on a crack, break her back so they think they're responsible for everything, such as abuse, drunk, lost jobs, tired."

Shame's impact on relationships beyond childhood was discussed. Mr. Ash contended that an individual unconsciously repeats shame-based relationships that developed during the early years in order to produce a more favorable outcome. "Of course, according to psychoanalytic thought, we spend the rest of our lives, trying to redo, recreate experiences as a child and try to get them right ... getting into bad relationships." Mr. Cypress remarked, "Those shame-based thoughts result in certain behaviors, difficulty in concentration, difficulty functioning at work, greater conflict or avoidance or withdrawal or isolation behaviors, and in turn, are going to impact relationships."
Summary.

In this section, the idea that shame develops in childhood and the importance of those earliest relationships with primary caregivers, usually parents, were topics of discourse. Participants discussed how parents' disapproval and lack of acceptance in childhood impact on relationships that individuals develop in adulthood. Some participants acknowledged that shame could develop throughout one's life although they felt that childhood is a time when individuals are more susceptible to shame.

Interpretation.

The finding that shame originates in childhood and that the relationship between primary caregiver and child plays a role in its development was expected because the traditional theories connect the development of an individual's personality, self-concept, and self-esteem, which participants linked to shame, to early significant relationships. Given the extensive training and likely exposure to the traditional theories that these participants have had, one would anticipate that they would look to the early years of an individual's development for the origins of shame. There were differences in the emphasis that particular theories put on the past; for example, cognitive-behavioral theory places much less importance on the past than psychoanalytic theory. However, no matter what lens a participant looked through, whether it was humanistic, cognitive-behavioral, or psychoanalytic, childhood figured prominently in the development of shame. The psychoanalytic concept that individuals cling to old patterns (repetition) was reflected in the responses of several participants. As applied to shame, individuals would continue to be involved in shaming relationships if that was the experience of their relationship with their
parents. Questions about how shame develops in an individual prompted a discussion of when and how shame develops in individuals.

**Theme: Disorders & Problems**

This theme was placed last, not because it is the least important, but because it stems from the previous themes in this grouping. Disorders and problems are often the result of an individual whose identity is closely linked to shame that most likely began in childhood and has continued to be reinforced through the growing-up years and beyond. This cross-case theme emerged from the clustering of sub-themes (See Table 5.1, p. 215) and the following themes: Anxiety, Trauma, & Depression; Disorders; Almost Every Diagnosis; Short Treatment; The Underpinnings of Most Counseling; Clients; Abuse; Disorders/Trauma; and A Lot of the People Have a Huge Shame History. These within-case sub-themes and themes came from eight participants.

Seven participants identified chemical dependency or addictions as being connected to shame, and four said that eating disorders are linked to shame. Mr. Elm stated, “You see this (shame) a great deal with addictions and eating disorders.” Mr. Oak discussed an association between eating disorders and shame.

Sure, eating disorders is a classic one, I think. Many of my clients over the years, intensely shamed about inappropriate sexual behavior at an age when they were formulating concepts and feelings and a relationship with their developing bodies, make a decision at some point in time that they’re not going to feel that way any more, and how they handle that, of course, is to be 150 pounds heavier.
Ms. Palm said, "I work with it (shame) a lot with people with addictions, and a lot of them have been shamed." Ms. Fig remarked, "Certainly substance abuse is rampant among people that feel shame." Mr. Fir talked about shame and addictions. "There's lots of shame for the addictive person and for significant others of the addictive person."

Mr. Maple talked about the presence of the construct of shame in substance abuse literature, particularly ACOA. "There is a lot of literature, I think, now out in this field, and I think it's (shame) in those two areas; it's ACOA language and it's sex abuse work." Mr. Fir discussed shame in the literature on addictions. "Of course, it's (shame) all through the professional literature on addictions or compulsions, that they are shame-based, and that you're not really going to be successful in treatment if you're not dealing with issues around shame." Mr. Oak talked about how he learned about shame from working with people in recovering from addictions and addictions literature.

From working with folks in recovery and from hanging around folks and talking, dialoging with folks who worked in recovery processes. We'd talk about shame. In some of their literature, some of the counselors' magazines addressing folks who worked in the recovery field would write articles occasionally about shame.

Eight participants said that anxiety or anxiety disorders are linked to shame, and seven participants identified depression as being connected to shame. Mr. Elm stated, "I see it (shame) in situations where people are struggling at times with chronic depression." Mr. Cypress remarked, "Those shame-based thoughts are going to produce some anxiety, some depression ..." Ms. Willow said, "Lots of depression, certainly depression would be the big one. Anxiety disorders, personality disorders could be linked to (shame)." Mr. Cypress
stated, “Some depression, I think, can be, especially exogenous depression, that which originates outside the person. Again, it’s how we internalize our external events.” Ms. Spruce stated, “Well, I don’t know if it (shame) even contributes to the development of the disorder, but maybe certainly it’s a part of the disorder as well, maybe like anxiety disorders. If somebody’s an agoraphobic, that’s usually part of it. They feel like something’s wrong with them, like they’re not living up to certain expectations or depression, not being able to get out of feeling depressed, mood disorders, eating disorders, ADHD.”

Four mentioned post-traumatic stress disorder as being associated with shame. Three stated that abuse is connected to shame. Mr. Maple said, “I will say unequivocally that whenever I have worked with abuse victims, physical, sexual, mental, emotional, then if I have the time to do a true therapy, there will be a journey into the dynamics of shame.” Mr. Elm stated, “It’s (shame) such a big part of people’s experience when they have suffered abuse of any kind.” Ms. Spruce remarked,

Working with people who’ve been victims of domestic or sexual violence, both children and adults, I think the shame construct and that feeling of guilt is one that is addressed, and it’s an issue that therapeutically surfaces frequently at different times.

Mr. Fir talked about men who had been sexually abused. “And then I work a lot with male sexual abuse survivors, and shame is a real issue for them, feeling that somehow I am responsible for that experience.” Ms. Gum spoke about the confusion mixed with shame that child sex abuse survivors experience. “The client has to learn to separate the shame
that her body responded to the sexual abuse positively from the fact that her body was responding naturally, and the shame is not hers."

Four participants remarked that shame is connected with most or all disorders or that most of their clients have shame issues, while one participant said that shame was not connected to any specific disorders. When asked, "Have you had any clients in which shame has played an integral part in their problems," Ms. Gum replied, "That's a very hard question because I truly believe that most of my clients come in with a big shame issue."

When asked, "Are there specific psychological problems connected to shame," she responded, "I imagine you could put it on every single one, attention deficit to learning to having an illness in the family." When asked the same question, Mr. Oak answered, "I think they're all connected to shame in some way, all of them." Ms. Hickory's answer was: "I wouldn't see a specific psychological disorder arising because of shame imposed from someone else. I wouldn't see that."

Other disorders that were mentioned by counselors were mood disorders, personality disorders, adjustment disorder, dissociative disorder, agoraphobia, eating disorders, obsessive-compulsive disorder, avoidant disorder social aversion disorder, low self-esteem, perfectionism, compulsions, sexual dysfunction, attention-deficit hyperactive disorder, and attachment disorder. Mr. Maple remarked,

I think shame plays a larger role in some disorders than in others—avoidant disorder, probably adjustment disorders, social aversion disorder, to be sure, post-traumatic stress disorder, generalized anxiety disorder, probably all the mood disorders that aren't biologically based ...
Participants also talked about certain populations, cultures, and religions in which they saw the presence of shame. Mr. Fir stated, “I see lots of people I work with, special populations that I work with, where shame is a real issue. I work a lot with gay/lesbian clients who have been overtly and covertly shamed about who they are, people with HIV ...

Ms. Palm spoke about a relationship between shame and certain cultures.

I grew up with German parents, very shaming. The whole fear theory of childrearing was all shame focused, and I think that was an ethnic process. I’m sure there’s other cultures. I know certainly Asian, certainly Korean and Vietnamese, It was all shame based. It still is. When I have families, maybe one generation in this culture, very venomous language is used with the children, with the spouses about being stupid.

Ms. Gum asserted that shame is linked with aging. “Shame is when adults, losing their functions, are totally humiliated – that they forget something or they’re slow. Younger people tend to rush them along or complete their sentences, a sense of loss of dignity.”

Mr. Fir discussed shame around appearance, particularly overweight people. “(O)ne of the targets of bullying in schools is kids who are overweight. Look at the commercials on TV. We’re always, in a sense, being shamed about – we’re supposed to look 24 when we’re 52.”

Summary.

This theme discussed various disorders and problems that the participants associated with shame. The following disorders were focused on: addictions; eating disorders; anxiety; depression; trauma; and sexual abuse. Of particular note were the opinions of several participants who said that shame is connected to almost every disorder and one
participant who stated that shame is not related to any disorder. A discourse on particular populations’ association with shame took place.

*Interpretation.*

The result of having shame as one’s identity and permeating every aspect of one’s life, including thoughts, feelings, behaviors, and relationships seemed to naturally progress to some identified disorder. Participants linked shame to the fundamental and common disorders of anxiety and depression, as well as the increasingly more identified problems of abuse and addictions. These associations alone speak to the significance of the construct of shame without mentioning the numerous other disorders that participants associated shame with.

*Unique Themes*

In order to honor all perspectives, themes that were exclusive to individual participants will be mentioned here. One participant discussed characteristics that are important for a counselor to possess that were not echoed by other participants. These characteristics included: pride in oneself; the ability to normalize clients’ feelings; and the ability to confirm a client’s sense of uniqueness. A theme that emerged for one participant was the lack of legitimacy for the construct of shame. One participant discussed her view of guilt and its connection to resentment in some detail. Many unique ideas of the participants were previously presented under broad themes.

*Chapter Interpretation*

The emergence of these particular themes as those most commonly talked about could have been anticipated because the topics of discourse were shaped by the questions that were asked of the participants. Because of the well educated, highly trained, and
experienced participant pool, their familiarity with the construct of shame would be expected. These participants had the opportunity for exposure to the construct of shame in counseling sessions with their clients, in their extensive training beyond graduate programs, in their discussions with other counselors, and in the literature. However, I would have expected less support for the construct of shame because of the culture's avoidance of the construct, the current trend for brief solution-focused therapies, managed care's focus on reduced symptoms and quick fixes, and the lack of attention that shame receives in counselor education and in the counseling field in general. I think we live in an age and culture that implies that for every problem, there is a solution, one that is rational and logical and once applied takes care of the problem. Some of the theories that are currently most popular, such as solution-focused and cognitive-behavioral, pay little attention to the past, which according to most theories and the participants is where shame originated.

Multiple Definitions quite naturally emerged as a theme because a variety of definitions and characterizations of shame, many of them arising from an assortment of counseling theories, surfaced. Shame is a construct that occurs across disciplines, history, sociology, biology, and theology. I would suspect that these participants probably had some notion of shame from these areas of study. The variety of definitions of shame presents a difficulty in the inclusion of construct of shame in counselor education programs. Questions about which definition to teach arise. There seems to be a lack of clarity about the construct of shame that leads to confusion about its meaning.

That Hidden Nature of Shame arose as a theme could have been anticipated because one of the assumptions of this study was that shame was neglected in counselor education and the counseling field. Although several participants stated that they did not use the word
“shame” with clients because of their concern about labeling, I wondered about this. I doubted that they used the same caution with other words that describe negative feeling states, like “mad,” “sad,” “disappointed,” “frustrated,” “confused,” “wary,” or “frightened.” I was confused about their rationale for not naming shame when they saw it. What message does the client receive when we as counselors cannot bring ourselves to say the word “shame?” Until counseling programs pay attention to the construct of shame in an intentional way, shame is likely to be avoided in counseling sessions. The construct of shame has much going against it: the culture; the client’s fear of exposure; the counselor’s discomfort with it; the insurance industry’s promotion of brief therapies; and, the counseling field’s dismissal of it. This theme brings together those elements that operate in concert to keep the construct of shame neglected in the counseling field.

*Theories* presented as a theme because there were questions about the participants’ theories and how shame was viewed in the theories which they used to guide their practice of counseling. The likelihood of participants’ exposure to a variety of theories in graduate school and the influence that these theories would have in shaping their perspectives on the construct of shame were predictable. The differences in the emphasis that certain theories place on the past impacted greatly on not only their view of shame but also whether shame would be addressed at all in counseling sessions. For example, in brief solution-focused therapy, there seems little impetus to address shame because time is limited and emphasis is placed on focusing on solutions and positive aspects of individuals. As one would expect, treatment of shame was also influenced by theory. Cognitive-behavioral theories such as RET that focus on core beliefs about oneself involve repudiating thoughts rather than the remedial working through of feelings that psychoanalytic, object-relations, and
humanistic theories advocate. *Self-Knowledge* was a theme because it was identified as a value that was important for a counselor to possess by a majority of participants who were asked about what values were important in a counselor and whether there was a connection between counselors' own shame issues and how they provide counseling to their clients with shame issues. Several participants expressed an awareness of the value of self-knowledge particularly in relation to ethical concerns. Discussion about the temptation for counselors to use counseling sessions to meet their very human needs for such things as esteem, intimacy, admiration, power and so forth indicated such an awareness of ethical issues. Their thinking about this issue extended to a discussion about taking care of oneself, living a balanced life, and meeting one's needs through relationships with a partner, family, friends, and colleagues in the form of consultation and peer support/supervision groups in order to ensure that they were not using sessions to meet their own needs. Several participants made the connection between lack of self-knowledge and a predisposition to shaming clients.

*Identity & Shame/Guilt* emerged as a theme because participants unanimously viewed a close association between shame and identity when they discussed their understanding of the construct of shame. In addition, all participants distinguished between shame and guilt when asked if there was a distinction. The participants' unanimous view that shame is linked to identity showed their understanding of the depth of the construct. Concepts of personality development and identity appear in most theories; therefore, a discussion of identity seemed probable. The recognition that several participants exhibited regarding not only close association between shame and guilt, but the role that guilt played in obscuring shame was a testament to their discernment regarding the construct of shame.
Childhood/Relationships was a predictable theme because most counseling theories to which the participants subscribed view childhood as a period in which the personality, identity, and self-esteem develop in human beings and when the first relationships are formed. Disorders & Problems was anticipated as a theme because when participants were asked if they associated shame with specific disorders and problems, they responded with the identification of numerous and assorted disorders and problems. Most participants, from their deep reservoirs of advanced education, extensive training, and much experience, were able to identify a wide-range of disorders from depression to violence and those in between. Disorders and problems can result when feelings of shame are not addressed. The following excerpt from a poem by Langston Hughes (1951) reflects my thoughts about what happens when shame is not addressed.

Does it dry up like a raisin in the sun? Or fester like a sore—And then run? Does it stink like rotten meat? Or crust and sugar over—like a syrupy sweet? Maybe it just sags like a heavy load. Or does it explode?

Chapter Summary

The cross-case analysis of participants’ themes was presented in this chapter. Cross-case analysis was conducted by examining all themes and sub-themes that emerged from within-case analysis of each of the twelve participants (cases). The within-case themes and sub-themes were clustered according to content. To qualify the themes had to be present in at least half of the cases. Theme titles are in my own words. The seven themes that emerged from this reduction process were organized into two groupings for the purpose of discussion. The first grouping was theoretical in nature and was associated with the counselors’ perspectives and the counseling field in general. The Theoretical Grouping
included Multiple Views (11), The Hidden Nature of Shame (8), Theories (6), and Self-Knowledge (10). The second group of themes, the Clinical Grouping, that emerged was less abstract and more closely connected to clients and includes: Identity & Shame/Guilt (12); Childhood/Relationships (11); and Disorders & Problems (8). Each theme was followed by researcher interpretation; in addition, there was an overall researcher interpretation section after all the themes had been discussed at the conclusion of the discussion of all themes.
CHAPTER SIX
Summary and Recommendations

Chapter Four presented analysis of each participant, including themes (with related sub-themes). Chapter Five presented the next step in data reduction: cross-case analysis of themes. This chapter summarizes the preceding research analysis and interpretation and additionally makes recommendations for further study. This chapter begins by revisiting the purpose of the study and the overarching questions that this study hoped to answer. Next, the literature is reviewed in light of these findings. The chapter then focuses on the implications of the research findings for future research, for counselor education and professional development, and for the practice of counseling. The chapter concludes with some personal reflections by the researcher concerning both the process and outcomes of this study.

Purpose of the Study

The purpose of this study was to explore perspectives on shame of twelve licensed professional counselors. This study documented the understanding of the construct of shame of twelve licensed counselors and its meaning to them in the practice of counseling. This study was guided by the following overarching questions:

1) What is the understanding that licensed counselors have of the construct of shame?

2) How does education and training, particularly graduate counseling programs, influence counselors' understanding of the construct of shame?

3) How is the construct of shame meaningful to licensed counselors in the practice of counseling?
Answers to these research questions were arrived at through a combination of specific responses to interview questions and thematic analysis findings.

Question #1

*What is the understanding that licensed counselors have of the construct of shame?*

Common and uncommon perspectives from the interview responses and thematic analysis are discussed in the following sections. The findings of previous studies are compared to the findings of this study. Sections covering the following areas are presented: Definitions; Empathy; Hidden Nature of Shame; Distinction Between Shame and Guilt; Childhood; Theories; and Psychological Disorders & Problems.

**Definitions**

<table>
<thead>
<tr>
<th>Participants</th>
<th>Multiple Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ash</td>
<td>Defect in ego; deeper embarrassment; overdeveloped superego; message of “I’m not good enough as a person;” judging myself in a negative way</td>
</tr>
<tr>
<td>Cypress</td>
<td>Fear of rejection; pervading sense that you as a person are inadequate</td>
</tr>
<tr>
<td>Elm</td>
<td>Internalized sense of violating something about oneself; Failure to live up to expectations of self or others</td>
</tr>
<tr>
<td>Fig</td>
<td>Something one puts on someone else; insidious, overwhelming; gets one stuck in development</td>
</tr>
<tr>
<td>Fir</td>
<td>Feeling bad about who I am; goes to person’s identity, their self-concept</td>
</tr>
<tr>
<td>Gum</td>
<td>Who you are &amp; what you lack; an emotion; lets us know that we are imperfect</td>
</tr>
<tr>
<td>Hickory</td>
<td>Feeling one has fallen short in a profound way; externally imposed; comes from disapproval</td>
</tr>
<tr>
<td>Maple</td>
<td>Incorporation of criticisms that a child grows up with; abnegation of the power &amp; richness &amp; authority of the self; self-doubt; linked with fundamental identity; lack of self-esteem</td>
</tr>
<tr>
<td>Oak</td>
<td>Intense sense of one’s badness, wrongness; pervasive internalized sense of self</td>
</tr>
<tr>
<td>Palm</td>
<td>Scapegoating issues; shunning about what was wrong with them &amp; their believing it; where people’s suffering is;</td>
</tr>
<tr>
<td>Spruce</td>
<td>Involved in crisis; keeps people stuck in development; can occur just by association</td>
</tr>
<tr>
<td>Willow</td>
<td>Core beliefs of “I’m not lovable; I’m not capable; I’m not good enough”</td>
</tr>
</tbody>
</table>

The many varied definitions, descriptions, and views of shame of this study’s participants are consistent with the numerous different ideas expressed by theorists. Shame is like an onion; at times there are layers that overlap; and sometimes there are distinct meanings (Pattison, 2000). The most prominent overlapping in the case of shame was the...
characterization of participants in this study that shame is feeling or believing that there is something bad, inadequate, or defective about oneself. This definition was consistent with that most commonly found in the literature. The finding that shame is viewed as believing or feeling that one is “not worthy,” “inadequate,” “bad,” or “something wrong” about oneself was supported most participants. A recurring theme in many definitions in the literature was shame’s connection to the self, a feeling of inadequacy and worthlessness as a human being, of being bad or defective (Bradshaw, 1988; Fossum & Mason, 1986; Fowler, 1993; Kaufman, 1996; Morrison, 1996; Nathanson, 1992). Furthermore, the link between shame and an inadequate sense of self was found in several theories: psychoanalytic theory (Schultz & Schultz, 1994), cognitive-behavioral theory (Corey, 1991); person-centered theory (Rogers, 1961), and object relations theory (Scharff & Scharff, 1998).

When participants in this study conceptualized how shame would be viewed in a variety of theories, they talked about shame’s close association to one’s sense of identity. One participant who talked about shame in psychoanalytic terms said, “They (psychoanalysts) look at it (shame) as a major disturbance ... as someone who was really pressured in their self-esteem and self-concept.” In the literature, from a psychoanalytic viewpoint, shame was defined as the result of internal conflict between intolerable drive impulses and the inflexible defenses raised against them (Morrison, 1996). One participant in this study described shame in cognitive behavioral terms as “disturbed thinking patterns ... a person ... mentally constructs the concept of himself as a shameful person.” A participant described shame in a humanistic approach. “Rogers would say that you just
didn’t get the support and the empathy and the understanding that you needed so it taught you were a bad person.”

Cook (1991) suggested an association between shame and self-esteem. The Internal Shame Scale (ISS) correlated significantly with the Tennessee Self Concept Test (-.66) for 118 college subjects and correlated with other shorter self-esteem measures ranging from .52 to .79 (Cook, 1991). Nichols (1995) stated, “Shame is an acute collapse of self-esteem” (p. 140). Several participants talked about a connection between shame and self-esteem that can best be characterized by one participant’s statement that shame in early childhood can “result in self-doubt, in the lack of development of a strong center, in the development of self-esteem.”

Participants in this study defined shame in many other ways, as did theorists in the counseling and psychology fields. In their initial definitions and descriptions of shame, participants in this study talked about shame as being “externally imposed” upon an individual, as stemming from “criticism” and “disapproval”, as an “internalized sense of self”, as “failing”, as “falling short” in “some profound way,” as “fear of rejection,” as “a real defect in the ego development,” as “scapegoating kind of issues” and so forth.

The different definitions and descriptions of shame found in the literature follow. Piers and Singer’s (1971) description of shame as occurring when a person fails to live up to her or his ego ideal was echoed by at one participant’s definition that shame is “failing to live up to something that we ... expected ourselves to do ...” Several theorists linked parental rejection and pervasive disrespect to shame in their descriptions of shame. “Shame is ... developmentally linked to parental failures to respond with adequate attention and appreciation to the child as a whole and worthwhile human being” (Nichols, 1995, p. 140).
A participant said that shame is “criticisms that a child grows up with early ... the message is and the experiences, typically of betrayal, in early childhood, result in self-doubt.”

Lee (1996), a Gestalt therapist defined shame as “the experience of that what is me is not acceptable” (p. 8). The definitions of many participants in this study resonated with this characterization of shame. The following participant’s definition is representative of the definitions of many participants: Shame is “some core beliefs that people may have such, as ‘I’m not lovable’ or ‘I’m not capable, I’m not good enough.’”

Other definitions were found in the literature that were not necessarily reflected in the initial definitions of participants in this study, but often later on in the interviews, some of these perspectives were articulated by the participants. Kaufman (1996) asserted that shame is activated by “severing the interpersonal bridge” (p. 32). Cook (1991) defined shame as being triggered “where there is a breaking off of the connection between individuals where one is seeking to establish or maintain that connection” (p. 410). Mindell (1994) defined shame as “the experience of feeling intensely unacceptable ... accompanied by the experience of being unable to think clearly and of being completely exposed to the critical view of another person, with an intense wish to hide oneself” (p. 33). Lewis (1971) described shame as an experience that often renders an individual inarticulate because of the confusion that he or she feels.

The multiple definitions and descriptions of shame point to the rationale for this exploratory study. Shame seems to be an indistinct, vague, nebulous, hazy, imprecise term that is bandied about. European languages distinguish between shame felt prior to an action and shame experienced after an action with words for both feelings; the English language has only one word to describe both feelings (Schneider, 1992). The results of this study,
which are consistent with the literature, indicate that individuals attach a variety of meanings to this term. However, even in the initial definitions there were some common features shared among the participants. Perhaps the shared definitions of shame theorists and participants can serve as an initial step in the discourse that will lead to a common definition of shame for the counseling field that could bring about inclusion of the construct of shame in counselor education and the counseling field.

*Empathy*

The notion that shame is part of one’s identity, a finding in this study that was consistent with the literature, seems to go to the core of the construct. The pain of feeling that one is inadequate or defective appears to have many implications. One implication might be that an intense focus on the self precludes the potential to connect to others. When an individual is preoccupied with self, she or he is not able to involve her- or himself with others’ thoughts and feelings. Tangney’s studies (1991, 1995a) found that feelings of shame are not compatible with empathy towards others because of the individual’s consuming focus on the negative qualities of the self. A study by Tangney, et al. (1994) found that empathy is much diminished during shame experiences and confirms Lewis’s (1971) observation that focus on the self is part of the shame experience while focus on a specific behavior is part of the guilt experience. Although participants did not use the words “focus on the self,” they seemed to imply that there was a consuming focus on the negative qualities of the self. They used words such as: “judging myself ... in a very negative way;” “it’s equivalent to cancer of the soul or your inner being;” and “an intense kind of experience of dis-ease with oneself at a core level.”
The lack of empathy in individuals with chronic shame was not a finding in this study, perhaps because empathy is a quality that counselors connect with characteristics that they themselves should possess. Possibly counselors are focused on encouraging chronically shamed clients to extend kindness to themselves. Conceivably, empathy for oneself is a prerequisite for empathy for others, and empathy towards others arises only much later in the healing of shame. Because the treatment of shamed individuals was viewed as a long-term process and long-term treatment was seen as a rarity in today’s counseling field by most of the participants in this study, the end-stage of treatment of chronically shamed individuals may not have been often experienced by these participants. I, myself, acknowledge that although the finding that a preoccupation with oneself precludes the ability to empathize with others makes sense, it is a perspective that had not occurred to me.

*Hidden Nature of Shame*

Studies have consistently shown that feelings of shame are often associated with a desire to hide (Barrett et al., 1993; H.B. Lewis, 1971; Lindsay-Hartz, 1984, Tangney, 1993). Many writers on shame noted that a chief feature of shame is a sense of unwanted and uncontrollable exposure (Kaufman, 1996; Lewis, 1992; Mindell, 1994). In a cross-sectional study, shame-proneness was associated with a tendency to withdraw (Tangney, et al., 1996a). One study of multiple factors involved in the experience of shame found that there was high intercorrelation among fear of exposure, embarrassment, and inferiority (Novak, 1996). The majority of participants in this study remarked that clients do not use the word “shame” or that clients take great pains to hide their shame from both others and themselves.
In this Western culture in which Freud's individualistic self model has played a dominant role, to be bothered by shame is shameful so one tends to cover it up (Wheeler, 1996). Therefore, the role of shame is difficult to talk about and deconstruct in an individualistic social system (Wheeler, 1996). Several participants in this study discussed reasons that clients did not use the word “shame.” Participants talked about clients’ confusion about the terms of shame and guilt. One participant said that “clients often use those words (guilt & shame) interchangeably.” Because shame is extremely difficult to recognize or distinguish from guilt (Pattison, 2000) and the states of guilt and shame may occur more or less at the same time (Lewis, 1971), the failure on the part of clients to discuss their shame may have to do with their difficulty in identifying it. Several participants endorsed the notion that guilt and shame usually merge. As one participant put it, “(I)f the person is expressing guilt, they also have unresolved issues of shame.”

Participants discussed that the word “shame” has negative connotations whereas the word “guilt” is more commonly used and considered more acceptable than shame. Several participants talked about clients using the word “guilt” as opposed to the word “shame. “Insofar as guilt is a more articulated experience than shame, and a more dignified one, it may actually absorb shame affect” (Lewis, 1971, p.42). As one participant put it, “They wouldn’t use that word (shame). ... (G)uilt is more just a word that people use a lot ...” In summary, a confusion about the meaning of shame and guilt, the more acceptable use of the word “guilt” as opposed to the word “shame,” the negative connotations associated with the word “shame,” the notion that guilt is a more respectable and commonly used term than shame were all offered as reasons by participants as to why clients do not use the word “shame.”
One participant offered as evidence that shame was not an important or legitimate construct the fact that her clients did not use the word "shame" or discuss "shame" in sessions. It seemed that in this participant’s view, that shame was not a problem for clients because they don’t use the word or discuss shame. Counselors with this participant’s perspective would tend to miss the opportunity to identify or discuss shame with clients who were experiencing shame. Her observation that the construct of shame was not discussed in any of her graduate counseling classes, that she has not seen any articles in the professional journals that she reads, and that her colleagues have never mentioned the construct of shame were further evidence to her that shame was not a legitimate construct. There may be other counselors who use this reasoning to conclude that shame is not a problem for their clients. In contrast to this view, the other participants’ comments on why their clients did not use the word “shame” or were reluctant to talk about their shame was an indication of their attentiveness to shame in clients and their thoughtfulness about the construct of shame, which they stated they had learned about from clients, from reading that they had done on shame, or from training (usually outside of graduate programs) that they had received on the construct of shame.

Kaufman (1993), Jacobs (1996), and Morrison (1996) discussed the difficulty that therapists have in addressing shame because encounters with shame involve, to some extent, a reexperiencing of one’s own shame. Thus, it is easier to explore guilt feelings. A few participants commented on counselors’ discomfort with their clients’ shame in connection with their discomfort with their own shame.

Participants proposed that counselors who have not dealt with their own shame issues would have a tendency to avoid addressing their clients’ shame issues. In the words of one
participant, “(I)f a counselor or therapist doesn’t pay attention to his or her issues around 
shame, it’s going to be really hard to address those with clients whose tendencies are, I 
think, to avoid them.” Jacobs (1996) stated that “perhaps the most common therapist 
contribution to the development of an impasse — is the therapist’s difficulty with her own 
shame” (p. 308). This line of thinking lends support for experiential learning or required 
therapy for counselors-in-training. One theme that emerged in cross-case analysis is that it 
was important for counselors to know themselves, and dire consequences were predicted if 
they do not. These consequences included: counselors would bring their own issues, i.e. 
shame, into counseling sessions; counselors would project their own shame onto clients; 
counselors would violate their clients’ boundaries; counselors would use therapy sessions 
to meet their own needs; counselors would inadvertently shame their clients; and 
counselors would avoid their clients’ experiences of shame.

Several participants in this study acknowledged that they did not use the word 
“shame.” One prominent reason for not using the word “shame” was that the counselors 
were concerned about “labeling” clients. I was mystified by this particular reason because I 
had never heard of counselors refraining from naming feelings and experiences, even 
negative ones such as anger, sadness, loneliness, despair, envy, or hatred. The literature 
discussed the culture’s avoidance of shame. Those writing about shame (Averill, 1996; 
Lindholm, 1990; Kaufman, 1996; Lindholm, 1990; Pattison, 2000) have discussed the ways 
that shame in particular and emotions in general have been hidden in the culture in a 
number of ways. Perhaps the culture’s avoidance of shame has influenced these 
participants who avoid using the word “shame” in ways in which even they are unaware, to 
the extent that they are wary of using the word. “Why is shame consistently overlooked:
Because shame remains under taboo in contemporary society" (Kaufman, 1996, p. 3). I agree with Pattison’s (2000) comment, “What happens in therapy is a reflection of the general cultural trend.”

Kaufman’s (1996) assertion that shame is neglected in counseling theories because it was ignored by Freud, the dominant force not only in psychology but also in the culture during the nineteenth and twentieth centuries, contrasts with one participant’s experience with psychoanalytic theory. He asserted that the construct of shame had figured prominently in his psychoanalytic training, and he framed his concept and treatment of shame using psychoanalytic theory.

Several participants talked about not using the word “shame” or not talking about shame in their discussions with other counselors. Conceivably, the general societal prohibition of discussion of shame, the lack of emphasis on the construct of shame in counselor education, in the counseling field, and in counseling theories, and the human tendency to avoid shame have contributed to practitioners’ neglect of the construct of shame. Several participants talked about the recent trends of brief therapies in the counseling field and the promotion of short-term treatment by insurance companies and managed care. A few participants talked about the medical model that managed care follows, a model that focuses on reduction of or elimination of symptoms rather than an in-depth exploration of root causes, that, according to participants, shame requires. Several participants talked about the construct of shame as “a core construct” that required long-term counseling. Most participants said that they did not receive any education about the construct of shame in their graduate programs. The culture’s avoidance of shame, the neglect of the construct of shame in the counseling field and counselor education, the
failure to name the experience of shame in counseling sessions by both counselors and clients, the omission of the construct of shame in counselors’ discussion with colleagues, and the promotion of short-term and solution-focused therapies that, according to participants, do not address the core issue of shame, by managed care have all seemingly worked together to keep shame hidden.

**Distinctions Between Shame and Guilt**

Several studies supported the distinction between shame and guilt (Ferguson, Stegge, & Damhuis, 1991; Ferguson & Stegge, 1995; Lindsay-Hartz, 1984; Lindsay-Hartz, de Rivera, & Mascolo, 1995; Tangney, 1993; Wicker, Payne, & Morgan, 1983). In this study, participants’ vivid descriptions of the experience of shame as “insidious,” “overwhelming,” “devastating,” “an insidious, nasty virus kind of thing,” and “equivalent to cancer of the soul” are consistent with two independent studies, (Tangney, 1993; Tangney, et al., 1996b), in which shame experiences were rated as significantly more painful and intense than experiences of guilt. The attitudes of participants in this study toward guilt were much more matter-of-fact, and their depictions of guilt were much less excruciating and extreme than their depictions of shame. They described guilt “as good because you take a look at your behavior” and “with guilt, individuals feel they can make amends.”

Other phenomenological experiences reported by people in these two independent studies by Tangney (1993) and Tangney, et al. (1996b) were that when experiencing shame, they felt physically smaller and more inferior to others. Although participants did not report that clients talked about feeling physically smaller, they discussed their observations of clients’ nonverbal behaviors. Ms. Palm’s remarks characterized participants’ discussions: “The body language of shame is the rounding of the shoulders
and the looking down.” Of course the inferiority that clients felt was a topic of discussion of many participants. They discussed how clients spoke about their feelings without using the word “shame.” Mr. Oak’s comments embodied the participants’ discussion of the inferiority that clients felt: “(T)hey don’t use that word (shame) ... They talk about feeling bad at their core, or feeling dirty, feeling like damaged goods.” In these same studies (Tangney, 1993; Tangney, et al., 1996b), a sense of exposure and a preoccupation with others’ opinions were more likely to be involved in shame experiences. In another study, people, when feeling shame, were more driven to hide and less likely to admit what they had done (Tangney, 1995a).

In a study of autobiographical accounts of shame and guilt experiences (Tangney, et al., 1994), systematic differences were found in the nature of participants’ interpersonal concerns as they described their personal misbehaviors. Guilt experiences tended to involve a concern with one’s impact on others, whereas shame experiences tended to involve a concern with others’ evaluations of the self. Lewis (1971) had previously observed that focus on a specific behavior is part of the guilt experience, whereas focus on the self is part of the shame experience. A majority of the participants in this study concurred that the major distinction between shame and guilt was that guilt is feeling bad about a behavior or action whereas shame is feeling bad about who one is, a view that was consistent with the literature. Awareness of the distinction between shame and guilt is important for clients. Understanding the nature of shame and what contributes to its development can have a great impact on clients, particularly when they make the connection between shame and their behavior. Awareness and insight into the experience of shame can be the initial steps toward the healing of shame. This study suggests that counselors who are aware of and
sensitive to shame can be instrumental in assisting clients in their awareness and understanding of shame.

Childhood

The emergence of shame in childhood is supported by a series of studies conducted by Lewis et al. (1989) that showed that young children first display signs of embarrassment (smiling together with gaze aversion, patting the face, etc.) in embarrassing situations between 15 and 24 months. Not surprisingly, this is the same period in which a rudimentary sense of self emerges. In addition, several psychological theorists (Bradshaw, 1988; Erikson, 1950; Karen, 1992; Kaufman, 1992; Morrison, 1996; Yontef, 1996) suggested that toxic shame originates interpersonally in the early years of development, in the source relationships of our original families. All participants stated that shame originated in childhood, usually in the context of the parent/child relationship.

Many theorists pointed to the development of shame in childhood, but it is possible for shame to develop at any time during the lifespan (Tantum, 1998). Rape victims, those who have experienced any abuse or trauma, are examples of adults who may develop shame later in life (Walker, 1992). A few participants discussed the possibility of shame’s development in adulthood. As one participant stated, “I’ve worked with people who ... grew up in a pretty healthy family, and then they married someone who was emotionally and verbally and physically abusive.”

Although all participants acknowledged that shame usually develops in childhood in one’s family of origin, several discussed their tendency not to explore clients’ childhood. Time constraints, often in conjunction with managed care requirements, and adherence to counseling theories that do not encourage examination of an individual’s past served as
reasons for participants’ failure to explore clients’ childhoods. A few participants recognized that exploration of childhood was not congruent with their counseling theories and seemed to struggle with that dichotomy. The comments of one participant, who practiced primarily brief solution-focused therapy, reflected that struggle: “(T)he big push by insurance companies to do solution-focused therapy, shame is just not going to come up at all in that kind of outlook, but it does need to be addressed somewhere.” Another participant, too, said that in the type of therapy that she used, primarily cognitive-behavioral, she would not be inclined to investigate a client’s childhood.

**Theories**

The major theoretical frameworks, namely, humanistic, cognitive-behavioral, and psychoanalytic theory share the view that problems, shame, for example, originate in childhood and that parents play an important role in their development. What is critical to the various theories is the importance each attaches to childhood. As previously discussed, psychoanalytic theory and its offshoot, object-relations theory, place great importance on early development whereas cognitive-behavioral theory places much less importance on it, and humanistic theory takes a more neutral stance towards it. Participants in this study expressed that children are vulnerable to parental disapproval, and shame plays a part in the socialization process that parents use in guiding children.

Internalization of parental messages during one’s childhood was an idea that participants in this study mentioned. These parental messages were often talked about in the context of Rational Emotive Therapy, that is, early-indoctrinated irrational thoughts. They proposed that parents’ messages to children that they are inadequate or worthless promote shame in individuals. These messages are carried into adulthood, and long after
the parents are no longer around, the individual continues to repeat the messages of inadequacy and worthlessness to her- or himself. "Not surprisingly, the most powerful adult experiences of being shamed are based upon the types of painful humiliation that we suffered during our tender developmental years" (Goldberg, 1996).

Several participants in this study used cognitive behavioral theory in their counseling practices and framed their conceptualization of shame in light of this theory. They talked about how clients’ core beliefs about themselves are connected to both their shame and identity. They discussed how clients’ negative self-talk continues the shaming process that perpetuates the self-destructive behaviors and involvement in self-destructive relationships. As one participant put it, "they, in essence, have picked up the microphone, and now they’re continuing to record" the same negative parental messages.

Most participants in this study described themselves as “eclectic” or engaged in the use of a variety of theories in their counseling practices and included cognitive behavioral theory in the group of theories that guide their practice of counseling. A particularly interesting phenomenon was that while several participants used cognitive behavioral therapy in their practices, and described their understanding of the construct of shame in cognitive behavioral theory terms, cognitive behavior theory is a theory that does not encourage exploration of an individual’s childhood, a process that participants in this study said is necessary in addressing the issue of shame. In addition, participants indicated that strong emotion accompanies the experience of shame, and one of the criticisms of cognitive-behavioral theory is that it ignores feelings (Corey, 1991). Cognitive behavioral theory, particularly, Rational Emotive Therapy, provides a valuable perspective and a clear explanation for the development and perpetuation of shame. However, its deficits, namely,
lack of providing insight into problems, its discouragement of exploration of causes and childhood, and its tendency to ignore feelings make the case for the importance of multiple perspectives. Other frameworks, such as object-relations theory and humanistic theories address some of these deficits.

Accordingly, therapies such as object relations, attachment, and person-centered would be more helpful in addressing shame. Cognitive-behavioral and RET appear to be effective in addressing core beliefs such as an individual's basic belief that she or he is inadequate; however, little emphasis is placed on working through the feelings that the shame experience produced. The thinking in theories such as object relations, psychoanalytic, and attachment are that those early shaming experiences must me revisited, worked through, and the emotions released. A few participants emphasized the notion that remedial work is necessary in addressing shame, while several stressed the idea that core beliefs need to be addressed. Although Kaufman (1996) asserted that the traditional counseling theories do not address shame, participants had conceptualized how shame is viewed in different theories, particularly theories that they use in their practices. Their conceptualization indicated thoughtfulness about the construct and an ability to make connections between their clients' behaviors and shame.

*Psychological Disorders & Problems*

Empirical studies connected psychological disorders and problems to shame. Proneness to shame was associated with an assortment of psychological symptoms, whereas proneness to guilt was effectively unrelated to psychological maladjustment. This pattern of results was consistent across independent studies of children as well as adults (Tangney, 1995a). Therapists and sociologists theorized that shame was the hidden cause
of much current societal harm (Kaufman, 1996). The Internalized Shame Scale (ISS) correlates, in both clinical and non-clinical populations with most measures of pathology; the implication is that shame is present in most psychopathologies (Cook, 1996). The findings of this study were consistent with the theoretical assertions and empirical data from the literature. All but one participant in this study agreed that shame was a contributing factor to psychological problems. Several participants in this study stated that shame was a factor in 50% or more of the problems their clients presented that. Only one participant said that shame was not a factor in any of the problems that any of her clients presented. Several participants remarked that shame is connected with most or all disorders while one participant said the shame was not connected to any specific disorders.

In one study clinical subjects made up of alcohol/drug patients scored significantly higher on the ISS (49.34) than non-clinical subjects (33.98) (Cook, 1991). Shame was identified as an important element in addictions in the literature (Bradshaw, 1988; Cook, 1991; Fossum & Mason, 1986; Kaufman, 1996; Zucker & Gomberg, 1986). A majority of participants in this study listed chemical dependency or addictions as a disorder in which shame was a factor. Several participants discussed learning about shame in addictions literature. They talked about the books of John Bradshaw, author of several books that were popularized in the press, particularly his book on shame, *Healing the Shame that Binds You* (1988), in which he discussed shame’s connection to addictions as well as other psychological disorders.

In a comparison between clinical subjects and non-clinical subjects on the ISS, the clinical subjects composed of eating disordered women scored significantly higher (68.92) than non-clinical subjects (33.98) (Cook, 1991). Several participants in this study talked
about the association between shame and eating disorders as well as the link between shame and trauma or abuse. When clinical subjects composed of post-traumatic stress patients (58.59) were compared with non-clinical subjects (33.98) on the ISS, the clinical subjects scored significantly higher (Cook, 1991). Several participants in this study made the case for the connection between shame and trauma. Furthermore, a few participants linked both shame and trauma and abuse (physical, emotional, and sexual) to a multitude of psychological disorders and problems. Their view is represented by the following participant’s statements: “(S)hame is the unholy byproduct of abuse of some kind. ... I have been startled to discover how pervasive early childhood abuse is and how it underlies so much of the major mental disorders, anxiety disorders, depression, recurrent depressions, panic disorders, eating disorders.” In a study using the ISS (Cook, 1991), the data indicated that severe sexual abuse in childhood precedes significantly higher levels of internalized shame.

Fear of making a fool of oneself is a prime example of anxiety’s connection to shame; shame-anxiety involves the fear of not being able to live up to others’ expectations as well as one’s own (Jacoby, 1994). Behind this failure is the fear of abandonment or loss of love in response to failure, and thus shame’s link to anxiety (Pattison, 2000). According to Elias (1994), part of the civilizing process involved the increase of inner fears as the outer fears decreased. A majority of participants in this study identified the belief that anxiety was connected to shame.

In one study shame-proneness was positively correlated both with boys’ self-reports of anger and teacher reports of aggression in a study of 363 fifth-grade children (Tangney et al., 1991). In another study the tendency to experience shame was positively correlated
with measures of trait anger and indexes of indirect hostility, irritability, resentment, and suspicion in a study of young adults (Tangney, 1995a). Tangney (1995a) stated, (S)hame was clearly related to maladaptive and nonconstructive responses to anger across individuals of all ages (8 years through adulthood), consistent with Scheff’s (1987, 1995) and Retzinger’s (1987) elegant descriptions of the ‘shame-rage’ spiral (p. 1140).

Several shame theorists discussed how anger and violence are ways that people may protect themselves against undeserved shame that threatens their fragile sense of identity and self-respect (Cushman, 1993; Gilbert, 1998; Fowler, 1993; Lansky & Morrison, 1997, Morrison, 1996; Nathanson, 1992; Retzinger, 1989; Scheff, 1994). Anger and aggression often fill-in for shame; an individual becomes angry at having her or his flaws pointed out and commented on (Nathanson, 1992; Retzinger, 1991; Tangney et. al., 1996a). A few participants in this study discussed shame’s connection to aggressive behavior and hostility. Conceivably, more participants did not discuss shame’s link to anger because shame is typically seen as a passive emotion, having more to do with withdrawn behavior than acting out behavior. Mindell (1994) suggested that anger is an emotion that masks shame and that because of its intensity and aggressive nature, one tends not to immediately associate it with such a passive emotion as shame.

Anger is a typical experience of feeling shamed (Tangney et. al., 1996a). The couple’s unwillingness or inability to address their shame can lead to marital breakdown (Retzinger, 1989). Couples often become involved in shame-rage spirals that can intensify to physical violence (Retzinger, 1989). When bonds are delicate and shame is unacknowledged or acknowledged with disrespect, violence will eventually occur (Fowler, 1993). A few

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participants in this study stated that shame is an element in couple problems and domestic violence. Most participants in this study saw primarily individuals, for the most part, in their counseling practices; therefore, their focus was not on couples.

The ISS correlated with measures of depression, a correlation of .75 with the Multiscore Depression Inventory with a non-clinical sample (N=193) and .72 for 300 college subjects and .75 for a clinical sample of 185 psychiatric patients (Cook, 1991). Suicide with its underlying depression is the most severe expression of shame (Morrison, 1996). Although participants in this study did not mention suicide, a majority of them discussed the association between shame and depression. Participants in this study discussed an association between shame and a host of other disorders and problems ranging from personality and mood disorders to attention deficit hyperactivity disorder (ADHD) and sexual dysfunction. Shame theorists also linked shame with a broad spectrum of disorders. The connection between shame and a multitude of psychological disorders strongly suggest that the construct of shame should receive more attention in the counseling field.

**Question 2**

*How does education and training, particularly graduate counseling programs, influence counselors' understanding of the construct of shame?*

This question arose from my own personal experience of not receiving education about the construct of shame in my masters social work program, my masters counseling program, or my doctoral counseling program, and only minimal training during my 15 years of working as a social worker or as a counselor. In the interviews, participants were asked about both their formal academic education and more informal kinds of training such
as workshops and conferences. Most participants in this study said that they had received or could remember receiving no education or training regarding the construct of shame in their graduate programs. For most of the participants, their graduate school education had been completed at least ten years before these interviews took place so memories could have been indistinct. A few participants had picked up pieces about the construct of shame in various courses in their graduate programs. A couple of participants said that, although they had attended several workshops and conferences, the construct of shame had never been addressed. Kaufman (1992) asserted that shame has been neglected in counseling and personality theories in the past 150 years. Therefore, the finding that participants did not learn about the construct of shame in their graduate counseling courses or at general conferences makes sense.

Several participants said that they had learned about the construct of shame from clients who talked about shame, from substance abuse training, and/or chemical dependency literature. According to Kaufman (1992), the issue of shame seems to be arising now due to the recent propagation of addictive, abusive, and eating disorders. Because shame plays a central role in these disorders, there has been a growing focus on shame (Kaufman, 1992). Individual participants had learned about the construct of shame from different types of training such as addictions training and sex abuse training. Other participants said that psychoanalytical training, psychosynthesis training, transpersonal training, and theological training involved discussions about shame.

Although most participants stated that they did not know whether the construct of shame is given adequate attention in graduate counseling programs because they had been out of school for many years, several participants said that the construct of shame does not
receive adequate attention in graduate counseling programs. Most participants said that
shame received attention in the counseling field, primarily in the addictions arena. One
participant said that practitioners paid attention to the construct of shame whereas
academicians did not. Some participants said that there were so many constructs to cover in
graduate programs that it was not possible to cover all of them.

Clearly, for these participants, there had been no systematic or systemic education or
training around the construct of shame in graduate programs. Learning about the construct
of shame through one’s clients suggests that there is a void in graduate counseling
education that needs to be filled. At present, it appears, as far as knowledge of the construct
of shame, that the counseling field is dependent upon seasoned counselors who have the
experience of encountering shame in their clients, have training beyond graduate programs,
and have kept abreast of certain segments of the counseling literature.

Question # 3

How is the construct of shame meaningful to licensed counselors in the practice of
counseling?

This question was intended to explore whether participants found the construct of
shame useful in their practices and meaningful for the way they conduct counseling and
conceptualize their clients’ cases. The participants in this study found the construct of
shame both meaningful and useful. It was meaningful to them in understanding their
clients’ behavior. Because the construct of shame helped participants make meaning of
some of their clients’ behavior, it was also useful to them in their practice of counseling.
Furthermore, some participants used the construct of shame to label the “confusing”
experience of shame for clients. Participants reported that naming the experience of shame
provided some relief to clients because it was an acknowledgement that this experience may occur to other individuals. However, other participants stated that they did not use the term "shame" because they were concerned about labeling clients.

All but one participant said that she or he thought that shame was an important construct. The reasons for finding the construct of shame important were wide ranging. Several participants stated that shame was important because shame was a problem for many of their clients. This perspective reflected the overall belief that was found in the literature that shame plays a meaningful role in human experience (Bradshaw, 1988; Fossum & Mason, 1986; Kaufman, 1996; Lee & Wheeler, 1996). A statement made by Nathanson, 1992, might best represent this view. “Shame is the hidden power behind much of what occupies us in everyday life.” An overwhelming majority of participants in this study said that shame was a factor in the problems their clients present from 20% to 100% of the time. Several participants said that shame is a factor 75% or more of the time. Only one participant said that she does not see shame in the problems that her clients present.

Participants in this study said that shame is important, but it tends to get overlooked because people are likely to hide shame. Pattison (2000) suggested that shame is such a painful experience that leaves one feeling confused, exposed, helpless and inarticulate so that people prefer to express guilt, which is associated with committing a specific offense. “Insofar as guilt is a more articulated experience than shame, and a more dignified one, it may actually absorb shame affect” (Lewis, 1971, p. 42). In this study, several participants stated that the construct of shame helped them to understand their clients’ behaviors. In the literature shame was associated with a number of behaviors. There are behaviors that are initiated in order to cope with or mask shame as it transpires (Gilbert, 1998). Anger and
aggression often fill-in for shame; an individual becomes angry at having her or his flaws pointed out and commented on (Nathanson, 1992; Retzinger, 1991; Tangney et al., 1996a). One way of dealing with shame is to keep it secret. "I don’t want to be seen" is the frequent message from shame-oriented people (Gilbert, 1998). Individuals hide their shame "behind the guises of anger, contempt, depression, denial, or superiority" (Morrison (1996, p. 10).

All counselors said that shame played a function in the behavior of people, usually contributing to self-destructive behavior. A majority of participants discussed that shame is associated with extreme behavior found on either end of the continuum, that is, with both passive and aggressive behavior, with hostility and social aversion, with timidity and flamboyant behavior. This opinion is consistent with the behaviors identified in the literature. Nathanson (1992) described attacking behaviors, such as verbal sarcasm, abusive language, or physical attacks of all kinds, that he associated with shame. Morrison (1996) described behavior at the other end of the spectrum that he linked to shame. He talked about depression and suicide where shame is focused on the self (Morrison, 1996). This study suggests that the construct of shame is a valuable tool for counselors to use in making hypotheses about their clients’ behavior.

When asked, "How do you address shame in counseling sessions," most participants in this study included in their responses the act of exploring clients’ feelings and thoughts. Several participants talked about the following characteristics as important for a counselor to possess: liking or caring about people; tolerance; compassion; and empathy for people. Most shame theorists support a more empathic, accepting posture toward the client, especially when needed in order to make up for what parents failed to provide (Karen,
A few participants mentioned using a Rogerian approach. A Rogerian approach emphasizes congruence (genuineness), unconditional positive regard (acceptance and caring), and accurate empathic understanding (the ability to deeply grasp the subjective experience of another person) (Corey, 1991). Although most therapies include establishing a rapport with the client and climate of safety in the session, Rogerian or person-centered therapy stresses the primacy of the counselor-client relationship. Several participants in this study talked about offering clients an atmosphere of trust. Creating an environment where the patient is able to share “horrible secrets” appears to be a critical first step in freeing oneself of crippling shame (Karen, 1992).

Several participants mentioned helping clients rewrite their scripts or reconstruct cognitions as ways of addressing shame. They talked about focusing on clients’ core values and beliefs and using cognitive restructuring to refute destructive thoughts and encourage constructive thinking. These remedies focus on thinking rather than feeling and follow the more cognitively oriented therapies such as cognitive-behavioral or solution-focused therapies. From my perspective, although working with cognitions is important, working through the feelings is a necessary first step.

Only a couple of participants focused on the necessity for clients to release their feelings associated with the experience of shame. One participant, with whom I heartily agree, stated his belief about the healing of shame in the following remarks: “It is generally not enough just to talk about it ... (T)here is a certain sense of the need for whatever emotion that is carried in the body, whatever that energy is, to be released, to be expressed. The expression of the affect, the release of it, my experience of it, is that it’s been pretty intense.” The long-term therapies, those that are of psychoanalytical origin, encourage re-
experiencing the deep feelings that accompanied the initial trauma (Corey, 1991). In psychoanalytic therapy, the therapist offers the explication of an unconscious conflict with all its byproducts; this gives the patient a sense that her struggles can be understood and felt by another, and can be recognized by another without judgment, disappointment, or scorn (Lansky, 1995). The act of interpreting in this manner removes some of the isolation and shame that is associated with repressed, unconscious material, material that was repressed in part because it was shameful (Lansky, 1995). In psychoanalytic therapy, both catharsis and insight are necessary (Corey, 1991).

The two different perspectives on self-disclosure represented two different ways to treat shame. One participant articulated a view that greatly restricted the counselor’s self-disclosure to clients because he said “the purpose of therapy is to deal with the patient, not with the therapist.” Another participant advocated the use of “intentional” self-disclosure because it provided clients with “another model” because often “they haven’t had the experience at home of seeing how somebody else moves through the world.” The literature was consistent with the view that self-disclosure is helpful when working with clients who experience chronic shame. “It is especially helpful when the therapist lets the patient know that he or she also has feelings of shame. In a sense, the shameful patient needs not to be the only one who is psychologically exposed” (Jacobs, 1996).

Most participants in this study concurred that it was possible for counselors to inadvertently shame their clients in some of the following ways: by expressing disapproval or disappointment that clients did not complete their homework; by suffering from burnout and stress; by having unresolved shame issues; and by asking questions that touch issues connected to a client’s experience of shame. Because of the counselor’s more powerful
position, she or he can easily shame the client through inattention, lack of attunement, or
defensiveness (Jacobs, 1996). Shame-provoking incidents often occur when a counselor is
too centered in her own perspective and out of touch with the client’s experience (Jacobs,
1996).

Limitations of the Study

This study examined the understanding of the construct of shame and its usefulness to
twelve licensed professional counselors through inductive analysis of their responses to
questions during two interviews. The participants in this study were Caucasian, middle-
class counselors with an average of 22 years of counseling experience, who presumably
treated predominantly Caucasian, middle-class clients. They provided primarily individual
counseling to adults in a southeastern state of the United States. There is no intention on the
part of the researcher to suggest that the results of this study should be generalizable to any
other sample. The reader must decide the extent to which information from these
participants may be generalized or applied to other groups of licensed counselors.

Implications for Research

The results from this study suggest the need for additional research in several areas. I
have seen no studies that have examined the understanding and usefulness of the construct
of shame to counselors in the field. This exploratory study is only a beginning and could be
expanded to include a larger population and replicated with different and more varied
populations. A much more multicultural, multiracial group of counselors as well as a more
socioeconomically, culturally, and racially varied clientele to which the counselors provide
services, would, no doubt, yield interesting findings. It would be worthy of note to look at
the understanding and usefulness of the construct of shame in novice counselors in contrast

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to the experienced counselors that made up this study's sample. Studies with novice counselors, who have presumably less knowledge or experience with the construct of shame, would most likely generate very different results from those of this study of more experienced counselors.

A cross-sectional survey design study based on the findings of this study could be developed and administered to large groups of counselors. Greater numbers of participants have the potential for producing generalizable results. Questionnaires or scales could be designed to examine current attitudes, beliefs, opinions, and practices regarding the construct of shame. Several items asking for demographic information should be included in the questionnaire in order to make distinctions among the results according to variables such as gender, age, race, ethnic group, socioeconomic status, cultural group, counseling experience, education and training, licensure, and make-up of counselors' clientele.

Follow-up studies based on this study's findings have the potential to corroborate, explore, and explain these findings in more depth. There are several findings under the theme of Hidden Nature of Shame that could be explored. One finding was that shame is generally neglected in the counseling field and in counselor education. A survey could be developed to ascertain where counselors have obtained knowledge about the construct of shame. A finding in this study was that most participants had not received education or training about the construct of shame in their graduate programs. Several participants, however, indicated that they had received education about the construct of shame in training outside of their graduate counseling programs, particularly in substance abuse workshops, substance abuse literature, and in their association with clients in recovery programs. Another finding was that both clients and counselors tend not to use the word
"shame." The research question here might involve the frequency and context in which the term "shame" is used in counseling and by whom (counselor or client). An exploration of why counselors choose to use the term "shame" or choose not to use the term "shame" could be included in the study.

The finding that clients do not usually initiate a discussion about their own shame experiences (they tend to hide shame) could be explored. Examination of counselors' experience with clients whom they perceive to have shame issues could be incorporated into a survey. Questions as to how shame experiences get discussed in counseling sessions and who initiates the discussions about shame could be included. The idea that managed care and insurance companies encourage short-term treatment that is not conducive to the exploration of a "core issue" such as shame was shared by several participants. A follow-up study that explores the impact that managed care and insurance companies has on addressing shame in counseling sessions might be an important factor in the application of the shame construct to practice.

Under the theme *Theories*, several participants reported that some therapies are not conducive to an exploration of shame. A follow-up study that examines counselors' perspectives on which theories best explain the construct to them and also which theories they use to explain the experience of shame to their clients would be helpful to practitioners. Based on the finding that the chief distinction between shame and guilt is that shame is a global negative feeling about the adequacy or worth of oneself and that guilt is a negative feeling about the commission or omission of a specific act, a follow-up study might attempt to validate these developing constructs of shame and guilt. As opposed to Tangney's (1990, 1993, 1995a, 1995b) research on clients regarding the constructs of
shame and guilt, research that validates counselors' distinctions between shame and guilt could help to clarify a definition of shame that is useful to the counseling profession. Case studies of counselors who deal predominantly with shame could be developed for a more in-depth exploration of shame's complexity and emphasis on "episodes of nuance, the sequentiality of happenings in context, the wholeness of the individual" (Stake, 1995, p. xii).

A follow-up study based on the finding that a counselor who is not aware of her or his own shame issues would most likely avoid shame issues or inadvertently shame their clients might be the development and administration to counselors of an instrument that measures awareness of one's shame. A comparison of these results to counselors' beliefs, opinions, attitudes, and practices regarding the construct of shame might yield valuable information. Studies that examine the shame experiences of counselors and/or clients in counseling sessions could present their multiple perspectives of factors that engender shame.

No research has been done on the ways in which people cope with their feelings of guilt and shame (Tangney, 2002). Exploration of strategies for dispelling feelings of shame could be helpful to people who experience chronic shame. Such strategies could be cognitively based, affectively oriented, or socially acquired (Tangney, 2002).

A study examining the outcomes of applying different therapies to clients with shame issues could be conducted. Given the importance that these participants have attached to the construct of shame and the number of clients in whom they have observed shame, knowing which therapies have been associated with positive outcomes for the treatment of shame would be useful to counselors. Based on the number of disorders and problems that
shame has been linked to, both in this study and in previous studies, research could be conducted into each disorder with which shame has been linked to more clearly delineate the role that shame plays in a particular disorder. Clearly there are endless possibilities for research because of shame's association to many disorders, problems, and relationships, as well as specific populations such as individuals with AIDS, gays, and lesbians, and certain cultural and religious groups.

Implications for Counselor Education

Although several participants remarked that there is not enough time in graduate programs to cover all counseling constructs, the hidden nature of shame, a finding of this study that was consistent with the literature, seems to give the construct of shame a special status. Precisely because it is a construct that is likely to be avoided in the culture and by clients and counselors alike, shame appears to be a construct that requires special attention in graduate counseling programs. While the majority of participants in this study indicated that they did not receive or could not recall receiving any education about the construct of shame in their graduate programs, they stated that they thought that shame was an important construct that helped them to understand their clients' behavior. The implication is that the construct of shame should be considered for inclusion in counselor education programs.

The finding that there are multiple definitions or views of shame presents a real challenge to counselor educators. A common definition that is useful to the counseling field needs to be established. Research studies on the construct of shame as well as discussion about the construct of shame in graduate counseling programs could help in clarifying the construct of shame and developing a definition that is useful in the counseling field. A
Delphi study might be helpful in finding common perspectives on the construct of shame within the counseling field. A doctoral research seminar that focused on students designing and conducting research studies, both quantitative and qualitative, on the construct of shame, would be an ideal way to elucidate the construct of shame.

When clarity about the construct of shame is achieved, it can then begin to be specifically addressed in counselor education. When counselors have a clearer understanding of shame, they can then clinically address this important issue. There are several possibilities for the inclusion of the construct of shame in graduate counseling programs. The basic theories course that is part of any accredited masters level counseling program is a logical place to include the construct of shame. In a systematic way, shame could be examined through the lens of each theory that is discussed. The construct of shame could also be included in courses that deal with specialized populations with which shame has been associated, such as courses on addictions or sexual abuse.

The finding of this study and other studies in the literature, that shame is associated with a multitude of psychological disorders, suggests that inclusion of the construct of shame in the Psychopathology course would make sense. Individual Appraisal is a course in which the appropriateness of the selection and administration of the Internal Shame Scale (ISS) could be examined. In addition, techniques for assessing and identifying shame in clients could be explored, particularly in light of clients’ desire to hide from others as well as themselves their sense of shame, or as one participant put it, “they orchestrate their behavior to hide those feelings (shame).”

Techniques of Counseling is a logical course in which to include the construct of shame because interviewing techniques that get at the deep feeling of shame could be
examined, and helpful responses to the emergence of shame in counseling sessions could be role played. In addition, the role that shame plays in impasses in therapy could be explored. The construct of shame could be addressed in a number of courses because shame seems to be a universal human experience and is connected with a multitude of problems and populations. Some course possibilities include: Human Sexuality; Marriage and Family Counseling; Individual Appraisal; Addictions and Family Systems; Theory and Practice of Multi-Cultural Counseling; and Techniques of Counseling. Participants associated shame with so many different psychological disorders and problems, with so many different populations, in so many different kinds of relationships that it seems more of a challenge to identify courses in which a discussion of the construct of shame would not be appropriate. Perhaps a systemic curricula approach in which the construct of shame is discussed in all counseling courses would be a way to integrate the construct of shame into the counseling program.

Based on this study’s finding of the importance that is attached to a counselor’s knowledge of self and awareness of her or his own issues as well as the value of remedial work in dealing with shame, an important aspect of any counseling program would be some experiential training or exploration of one’s own shame issues. This finding also suggests that counselors-in-training go through their own counseling as a way of being aware of their own shame issues and sensitive to how easily their shame can be triggered in the counseling process, as well as gaining a deep respect for the position of the client in the therapy process.

Implications for Professional Development

Because therapists who are not taught about shame or whose shame is augmented in
training or supervision are likely to follow the modeling of their training and augment the shame of their patients, further explication of shame is needed in therapist training, including teaching about shame, shame treatment, and shame induction or shame sensitivity in training (Yontef, 1997, p. 379).

Most of the participants in this study stated that the construct of shame was not discussed in their graduate counseling programs, which makes the construct of shame an ideal topic for professional development. Many participants said that the construct of shame is an important construct, one that they use in their counseling practices and that it should be taught in counseling programs. These participants’ lack of education about the construct of shame suggests that there may be many other counselors who have received no training or education about the construct of shame and who, additionally, have a desire to learn about this construct which these participants found to be useful to their practices. A way to rectify this lack in education is to offer evening or weekend workshops, seminars, short conferences, or in-service training on the construct of shame. The construct of shame could be examined in the context of particular populations, such as addicted individuals, adolescents, the elderly, gays, lesbians, HIV-infected people, disabled persons (physically, mentally, or learning), or the chronically ill for counselors who specialize in these areas. The emphasis in these seminars would be shame’s connection to whichever population was being focused on.

Participants in this study used a variety of counseling theories to explain their understanding of the construct of shame and in their treatment of shame. Shame could be looked at through the lenses of various theories, both traditional and non-traditional theories. Shared and divergent perspectives about the construct of shame in various theories
could be explored. Workshops on the construct of shame could be presented to counseling associations that espouse specific theories, for example, associations of Jungian analysts, cognitive-behavioral therapists, transpersonal therapists, structural family therapists, or group therapists. A detailed look at how their particular theory looks at shame and a brief introduction to affect theory, a theory that proposes that emotions are the primary motivators of human behavior, could be presented. Points of agreement, as well as differences, between their specific theory and affect theory could be discussed. Perhaps in the discourse about shame, a more precise language about shame and all its nuances can be developed. Conceivably, a coherent, integrated theory about shame that has application to practice could eventually emerge.

Participants in this study stated that shame was associated with a variety of disorders. Another interesting way to present the construct of shame, especially for counselors in a general practice who see a broad spectrum of clients, would be to examine shame’s connection to a variety of disorders. The role that shame plays in each disorder, as well as an investigation into the best forms of treatment, could be explored. The above suggestions for professional development focus on increased awareness. An exploration of or consciousness-raising about the construct of shame, a first step in establishing legitimacy of the construct of shame in the counseling field.

The participants discussed the importance of self-knowledge in dealing with shame issues. They predicted that if counselors had not explored their own shame issues, they would tend to not notice shame in their clients, avoid addressing shame in their clients, project their own shame onto clients, and inadvertently shame their clients. Inclusion of an experiential portion to shame seminars or workshops would be helpful in assisting
counselors in getting in touch with their own shame. Experiential training for such brief
training ventures should not necessarily be intense in-depth exercises but more
consciousness-raising endeavors that involve some self-exploration and self-reflection.
Journal keeping, role-playing, or limited sharing in dyads or small groups might be
appropriate for these professional development programs. On-line courses are also a
convenient way of providing professional training to busy counselors. Continuing
education units (CEUs) needed to maintain licensure should be provided for as an incentive
for this type of professional development.

Implications for Practice

This study's implications for counselors and therapists are considerable. It is time for
empirical research to approach theoretical literature, and it is time for practice to come
closer to both.

One might think that shame, this most deeply personal of emotional experiences,
would be a common subject in the world of psychotherapy. It is, after all, in our
personal therapy that most of us learn to overcome the shame associated with the
revelation of our most cherished and painful secrets (Nathanson, 1992, p. 21).

However, in this study several participants stated that they did not use the word “shame” in
speaking with clients or, for that matter, with colleagues. To begin with, counselors should
recognize the power that they wield in terms of what is recognized and acknowledged in
the counseling session. Therapy is a place in which the client is particularly vulnerable to
being shamed because the therapist's silence or words have a greater impact than those of a
friend who occupies a more mutual position (Simon & Geib, 1996). Failure on the part of a
counselor to articulate an experience conveys a powerful message to clients, most likely an
unintended message that the therapy session is not a safe place to divulge secrets or that shame is too awful of an experience that its name cannot be uttered even in the sanctity of the counseling session.

The finding that shame originates in childhood, usually in the initial relationship between child and primary caregiver, suggests that the construct of shame should be discussed in the context of parenting. Whether a counselor is a marriage and family therapist or provides individual therapy, clients often want to know her or his attitudes, opinions, and beliefs around parenting issues. Furthermore, counselors sometimes lead parent-training groups, perhaps an ideal forum for addressing the power that parents possess, and consequences of abuse, neglect, and lack of attunement between parent and child. Many opportunities exist for counselors to share their knowledge and beliefs about the impact of shame on children, whom the literature suggests are especially vulnerable to parents’ disapproval and disappointment.

The finding that shame originates in childhood, usually in the initial relationship between child and primary caregiver, suggests some exploration of childhood experiences, that according to participants in this study, does not lend itself to brief solution-focused therapies that focus on strategies that are currently working or cognitive-behavioral therapies that focus on changing present beliefs. The implication for practitioners, especially those who practice brief solution-focused therapy or other short-term therapies, is that they would need to discriminate what problems their therapies can address. If their particular brand of therapy does not address shame, then perhaps they could share their observations that shame may be an issue that the clients might choose to work on with another practitioner who deals with core issues such as shame or steer them to a group that
handles core issues or recommend literature that might be helpful to them. Yontef (1996) suggested that the therapist must often bring up the subject of shame in order to teach the client about the prospect of shame, and she or he should share her or his observation, personal experiences, and knowledge to encourage self-observation in the client.

It is important for counselors to be aware of the role that shame can play in a variety of disorders, and the power and healing effect that just naming an experience and normalizing a powerful emotion such as shame has on individuals who have felt, due to the societal prohibition about discussing one’s own shame, that they are quite alone with the insidious feelings of shame. There ought to be a recognition that therapy is not just focusing on solutions and emphasizing clients’ strengths and positive qualities; nor must it always focus on the exploration of clients’ suffering and agonizing shame experiences. If, as some theorists have suggested, the therapy session is a microcosm of life, both are necessary. Not many clients, nor, for that matter, counselors, could endure endless sessions devoted to the experience of suffering; however, counselors perhaps have a special obligation to attend to clients’ suffering and secrets, particularly shame, because there are few safe places that encourage or even permit that kind of exploration and release of emotion.

The critical role that shame plays in the development of impasses and the possibility that addressing shame experienced in the therapy session has for the building of a stronger and deeper relationship between the counselor and therapist with its implied potential for building stronger and deeper relationships outside of therapy is an area that is valuable for counselors to explore. Impasses can be viewed as great opportunities for both client and counselor. For the client, the opportunity exists for her or him to acknowledge the shame, a part of the self, and to gain, not only acceptance of this part of the self, but perhaps a deep
respect and reverence for this aspect of oneself, After all, this aspect represents a personal history and sensitivity that has formed the person that she or he is. Impasses worked through in counseling have the potential to be generalized to impasses in important relationships outside therapy. For the counselor, impasses offer the opportunity to gain insight, not only to the client’s ways of interacting with others, but also insight into the impact that her or his ways of interacting have on clients. The opportunity is there for the counselor to refine her or his interactions with clients. This study suggests that shame is an emotion, an experience that begs to be explored because it is one that is common and greatly impacts the lives of many clients.

Personal Reflections

I had strong opinions about the construct of shame before I began this study based primarily on what I had read in the literature but also from my own personal and clinical experience. I was encouraged throughout the interviewing process about the thought that participants had given to the construct of shame and by their sensitivity and ability to observe shame in their clients. Several participants had well-constructed theories of shame that they applied to their practices. Many participants had perspectives of shame that expanded my own view of shame. The images and descriptions of their perspectives helped to clarify my own thinking about the construct of shame, and made the experience of shame come alive for me. As the discussions with participants progressed, I sensed in a few of them the struggle that they had in coming to grips with the possibilities that although cognitive and brief solution-focused therapies are useful, normalizing, practical skill-building therapies that address many needs of their busy clients in terms of the money and time that clients are willing to put into counseling, there exist painful areas, such as shame,
in clients that do not get addressed, and, therefore continue to impact negatively on their lives.

I appreciated greatly the participants’ willingness to share not only their ideas and beliefs about shame, but also their willingness to “expose” their own practice of counseling by sharing examples of cases in which they observed shame and how they dealt with those experiences. I was touched by one participant’s telling of an experience in which he felt that he had inadvertently engendered shame in his client. His ability to relate that experience illustrated his sensitivity to the subtleties and nuances of shame.

I learned to work with my limitations, limitations of procrastination, of being easily distracted, of becoming overwhelmed. I recognized that these limitations are not unique to me, that these sorts of conditions are universal to all human beings. This study offered me the opportunity to wrestle with these fundamental elements in a way that I had never before wrestled with them. I had struggled with them before but in more measured and manageable doses. This study was a sustained wrestling, sometimes accommodating them, and sometimes challenging them. Perhaps the greatest gift of this study was a little more self-acceptance.

During the process of collecting data for my study, I was also studying to take the test for counselor licensure in the state of Virginia so I found interviewing counselors who were already licensed a fascinating and illuminating experience. During the interviews with participants, the joy for their profession and reverence for their clients shone through even as they discussed the struggles, challenges, and frustrations of their work. I felt privileged to have this glimpse into the arena of private practice, an arena that I hope to participate in one day.
In the final analysis, I have come to an eclectic view of shame, which, to me, means that I can accommodate material from a variety of discourses based on experiential congruence and language that elucidates my understanding of shame. In conjunction with an assumption of qualitative research, I have found that there are a plurality of concepts and approaches regarding shame. I have found definitions and perspectives of shame not just across many therapeutic approaches and theories, but also across many different academic disciplines such as sociology, history, anthropology, and literature. No one theory or set of theories gives a comprehensive explanation of shame. A particular, narrow definition of a complex phenomenon does not accommodate the insights provided by different discourses and approaches. Instead of adopting a narrow definition or a synthesis of views across the various approaches and disciplines, I have chosen a broader perspective.
References


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Appendix A
Letter to Potential Participant

June , 2001

Dear Potential Participant:

You are invited to participate in a research project as part of a doctoral dissertation conducted by Mary Kresser entitled “A Qualitative Study of the Meaning of the Construct of ‘Shame’ to Licensed Professional Counselors.” The study will be conducted through the College of William and Mary under the direction of Jill Burruss, Ph.D. (757 221-2361), and Rick Gressard, (757 221-2352), Ph.D., co-chairpersons.

The purpose of this study is to explore the understanding of the construct “shame” and its meaning in the practice of counseling through the process of interviewing twelve licensed counselors. There has been a proliferation of books and articles on the construct shame in the last 15 years. Although much of this literature has been theoretical, empirical studies are beginning to appear. This study will provide a glimpse of the impact of the literature on the counseling profession.

Two semi-structured interviews will be held with each participant. Interviews will be approximately one to one-and-a-half hours in length and will be conducted at least a week apart from June to September 2001. In addition, each participant will be asked to write a short reflective piece after each interview.

A copy of the questions that I will ask will be mailed or e-mailed to you at least a week before the interview. I want to see if and how you think about the construct of “shame” in your conceptualization of cases and its usefulness to you in the practice of counseling. Therefore, I do not want you to do any research on the construct “shame.”

If you choose to participate in the study, all reasonable effort will be taken to decrease risk to you. Individual privacy will be maintained for all participants. Participation in the study is completely voluntary and you may withdraw from the study at any time. If you have questions about the study, please call me at home (804) 674-0299 or at the College of William and Mary (757) 221-2363. I look forward to talking to you.

Sincerely,

Mary Kresser
College of William and Mary
Appendix B
Letter of Informed Consent

Project Title
You are invited to participate in a research project as part of a doctoral dissertation conducted by Mary Kresser entitled “An Exploratory Study of the Meaning of the Construct of ‘Shame’ to Licensed Professional Counselors.” The study will be conducted through the College of William and Mary under the direction of Jill Burruss, Ph.D. (757-221-2361), and Rick Gressard, (757-221-2352), Ph.D., co-chairpersons.

Purpose of Research and Methodology
The purpose of this study is to explore the understanding of the construct “shame” and its meaning in the practice of counseling through the process of interviewing twelve licensed counselors. Two semi-structured interviews will be held with each participant. Interviews will be approximately one to one-and-a-half hours in length and will be conducted at least a week apart from June to September 2001. Each interview will be audio taped for later transcription. This method permits thorough evaluation and analysis of data. In addition, each participant will be asked to write a short reflective piece after each interview.

Risks and Procedures
If you choose to participate in this study, all reasonable efforts will be taken to decrease any risk to you. Participation in the study is completely voluntary. Although potential psychological risk is minimal, the names of appropriate therapists will be made available to you if necessary.

Confidentiality and Anonymity
Individual privacy will be maintained for all subjects in the written material resulting from this study. Identifying personal characteristics that might lead to recognition will be changed. However, there can not be a one hundred percent guarantee someone would not recognize themselves or some other participant in this study. Only the principal investigator and the Dissertation co-chairpersons will have access to the identities of the participants. Audio tapes will be destroyed after the analysis of data is completed for the dissertation.

Voluntary Participation
Although your participation in this study is greatly appreciated, your participation is voluntary. You may withdraw from the study at any time. Additionally, you have the right to refuse to answer any question(s) for any reason.
Questions or Concerns
If you have any concerns or complaints about how you were treated during the interview sessions, please contact either Rick Gressard (757-221-2352) or Jill Burruss (757-221-2361) at the College of William and Mary.

Exceptions to Confidentiality
There are exceptions to the promise of confidentiality. If information is revealed concerning suicide, homicide, or child abuse and neglect, it is required by law that this be reported to the proper authorities. In addition, should any information contained in this study be the subject of a court order or lawful subpoena, the College of William and Mary might not be able to avoid compliance with the order of subpoena.

I have read and understood the descriptions of the study to be conducted by Mary Kresser. I have asked for and received a satisfactory explanation of any language that I did not fully understand. I agree to participate in this study. I understand that I may withdraw my consent to be a part of the study at any time. I also agree to be audio taped. I have received a copy of this consent form.

____________________________
Signature
Appendix C
Demographic Information

Give yourself a name for this study.

The following information will be used for research purposes.

Please circle the following appropriate information.

1. Gender
   Male       Female

2. Age
   24-30 yrs.  31-40 yrs.  41-50 yrs.  51-60 yrs.  61-70 yrs.
   71-80 yrs.  81-90 yrs.

3. Level of Education
   Master’s Degree  Ph.D. or Ed.D.  ABD (All But Dissertation)

4. Length of Time Counseling Before Becoming Licensed
   0 - 5 yrs.  6 - 10 yrs.  11 - 15 yrs.  16 - 20 yrs.
   21 - 25 yrs.  26 - 30 yrs.  31 - 40 yrs.  41 - 50 yrs.  51 - 60 yrs.

5. Length of Time Counseling as an LPC
   0 - 5 yrs.  6 - 10 yrs.  11 - 15 yrs.  16 - 20 yrs.
   21 - 25 yrs.  26 - 30 yrs.  31 - 40 yrs.  41 - 50 yrs.  51 - 60 yrs.
Appendix D

PROTOCOLS

Following are the interview guides for the two interviews. Each question is followed by a rationale that connects the question to the literature.

1ST INTERVIEW

INTRODUCTORY QUESTIONS

Why did you become a counselor?
Those in the helping profession “share a desire, a need, or even a mission to be of help” (Hackney & Cormier, 1994, p.1). “Many would-be helpers are driven by the need to be helpful and use the helping relationship for their own ends. This is rarely a conscious act. Neediness has a way of camouflaging itself in more respectable attire. But when the relationship is dictated by the helper’s needs, the possibilities for helping are minimal. It is important to recognize and accept your needs. All people have needs for such things as intimacy, power, esteem, admiration, and so on. It is also important to be certain that you are not dependent on your interactions with clients for fulfilling these needs in a primary way. One of the best ways to ensure that you do not depend on clients inappropriately to meet your needs is to take care of yourself and to live a balanced life in which your needs are met through relationships with a partner, family, friends, or even a support group of other helpers. If you are living your own life in a healthy and balanced way, then your clients will not have to provide you with intimacy, approval, and admiration and will be free to receive from you the kinds of things that they need” (Hackney & Cormier, 1994, pp. 2-3).

What are some of the characteristics and values that you think are important in a counselor?
Based on a national survey, a consensus among a representative group of mental health practitioners identified the following values: “developing effective strategies for coping with stress; developing the ability to give and receive affection; increasing one’s ability to be sensitive to the feelings of others; becoming able to practice self-control; having a sense of purpose for living; being open, honest, and genuine; finding satisfaction in one’s work; having a sense of identity and self-worth; being skilled in interpersonal relationships, sensitivity, and nurturance; being committed in marriage, family, and other relationships; having deepened self-awareness and motivation for growth; and practicing good habits of physical health (Corey, Corey, & Callanan, 1993, p. 62).

According to Corey (1991), Combs (1986) summarized 13 studies in five helping professions to identify characteristics of effective helpers. “They hold positive beliefs about people, seeing them as trustworthy, capable, dependable, and friendly. They have a positive view of themselves and a confidence in their abilities” (Corey, 1991, p. 12).

In Hackney & Cormier (1994), Corey, Corey, and Callanan (1988) “identified 10 personal qualities that are found in effective counselors:

1. Good will--a sincere interest in the welfare of others
2. The ability to be present for others; the ability and willingness to be with them in their experiences of joy and pain
3. A recognition and acceptance of one's personal power; being in contact with one's own strength and vitality; without need to diminish others or feel superior to them
4. The knowledge that one has found his or her own counseling style, that style being an expression of one's own personality
5. A willingness to be vulnerable and to take risks
6. Self-respect and self-appreciation; a strong sense of self-worth
7. A willingness to serve as models for their clients
8. A willingness to risk making mistakes and to admit having made them
9. A growth orientation
10. A sense of humor (pp. 28-30)

...Another related and personal quality involves open-mindedness and flexibility—that is, the capacity to hear, believe, and respond in an open and nonjudgmental fashion to clients who may have values, beliefs, and lifestyles different from your own” (Hackney & Cormier, p. 7).

When did you become a licensed counselor?
Licensure indicates an advanced level of counseling based on the standards of the profession (Corey, Corey, & Callanan, 1993)

Why did you become a licensed counselor?
Licensure requires “applicants to meet specific requirements in terms of education and training and acceptance from practicing professionals” (Corey, Corey, & Callanan, 1993, p. 181). Because “insurance companies frequently reimburse clients for the services of licensed practitioners” (Corey, Corey, & Callanan, 1993, p. 183), the licensed counselor becomes more marketable and increases her or his earning potential.

Tell me about the theoretical framework(s) that guide(s) your counseling practice.
Wheeler (1996) alleged that in Freud’s psychoanalytic theory, dependency is seen as inferior, infantile, and weak. Shame hinges on dependency, that is, reference to and acceptance by others; to experience shame is seen as inferior. From an object relations theory perspective and according to Bion’s (1962) theory, shame develops when the primary caregiver or the therapist does not contain the anxiety of the individual. It is the primary caregiver’s and the therapist’s task to contain the child’s or client’s anxiety and give it back to the child or the client in a more manageable form. In both RET and other cognitive-behavioral therapies, shame would be viewed as irrational thinking. Therefore, adults who experience shame, are essentially reinstilling beliefs that they learned from parents or other significant caretakers. In line with humanistic principles, shame would be seen as an aspect of an individual’s subjective experience. Shame would be described in terms of how the individual perceives and values him or herself. Dysfunctional shame would result from the disruption of the natural process of an individual’s natural drive toward self-actualization. Based on Rogers’ Person-Centered Theory, dysfunctional shame would likely occur in the absence of “unconditional positive regard” and in the presence of “conditional positive regard.”

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Describe the education you have received.
Because therapists who are not taught about shame or whose shame is augmented in training or supervision are likely to follow the modeling of their training and augment the shame of their patients, further explication of shame is needed in therapist training, including teaching about shame, shame treatment, and shame induction or shame sensitivity in training (Yontef, 1996, p. 379).

What kind of education and/or training re: the construct/issue of shame have you received in your master’s counseling program or your doctoral counseling program?
Kaufman (1996) stated that although there has been a proliferation of books on shame in the last fifteen years, many graduate programs do not offer courses that address the construct “shame.” The traditional counseling theories do not address shame; rather, the focus has been on libidinal drives, psychosocial stages of development, ego states, irrational thoughts, and conditioned responses.

SHAME IN COUNSELING

Do you think the construct “shame” is an important construct? Why or why not?
“Shame” is an important construct in the counseling field for various reasons. Several counseling theorists (Bradshaw, 1988; Cook, 1996; Fossum & Mason, 1986; Kaufman, 1996; Lansky, 1995; Mokros, 1995; Morrison, 1996; Nathanson, 1992) linked shame to a multitude of psychological problems. Mokros (1995) posited that shame plays a central role in the motivation of human behavior. Some theorists (Kaufman, 1996; Lansky, 1995; Mokros, 1995; Morrison, 1996) found that shame is an important factor in identity development. Others (Fowler, 1993; Kaufman, 1996; Lansky, 1995) maintained that shame plays an important role in the operations of conscience. Lewis (1971) and Jacobs (1996) concluded that many therapeutic impasses have resulted from shame experiences that occurred in sessions that were unacknowledged.

Do you think the construct “shame” has been given adequate attention in graduate counseling programs? in the counseling field? Why or why not?
Kaufman (1992) claimed that shame has been neglected in counseling and personality theories in the past 150 years because achievement and success are worshipped in this culture making shame a forbidden topic.

Why do you think that the construct “shame” is not given more attention in counseling?
Kaufman (1992) suggested that beginning with Freud, guilt has been emphasized which has concealed the role of shame. He claimed that because of Freud’s enormous influence, the primitive instincts of sex and aggression were believed to be the central forces motivating human behavior.

DEFINITIONS
From your perspective, is there a distinction between “shame” and “guilt?”
Fossum & Mason (1986) articulated that while guilt is a hurtful feeling of disappointment and responsibility for one's actions, shame is a hurtful feeling about oneself as a person. They stated that shame is a matter of identity, not behavioral transgression. Fowler (1993) and Nichols (1995) agreed that guilt is about something that one has done or contemplated doing; shame is about something one is or is not.

In practice, do shame and guilt show up as two separate entities or do they merge? Shame's proximity to other emotions such as guilt, embarrassment, or humiliated rage makes it hard for people to identify it. Shame may be difficult for people to distinguish from other emotions such as shyness, guilt, social anxiety, and embarrassment (Macdonald, 1998).

In counseling terms, is there a distinction between useful shame and harmful shame?
Theorists (Fowler, 1993; Mokros, 1995; Retzinger, 1989; & Scheff, 1994) acknowledged that shame serves a useful function for individuals and society. Fowler (1993) claimed that it is important to see that not all shame is crippling, and, in fact, is necessary for the development of one's conscience. Scheff (1994) and Retzinger (1989) asserted that shame that is acknowledged and addressed with mutual respect between individuals and groups can be a wellspring of strengthened bonds. Mokros (1995) asserted that feelings aroused along the shame-pride continuum regulate an individual's behavior by calling attention to one's place and responsibility to the social bond. When a person experiences pride, she or he experiences integration into the social bond. When one feels shame, she or he experiences separation and the pull to social reintegration (Mokros, 1995).

HUMAN DEVELOPMENT

How do you think shame develops in an individual?
"Since the mother-infant relationship is so crucial in the development of self, it is likely that the beginnings of this sense of self are linked to the quality of the mother's attunement. If a dominant quality of the responding mother is one of shame stemming from feelings of her weakness and incompetence, these qualities will also be taken in through identification, by the infant" (Morrison, 1996, p. 63). According to Karen (1992), a climate of periodic rejection or pervasive disrespect on the part of a parent steadily erodes the child's sense of self-worth and makes her or him predisposed to shame. Nichols (1995) took the same position, "Shame is an acute collapse of self-esteem, developmentally linked to parental failures to respond with adequate attention and appreciation to the child as a whole and worthwhile human being" (p. 140).
From your theoretical perspective, does shame play a function in the behavior of people? If so, how?
According to Scheff (1994) and Retzinger (1989), people behave and follow social mores, in large part, to fit in, be accepted, and escape the pain of shame and humiliation. There are behaviors that are initiated in order to cope with, or mask, shame as it transpires (Gilbert, 1998). Anger and aggression often fill-in for shame; an individual becomes angry at having her or his flaws pointed out and commented on (Nathanson, 1992; Retzinger, 1991; Tangney et. al., 1996). In an effort to avoid shame, individuals may withdraw from those situations where it could be experienced (Gilbert, 1998). Individuals hide their shame “behind the guises of anger, contempt, depression, denial, or superiority” (Morrison (1996, p.10).

From your theoretical perspective, what role does shame play in the development of conscience?
Shame plays a role in the operations of conscience (Fowler, 1993; Kaufman, 1996). Shame is necessary for the development of one’s conscience (Fowler, 1993). To an individual the experience of shame signals the need for one to assess and possibly amend her or his ways (Fowler, 1993). “The optimal development of conscience depends on adequate and appropriately graded doses of shame that do not overwhelm the child ...” (Kaufman, 1996, p.147).

Does shame play a role in identity formation?
Psychologists (Kaufman, 1996; Morrison, 1996; Wurmser, 1991) identified shame as playing a role in identity formation. “Shame is the affect of inferiority. No other affect is more central to the development of identity. None is closer to the experienced self, nor more disturbing” (Kaufman, 1996). “Identification is one vital source from which identity evolves” (Kaufman, 1996, p. 72). “Identification is a human process. The identification need continues throughout the life cycle; it is by no means confined to childhood” (Kaufman, 1996, p. 73). Wurmser (1991) declared that shame calls one’s entire identity into question and shatters basic trust in the world. He stated that shame is a form of self-punishment, a savage condemnation of the self that is rooted in the absolute sense of being unlovable.

LINK TO PSYCHOLOGICAL PROBLEMS

Do you think there is a connection between psychological problems and shame? If so, what?
Many counseling theorists theoretically linked shame to a multitude of psychological problems. The Internalized Shame Scale (ISS) was developed to identify an enduring constellation of shame feelings that result from frequent shaming experiences that have become internalized over time, beginning with childhood experiences. The scale correlates, in both clinical and nonclinical populations with most measures of pathology; the implication is that shame is present in most psychopathologies (Cook, 1996).

Are specific psychological disorders connected to shame? If so, what are they?
Many counseling theorists theoretically linked shame to a multitude of psychological
problems such as addictions (Bradshaw, 1988; Fossum & Mason, 1986; Kaufman, 1996),
phobias (Kaufman, 1996), sociopathic and psychopathic syndromes (Kaufman, 1996),
narcissism (Kaufman, 1996; Lewis, 1992), schizoid and paranoid syndromes (Kaufman,
1996), depression (Kaufman, 1996; Lewis, 1992; Morrison, 1996), mania, (Morrison,
1996), suicide (Mokros, 1995; Morrison, 1996), and compulsive behaviors (Bradshaw,
1988).

Have you had any clients in which shame has played an integral part in their
problems. If so, please discuss a couple of examples.

Nathanson (1992) held that experiences of shame not integrated into one’s awareness in a
healthy way, are defended against in one of four manners: withdrawal; avoidance; attack
of self; attack of other. These four patterns encompass almost the full range of
psychopathology.

2ND INTERVIEW

PRACTICE OF COUNSELING

Construct

Tell me about your understanding of the construct “shame.”

Much has been written about the shame clients bring into therapy, but it is important to
look at shame experienced in the present. Simon & Geib (1996) claimed that because
shame is an interactive experience, the potential for shaming is present in any relationship.
Transference, the process by which a client reacts to the therapist as she did to some
significant person (Corey, 1993) often occurs in therapy. In psychoanalysis, there is always
the danger of countertransference in which the analyst takes an emotionally safe, superior
position, while relegating the patient to a shameful, inferior one (Lansky, 1995).

Apart from anything the client brings to therapy, a therapist can sometimes be an
instrument of shame. Many theorists (Jacobs, 1996; Lansky, 1995; Morrison, 1996; Simon
& Geib, 1996) have written about the power dynamics of the helping relationship. “From
its very inception ... the therapeutic relationship is an unequal and hierarchical one
between the patient as supplicant and the therapist as expert (Morrison, 1996, p. 138).
Therapy is a place in which the client is particularly vulnerable to being shamed because
the therapist’s silence or words have a greater impact than those of a friend who occupies a
more mutual position (Simon & Geib, 1996). Jacobs (1996) maintained that the therapist is
usually more important to the client than contrariwise because the client reveals more of
herself than the therapist. She further asserted that this differential exposure breaks the
social code of reciprocity in which the one who discloses too much usually feels ashamed.
The difference in exposure places the therapist in a comparatively more powerful position
(Jacobs, 1996). Thus, through inattention, lack of attunement, or defensiveness, the
therapist can more easily hurt the client. A possible explanation for why shame has been
consistently overlooked by psychotherapists may be the contagious nature of shame
(Morrison, 1996).

In contrast to guilt (which has to do with harmful actions or thoughts against other),
shame is difficult to encounter in another without recalling and even reexperiencing
one’s own shame experiences. Since guilt-inducing behavior is specific to a given
person, it doesn’t usually reverberate with someone else’s experience. On the other
hand, another person’s shame recalls our own feelings of failure, inferiority, and incompetence. Shame begets shame, but this time, between people (p. 8).

**How is the construct “shame” meaningful to you in the practice of counseling?**

In 1971, shame emerged as a major focus in psychoanalytic thinking with Helen Lewis’s book, *Shame and Guilt in Neurosis*. Lewis (1971) used detailed transcripts of treatment sessions to mark shame experiences in those interchanges. She concluded that many therapeutic impasses resulted from shame experiences that were unacknowledged. Furthermore, hostility, overt anger, and outright rage in the sessions themselves immediately followed a clear-cut experience of shame that was not acknowledged either by the therapist or the patient. Lewis (1971) identified “bypassed shame “ in analytic encounters. The therapist, in bypassed shame, responds to a painful or sensitive self-disclosure in a way that wounds the patient or fails to give importance to what the patient has risked. Initially the patient experiences anger at the therapist, then guilt about the anger (How can I feel anger toward this person who is trying to help me get better?) followed by depression and then shame as the anger that was directed toward the therapist turns back upon the self. Lewis (1971) suspected that therapists often create bypassed shame by neglecting to hear things their clients present that elicit their own unaddressed and bypassed shame.

Therapists (Jacobs, 1996; Kaufman, 1996) identified the therapist’s human tendency to avoid her own shame. The therapist does this through defenses such as denial, blaming, contempt, and efforts to transfer the shame onto the client. “Therapists who avoid or otherwise defend against their own shame, however activated, unfortunately recreate their client’s familial patterns” (Kaufman (1996)p.158). In Jacobs (1996) view, all human beings have developed character patterns designed to reduce their potential for being shamed. However, if a therapist is generally organized around avoiding experiences of shame, she is inclined to be very constrained in her therapeutic approach. The authoritarian or expert is an example of such a constricted therapeutic style that is rationalized as an appropriate therapeutic stance. Shame-provoking incidents often occur when a therapist is too centered in her own perspective and out of touch with the client’s experience (Jacobs, 1996).

According to Jacobs (1996), many therapists operate from the perspective that they have privileged access to what is “real” and label the viewpoints of their clients as “projecting” or “distorting.” This perspective can serve as a defensive shield for therapists who avoid shame. Shame-avoidant therapists are frequently reluctant to expose their work, seek out supervision, or go into therapy themselves. Their tendency to hide is unfortunate because they rarely have an opportunity to learn about their own shaming tendencies (Jacobs, 1996). Jacobs (1996) and Kaufman (1996) both discussed the connections between shame and impasse in therapy) “Perhaps the most common therapist contribution to the development of an impasse — is the therapist’s difficulty with her own shame” (Jacobs, 1996, p.308).

Impasses in the relationship are inevitable and often triggered by mistakes made by therapists. Mistakes are natural, to be expect; they are even necessary. When therapists are able to recognize their mistakes, openly acknowledge them with their clients, and directly own them, the relationship is restored: therapist and client become allies once again. But impasses will generate shame for therapists who cannot allow themselves to be human and imperfect. Their further refusal to
acknowledge the natural shame initially caused by the impasse will prevent their restoring the relationship with the client (Kaufman, 1996, p. 221).

**Treatment**

**How frequently is shame a factor in the problems your clients present?**

Nathanson (1992) held that experiences of shame not integrated into one’s awareness in a healthy way, are defended against in one of four manners: withdrawal; avoidance; attack of self; attack of other. These four patterns encompass almost the full range of psychopathology.

**How do you address shame in counseling sessions?**

Morrison (1996) believed that because shame is first experienced in relationship, it can be alleviated only in a relationship with another (or others) whom are perceived as accepting, attuned, and receptive. He held that the developmental wounds generated by shame cannot be undone by the nurturing person, but she or he can assist in softening the harshness of the individual’s self-judgments and give a more positive outlook on how the individual is experienced by others. Gestalt theory stresses contact in the present between therapist and client as the chief method of therapy (Lee, 1996).

**Can you give me an example of an experience of working with a client who is experiencing shame in a counseling session?**

“Just as children require a security-giving relationship for optimal growth, so do clients. The conditions for growth do not change upon becoming an adult or entering into a therapeutic alliance. A therapeutic relationship is not identical to a parenting relationship, but they are functionally equivalent. ... And shame becomes healed through experiences of identification between client and therapist” (Kaufman, 1996, p. 157).

**IMPASSES**

**How do you recognize shame in a client?**

An observer may identify that a person is having a shame reaction. The person herself may identify that it is retreat ing, but while shame is occurring the person herself is unable to communicate. She may only report feeling “bad,” “tense,” or “blank.” This kind of shame is called overt, unidentified shame (Macdonald, 1998). There are behaviors that are initiated in order to cope with, or mask, shame as it transpires (Gilbert, 1998). Anger and aggression often fill-in for shame; an individual becomes angry at having her or his flaws pointed out and commented on (Nathanson, 1992; Retzinger, 1991; Tangney et al., 1996). In an effort to avoid shame, individuals may withdraw from those situations where it could be experienced (Gilbert, 1998). Individuals hide their shame “behind the guises of anger, contempt, depression, denial, or superiority” (Morrison, 1996, p.10).

There are many such situations in which we fail to recognize that we are in a moment of shame, so it is important to acknowledge that the affect is not always interpreted as one of the feelings normally associated with shame. In general, what we call ‘hurt feelings’ is caused by shame affect—these are always moments when a positive affect is interrupted by the painful affect of shame (Nathanson, 1993, p. 145).
As Lansky (1995) said, “Shame, overt or hidden, and its more visible consequents—envy and rage—result from interpretations; lapses of attention; failures of acknowledgement or unresponsiveness that make the patient feel fragmented disconnected, or relegated to inferior status (p.1083).”

If you become aware that your client is experiencing shame during a session, do you acknowledge that in the session? If so, how?

Most shame therapists advocate making an effort to help the client see the connection between shame and its offshoots, such as rage, obsessiveness, or overeating. They support a more empathic, accepting posture toward the client, especially when needed in order to make up for what parents failed to provide. Creating an environment where the patient is able to speak the awful “truths” she nurses about herself seems to be a crucial first step in freeing oneself of the crippling shame (Karen, 1992).

Do you think it happens that counselors inadvertently shame their clients? If so, how?

The therapist, in bypassed shame, responds to a painful or sensitive self-disclosure in a way that wounds the patient or fails to give importance to what the patient has risked (Lewis, 1971). The lack of awareness of shame on the counselor’s part, can result in counselor shaming that may lead to an impasse in therapy (Jacobs, 1996). Therapy is a place in which the client is particularly vulnerable to being shamed, that the therapist’s silence or words have a greater impact than those of a friend who occupies a more mutual position (Simon & Geib, 1996). H.B. Lewis (1971) used detailed transcripts of treatment sessions to mark shame experiences in those interchanges. She concluded that many therapeutic impasses resulted from shame experiences that were unacknowledged.

What connection is there between counselors’ own shame issues and how they provide counseling to their clients with shame issues?

In Jacobs (1996) view, all human beings have developed character patterns designed to reduce their potential for being shamed. However, if a therapist is generally organized around avoiding experiences of shame, she is inclined to be very constrained in her therapeutic approach. The authoritarian or expert is an example of such a constricted therapeutic style that is rationalized as an appropriate therapeutic stance. Jacobs (1996) asserted that shame-provoking incidents often occur when a therapist is too centered in her own perspective and out of touch with the client’s experience. Jacobs (1996) stated that “perhaps the most common therapist contribution to the development of an impasse — is the therapist’s difficulty with her own shame” (p.308).

Impasses in the relationship are inevitable and often triggered by mistakes made by therapists. Mistakes are natural, to be expect; they are even necessary. When therapists are able to recognize their mistakes, openly acknowledge them with their clients, and directly own them, the relationship is restored: therapist and client become allies once again. But impasses will generate shame for therapists who cannot allow themselves to be human and imperfect. Their further refusal to acknowledge the natural shame initially caused by the impasse will prevent their restoring the relationship with the client (Kaufman, 1996, p. 221).
CONCLUDING QUESTIONS
What sets shame apart from the other emotions?
Capps (1993) summarized Lynd’s (1958) analysis of shame. “(T)he totally self-involving nature of shame … tends to involve one’s body as well as one’s mind” (p. 75). “(S)hame and the self are intimately related” (Capps, 1992, p. 72). “Shame is the affect of inferiority. No other affect is more central to the development of identity. None is closer to the experienced self, nor more disturbing” (Kaufman, 1996, p. 16).

How can a counselor most effectively deal with her own shame when it emerges in counseling sessions?
Impasses in the relationship are inevitable and often triggered by mistakes made by therapists. Mistakes are natural, to be expected; they are even necessary. When therapists are able to recognize their mistakes, openly acknowledge them with their clients, and directly own them, the relationship is restored: therapist and client become allies once again. But impasses will generate shame for therapists who cannot allow themselves to be human and imperfect. Their further refusal to acknowledge the natural shame initially caused by the impasse will prevent their restoring the relationship with the client (Kaufman, 1996, p. 221).

According to Jacobs (1996), many therapists operate from the perspective that they have privileged access to what is “real” and label the viewpoints of their clients as “projecting” or “distorting.” This perspective can serve as a defensive shield for therapists who avoid shame. She has further contended that shame-avoidant therapists are frequently reluctant to expose their work, seek out supervision, or go into therapy themselves. Their tendency to hide is unfortunate because they rarely have an opportunity to learn about their own shaming tendencies.

Mindell (1994) discussed treating a client who is contemptuous towards the therapist during a session. It involved searching for the error that the therapist made which prompted the outbreak, and acknowledging what happened to the client in order to appreciate how the client perceived it. This process helped the client feel, once again, that he was accepted by the therapist and recreated a bridge between them.

How could the construct “shame” be dealt with more effectively in counselor education and training?
Do you have any suggestions on the best way to address shame in counseling sessions?
Appendix E

Protocols

1ST INTERVIEW

INTRODUCTORY QUESTIONS

Why did you become a counselor?

What are some of the characteristics and values that you think are important in a counselor?

When did you become a licensed counselor?

Why did you become a licensed counselor?

Tell me about the theoretical framework(s) that guide(s) your counseling practice.

Describe the education you have received.

What kind of education and/or training re: the construct/issue of shame have you received in your master’s counseling program or your doctoral counseling program?

SHAME IN COUNSELING

Do you think the construct “shame” is an important construct? Why or why not?

Do you think the construct “shame” has been given adequate attention in graduate counseling programs? in the counseling field? Why or why not?

Why do you think that the construct “shame” is not given more attention in counseling?

DEFINITIONS

From your perspective, is there a distinction between “shame” and “guilt?”

In practice, do shame and guilt show up as two separate entities or do they merge?

In counseling terms, is there a distinction between useful shame and harmful shame?
2ND INTERVIEW

HUMAN DEVELOPMENT

How do you think shame develops in an individual?

From your perspective, does shame play a function in the behavior of people? If so, how?

From your theoretical perspective, does shame play a role in the development of conscience?

Does shame play a role in identity formation?

LINK TO PSYCHOLOGICAL PROBLEMS

Do you think there is a connection between psychological problems and shame? If so, what?

Are specific psychological disorders connected to shame? If so, what are they?

Have you had any clients in which shame has played an integral part in their problems: If so, please discuss a couple of examples.

PRACTICE OF COUNSELING

Construct
Tell me about your understanding of the construct “shame.”

How is the construct “shame” meaningful to you in the practice of counseling?

Treatment
How frequently is shame a factor in the problems your clients present?

How do you address shame in counseling sessions?

Can you give me an example of an experience of working with a client who is experiencing shame in a counseling session?

IMPASSES
How do you recognize shame in a client?

If you become aware that your client is experiencing shame during a session, do you acknowledge that in the session? If so, how?

Do you think it happens that counselors inadvertently shame their clients? If so, how?
What connection, if any, is there between counselors’ own shame issues and how they provide counseling to their clients with shame issues?

CONCLUDING QUESTIONS
What sets shame apart from the other emotions?

How can a counselor most effectively deal with her own shame when it emerges in counseling sessions?

How could the construct “shame” be dealt with more effectively in counselor education and training?

Do you have any suggestions on the best way to address shame in counseling sessions?
Appendix F

INTERVIEW GUIDES WITH PROBES & PROMPTS

1ST INTERVIEW

ESTABLISHING RAPPORT
As you are aware, I’m going to ask you some questions about your understanding of the construct “shame” and what meaning it has for you in the practice of counseling. I am interviewing several licensed counselors in order to get a variety of perspectives. Shame is a nebulous construct. There are no right or wrong answers. This is an exploratory study, and I am interested in obtaining a broad spectrum of thinking re: the construct “shame.”

INTRODUCTORY QUESTIONS

1) Why did you become a counselor?
Probes/Prompts:
What attracted you to the profession of counseling?
Were there any seminal (influential, decisive) events that pushed you in the direction of counseling?

2) What are some of the characteristics and values that you think are important in a counselor?
Probes/Prompts:
Which characteristic is most important? least important?
Why is that particular characteristic important in a counselor?
Which value is most important? least important?
What is your idea of the ideal counselor?

3) When did you become a licensed counselor?
Probes/Prompts:
How long were you a counselor before you became licensed?
Has your counseling changed as a result of becoming licensed?

4) Why did you become a licensed counselor?
Probes/Prompts
What were the motivating factors?

5) Tell me about the theoretical framework(s) that guide(s) your counseling practice.
Probes/Prompts:
Talk about how the construct “shame” is viewed in the theory to which you ascribe.

6) Describe the education and training you have received.
Both formal and informal.
Degrees? Workshops? Conferences?
7) What kind of education and/or training re: the construct/issue of shame have you received in your master’s counseling program or your doctoral counseling program?

Probes/Prompts:
Was the “shame” focused on in your education/training?
Was it mentioned in your counseling theories courses?
What other kinds of education and/or training re: the construct/issue of shame have you received?

SHAME IN COUNSELING

8) Do you think the construct “shame” is an important construct? Why or why not?

Probes/Prompts:
If no,
Walk me through your thinking on this.
How did you come to your thoughts on this?
What is your rationale for this conclusion?
If yes,
Is it a construct that is useful to you?
Do you use the construct to conceptualize cases?
How could the construct “shame” be useful to you?

9) Do you think the construct “shame” has been given adequate attention in graduate counseling programs? in the counseling field? Why or why not?

10) Why do you think that the construct “shame” is not given more attention in counseling?

Probes/Prompts:
In theories?
In counselor education programs?
In the counseling field?

DEFINITIONS

11) From your perspective, is there a distinction between “shame” and “guilt”? By the way, how do you define “shame?”

How do you define guilt?

12) In practice, do shame and guilt show up as two separate entities or do they merge?

Probes/Prompts:
Do you distinguish between the two entities?
Is the distinction important?
13) In counseling terms, is there a distinction between useful shame and harmful shame?
Probes/Prompts:
Does shame have any positive aspects?

HUMAN DEVELOPMENT

14) How do you think shame develops in an individual?
Probes/Prompts:
What factors contribute to the development of shame?

15) From your perspective, does shame play a function in the behavior of people? If so, how?
Probes/Prompts:
Does shame influence how people behave?

16) From your theoretical perspective, does shame play a role in the development of conscience?

17) Does shame play a role in identity formation?

LINK TO PSYCHOLOGICAL PROBLEMS

18) Do you think there is a connection between psychological problems and shame? If so, what?
Probes/Prompts:
Is shame part of individuals’ emotional problems?

19) Are specific psychological disorders connected to shame? If so, what are they?

20) Have you had any clients in which shame has played an integral part in their problems: If so, please discuss a couple of examples.

2ND INTERVIEW

INTRODUCTORY QUESTIONS
The second interview will begin with follow-up questions or clarifications that I may need to make based on the analysis of the first interview.
“Probing Questions: ‘Could you say something more about that?’; ‘Can you give a more detailed description of what happened?’; Do you have further examples of this?’ (Kvale, 1996, p. 133)

PRACTICE OF COUNSELING
Construct
21) Tell me about your understanding of the construct “shame.”
22) How is the construct “shame” meaningful to you in the practice of counseling?  
Probes/Prompts:  
What does the construct “shame” contribute to the counseling field?  
How is the construct “shame” viewed in other theories?  
Are there commonalities among theories on their perceptions of shame?

Treatment  
23) How frequently is shame a factor in the problems your clients present?

24) How do you address shame in counseling sessions?

25) Can you give me an example of an experience of working with a client who is experiencing shame in a counseling session?

IMPASSES  
26) How do you recognize shame in a client?  
Probes/Prompts:  
Are there nonverbal clues? Facial expressions? Body language?  
Are there telltale phrases that indicate shame?  
Are there emotions that the client expresses that alert you to shame?  
How do recognize whether shame is a factor in your client’s problems?

27) If you become aware that your client is experiencing shame during a session, do you acknowledge that in the session? If so, how?  
Probes/Prompts:  
If not, what do you do?

28) Do you think it happens that counselors inadvertently shame their clients? If so, how?  
Probes/Prompts:  
How is it possible that a counselor could trigger shame in a client?  
Is it possible that it might be positive that shame be triggered in a client?  
29) What connection, if any, is there between counselors’ own shame issues and how they provide counseling to their clients with shame issues?

CONCLUDING QUESTIONS  
30) What sets shame apart from the other emotions?  
Probes/Prompts:  
Is shame different from other emotions such as anger, joy, surprise?  
Is shame just another emotion, no different than other emotions?

31) How can a counselor most effectively deal with her own shame when it emerges in counseling sessions?
32) How could the construct “shame” be dealt with more effectively in counselor education and training?

33) Do you have any suggestions on the best way to address shame in counseling sessions?

This is an exploratory study. The waters are muddy. There are no answers re: the construct “shame.” There’s been little or no training on shame. People have had to come up with decisions on their own. I wanted to obtain multiple perspectives on the construct “shame.” You have helped me immensely to do that. I want to thank you profusely for your time, effort, and thoughtfulness.
Appendix G
Question by Question Analysis of Interview Questions

1. Why did you become a counselor?
Most of the counselors stated that they liked working with people. Seven of the twelve LPCs interviewed said that they liked working with people.

“...really liked working with people and sort of coordinating services...” (Fig)

“...I knew that somehow I wanted to be working with people...that I really wanted to work with folks...” (Oak)

“Oh, I've always been a people person...” (Cypress)

Six of the LPCs talked about their curiosity, interest, and fascination about people, their thoughts, feelings, and behavior.

“I've always been real curious about why things are the way they are, and more so about people.” (Elm)

“...I've always been fascinated by human beings and how they operate and how they make their choices...” (Fir)

“...I was always interested in people and curiosity about behavior and thoughts and feelings so I transferred to a four-year institution and went into the field of psychology.” (Ash)

Five LPCs spoke of their desire to help people.

“To think that if I could help one person have a better life, then it would be worth it, so it was really to help other people...” (Palm)

“...I'm very, very interested in helping people heal, helping people live quality lives, meaningful lives, full lives, helping people be fully alive.” (Fir)

“Because I grew up with a deep desire just to help folks.” (Elm)

Four reported that they had worked for a while in the school system.

“While I was still working as an ED teacher, I went back to school and got my endorsement in counseling...” (Hickory)
Two mentioned that they had come from dysfunctional families.

"I grew up in a very dysfunctional family with a mother who was a chronic pain patient and pill addict..." (Palm)

Two said that they had become a counselor to gain a better understanding of themselves.

"Again probably also, partly out of trying to gain a better understanding of myself and my own family of origin." (Cypress)

Only one said that disliking the way she or he had been treated by medical professionals was a reason for becoming a counselor.

"...not liking the way I was being treated by professionals and thinking that there was a better way of working with people and treating people and dealing with people." (Willow)

2. What are some of the characteristics and values that you think are important in a counselor?

Seven LPCs spoke about liking or caring about people, having tolerance, compassion, or empathy for people as an important characteristic for counselors to possess.

"...a caring curiosity,...a capacity to genuinely love,..."

"Well, I think that it's very important to care about people,...."

"Satir used to say if you don’t care about people, get out of the business. That would be, if anything, number one. I think people know when they’re cared about or not."

"first, humanness and the ability to really like and see that the person you’re counseling has value."

Five LPCs said having training, knowledge, or a skill base is important for a counselor.

"...to be trained so that you actually know what you’re doing."

"...being very bright and well-educated, with knowledge of lots of different theories."

"...in terms of keeping up with what’s out there, training wise, like if there’s
really some excellent raining to be had, keeping up with content areas.”

Five LPCs discussed that self-awareness and knowing oneself is an important characteristic.

“The better you know yourself, the better that you can help other people. I think an important value is to do your own work, meaning to do your own counseling, to explore your own unconscious and your own being, so to speak. I would never go to a therapist or recommend someone to go to a therapist if I knew that that person had never done any of their own personal exploration.”

“...and I think it’s even probably more important to be committed to a process of knowing oneself pretty well.”

“The willingness to look at one’s personal dynamics or problems that get triggered in the counseling process, and a willingness to work through those.”

Three LPCs talked about listening and being attentive to clients as an important characteristic.

“It amazes me their telling me that other people weren’t really willing to listen, and I think that’s very important to try to understand why and how a person is thinking and try to help them figure out what’s going to be workable for them to make changes.”

“characteristics would be the ability to listen well, the ability to attend and track what’s happening with a client.”

Three mentioned that being trustworthy is an important characteristic in a counselor.

“...I think trust, integrity are important things for the counselor to have.”

“I think you have to have a sense of being trustworthy.”

Two counselors in various configurations identified the following important characteristics in a counselor: being nonjudgmental; the ability to set up an environment in which clients feel a sense of control; integrity; valuing confidentiality and consent; doing what is in the best interest of the client; a genuine interest in people; valuing boundaries; looking at all aspects of a person, including the spiritual; that a counselor should go through counseling her or himself; treating clients with respect; a realization that one cannot counsel everyone; a willingness to talk to colleagues; understanding human personality; authenticity.

Only one counselor identified the following as characteristics important in a counselor: belief that people are capable of change; pride in oneself; the ability to normalize
clients' feelings; the ability to confirm client's sense of uniqueness; a shared worldview; knowledge of community resources; seeing counseling as a wellness model as opposed to a pathological model; honesty; valuing the process of counseling; warmth; and practice what you preach.

3. When did you become a licensed counselor?
The mean length of time for working as a counseling was 22 years, and the median was 23 years. The mean length of time for counselors to be LPCs was 15 years, and the median was 16 years.

4. Why did you become a licensed counselor?
Six said that they became licensed counselors in order to be in private practice; three mentioned autonomy and greater flexibility. Two discussed more selectivity about clients and issues. Other answers included that the trend was toward licensure, that it was the next step, and that licensure was required to continue in the profession.

5. Tell me about the theoretical framework (s) that guide(s) your counseling practice.
Ten identified themselves as eclectic in approach. One described himself as using a combination of psychoanalytic and cognitive-behavioral approaches. One said that he used chiefly psychosynthesis but was trained in many disciplines. Those who did describe themselves as eclectic identified some primary approaches. One described his underlying worldview as Christian. One described her primary approach as cognitive-behavioral. Another said that her approach was basically a developmental one. One used primarily a Jungian approach. Ten LPCs talked about including a cognitive-behavioral approach in the counseling they provided.

5a. How is the construct of shame viewed in the theory to which you subscribe?
Five described how shame would be viewed in a cognitive behavioral approach. Two talked about how shame would be seen from a Rogerian approach. One described how shame would be seen in a psychoanalytical approach; one, in a Jungian approach; one, for a psychosynthesis framework; one from a developmental approach and an attachment theory perspective.

6. Describe the education and training you have received.
Five counselors had their Ed.D. degrees. Five counselors had their Ed.S. degrees and two had their master's degrees in counseling.

7. What kind of education and/or training re: the construct/issue of shame have you received in your master's counseling program or your doctoral counseling program?
Ten counselors said that they had received or could remember receiving no education or training regarding the construct of shame in their graduate programs. Three counselors had picked up pieces about the construct of shame in various courses in their graduate programs. Three LPCs stated that they had learned about the construct of shame from clients who talked about shame. Four counselors said that they had learned
about the construct of shame from substance abuse training, and five said that they had read about shame in the chemical dependency literature. Two LPCs had said that, although they had attended several workshops and conferences, the construct of shame had never been addressed. One had learned about shame from psychoanalytical training, one from psychosynthesis training, one from transpersonal training, one from theological training, one from sex abuse training, one from training with Elisabeth Kubler-Ross, and one from a couple of sessions at conferences that he attended.

“No. I don’t think that was ever mentioned in any class I had other than talking about somebody must feel ashamed. I don’t recall anything where we really talked about how shame was formed, the power and influence it holds over a person.”

“That (knowledge of the construct of shame) came more from my own experience of, practice, actually being in the trenches and also in reading, people like John Bradshaw, for example. This is a very big theme in his work. John Bradshaw was also a student of Satir’s.”

“I wouldn’t say in any of the degree programs that we talked much about the construct of shame. I can’t remember anything specific so obviously it didn’t stay with me; in the psychoanalytic training, yes.”

“I don’t recall anything about shame in my graduate program. In training since then, again, back when I was going to workshops, conferences that had to do with substance abuse, chemical dependency, reading those types of books, that’s where I am aware of seeing that terminology.”

“The discipline of psychosynthesis and the training in psychosynthesis dealt with the issues of shame in a way that I have mentioned because we believe in and we foster the development of the connection of the ego with the higher self or that inner genius, so that’s sort of one of the goals of psychosynthesis.”

8. Do you think the construct of shame is an important construct? Why or why not?

Eleven of the twelve counselors said that they thought shame was an important construct, and one thought that it was not. The reasons for finding the construct of shame important were wide ranging. Five LPCs stated that shame was a problem for many of their clients. Three counselors said that shame keeps people stuck so that they continue to repeat experiences or relationships. Two stated that the cognitive-behavioral framework has been a helpful perspective for them to use in looking at the construct of shame. Two LPCs remarked that “shame” is not a word that their clients use. Two stated that shame is the result of abuse or trauma. Two mentioned that shame tends to get overlooked because people tend to hide shame.

“Most clients interact with those constructs somewhere in life. I come from a cognitive-behavioral and a systems approach, primarily, so I pay a lot of attention to self-talk.”
"...it helps to explain and understand a fair amount of the behavior that I see in some of my clients. I also think it's an organizing principle in most cultures."

"I think shame functions to keep people stuck in what they're in, when people will just keep repeating the same patterns over and over and over again."

"Yeah, it is, and I think it gets overlooked because people don’t usually come in and verbalize that and because they orchestrate their behavior to hide those feelings."

"Right off the top of my head my response would be: No. To me, it is not important. That may be my lack of exposure to it."

"There is a lot of literature, I think, now out in this field, and I think it’s in those two areas; it’s ACOA language and it’s sex abuse work. ... I think it’s key to these two domains. ... It’s an artifact of abuse of some kind, in childhood, in early childhood."

"...the word “shame,” the actual word or construct, I don’t think it’s used very much, the word is what I’m saying, but the actual—what the person is feeling and the emotion and what’s being experienced, I think that very frequently, that a lot of the time you’re looking at that..."

9. Do you think the construct of shame has been given adequate attention in graduate counseling programs? In the counseling field? Why or why not?

Most of the counselors did not know whether the construct of shame is given adequate attention in graduate counseling programs because they had been out of school for many years. Five LPCs said that the construct of shame does not receive adequate attention in graduate counseling programs. In the counseling field, eight counselors felt that shame is receiving attention in the counseling field, primarily in the addictions arena. Two counselors stated that practitioners paid attention to the construct of shame whereas academicians did not. Three counselors credited the popular author and lecturer, John Bradshaw, with bringing attention to the construct of shame in the counseling field.

"I would say in graduate programs, in general, no. I think some Bible colleges and some Christian-oriented seminaries and graduate schools do probably address it, again, maybe not directly but maybe a little bit more pervasively in their courses because of the concept and spiritual development. ... in the field itself? Oh, I think there’s elements of it. You look at all of john Bradshaw’s work and people who sort of follow his ‘inner child.’ He talks a lot about shame issues. I think there are certainly streams within the profession that spend more focus on it than not. That’s usually because clinicians are out there doing the work, and so clinicians are talking about what’s really out there."

"I think that the attention given, certainly in the addictions field, is very important. I think we do that a lot. Certainly in my work with addictions and family therapy, I think that there is a lot of attention paid to that—guilt, shame. I think that shame is often a
piece that you see with eating disorders, shame about your body, shame about being too little, too big. Certainly in those areas, I’ve seen it written about, but that’s all I know.”

“Well, in my experience, I can’t remember any real significant impact, any course, any particular lecture of discussion. I think it’s something that I just picked up along the way. When you say, ‘Is it adequate?’ I’m not sure what would be adequate. How important is it to really emphasize the concept of shame? I’m not sure, but I think as long as it’s mentioned, as long as it’s brought up, as long people are encouraged to look into that as one of the concepts. That’s only one construct that we talk about in terms of dealing with people.”

“My experience has been, for the most part, that outside of the addictions field, you don’t hear very much about shame.”

“I would say, since most of the interaction I have these days is with other practitioners, I would say people who are actually in the trenches, people who are actually meeting with clients, doing therapy day to day, yes, this is very much a topic that is considered in in-service training, in supervision. Yes, I think it’s a topic that’s very well known and very well addressed in practice, in the actual application of therapy. I can’t speak to academia because I’ve been away from that for a decade, but in the actual practice, I would say yes, particularly with counselors and social workers.”

10. Why do you think the construct of shame is not given more attention in counseling?

There were no common answers to this question. Two counselors said that there were so many constructs to cover in graduate programs that it was not possible to cover all of them. Two LPCs thought that shame is a deep issue that does not lend itself to the more popular surface types of counseling theories. Two counselors stated that counselors are not comfortable with shame issues. There were a variety of other answers to this question.

“One is that counselors are fairly uncomfortable dealing with shame. It’s a pretty amorphous concept, and it’s really a core kind of issue, and if you’re trying to deal with folks from a more surface cognitive-behavioral type place and dealing with that kind of murky stuff, it sounds almost like Freudian, below the surface, and it’s not something one would deal with.”

“...a lot of therapists don’t do their own unfinished business, and they don’t want to go there.”

“A lot of it these days is driven by third-party payers and meeting those needs, and having clients in and out as quickly as possible so people are focusing on strategies that are quick, strategies that work. They’re not focusing on long-term issues so much.”

“...it’s been an uphill struggle for psychology and counseling to kind of legitimize itself as a field of study in science. I think we spent a lot of years looking at things that we
could kind of reconstruct in a laboratory and not so much looking at some of the more subtle dynamics of what happens in human interactions that are much harder to measure and objectify.”

“Perhaps because it hasn’t had a charismatic spokesperson. Because if you think about other theories and concepts in counseling, there’s usually a name.”

11. From your perspective, is there a distinction between “shame” and “guilt?”
Nine counselors saw the major distinction between shame and guilt as follows: Shame is feeling bad about who you are as a person; it is who I am; it is self-esteem or self-concept whereas guilt is feeling bad about specific behaviors or actions, either having done something or having failed to do something. One counselor saw the major distinction as shame as something one can acquire through association whereas guilt is associated with someone having participated in something. One counselor saw shame as something externally imposed whereas guilt is internal. One counselor saw shame as something that one has no choices about because it is imposed from the outside whereas guilt is something one has choices about and can make changes from; it is related to one’s conscience.

“My sense of a difference is that guilt is a feeling of regret of something they you’ve done or haven’t done, but shame is more of a core belief; that guilt is a result of something, but it seems like that shame, a person feels more like it’s really who they are versus a result of behavior or something.”

“I see guilt as people addressing behavior. Guilt, to me, usually has to do with what I did or what I didn’t do but maybe I should have, either acts of commission or acts of omission. ... I think shame has a little bit more to do with how I perceive myself as a person, and so it’s a little deeper, I think.”

“...shame is externally imposed, and guilt is internal. Guilt is something that arises in the person. It may have to do with that person’s basic way of viewing the world or personality, if you want to use a popular phrase. Guilt, to me, is internal; shame is externally imposed.”

“I would say that my concept of guilt is that it’s mostly focusing on behavior. ... My concept of shame is much more internally oriented. It’s personality; it’s self-esteem. It’s self-concept, that I am a shameful person.”

12. In practice, do shame and guilt show up as two separate entities or do they merge?
Seven counselors stated that shame and guilt usually merge. Three indicated that sometimes shame and guilt sometimes merge. One participant said that he saw shame and guilt as separate entities. Four discussed that people use the words guilt and shame interchangeably and often do not know the difference between the two constructs. Three said that shame is often presented as guilt. One said that she has worked with people guilt but not people with shame.
“They tend to merge from my experience. ... You come across these people who are apologizing for everything. They’re always feeling guilty for something. My experience has been when you sit with that long enough and kind of dig a little bit more deeply with it, what you find is a great deal of shame.”

“I think that they’re two separate entities, but I think that they get confused. I think that people interchange words and don’t really necessarily define the word in the same way that Maybe I would so it’s important to clarify when someone uses one of those words, what they’re actually talking about.”

“I certainly have worked with people who have felt guilty about things that they have done or failed to do. I’m thinking. I’m trying to think of an example of someone who was experiencing shame according to my definition of shame, something that had really been externally imposed. I can’t think of one at the moment.”

“What is more typical is both. It’s that they feel badly about things that they have done and feel badly about who they are.”

13. In counseling terms, is there a distinction between useful shame and harmful shame?
Seven counselors said that they did not think that shame could be useful or healthy, and five thought that shame could serve a useful purpose.

“I think shame is never useful. I think guilt is useful. An appropriate sense of guilt is very useful, but shame, I think, gets deeper into the self-concept...”

“Shame, for me, is a shadow on the soul, a shadow on the self. It isn’t anything that I would encourage or foster or try to celebrate or use.”

“I think so because I believe most people are really good and when they do something that they are experiencing feelings of shame, it is sort of a trigger for ‘Okay, how do I change or what needs to be different?’ I think it can trigger good.”

“A useful shame would be a deterrent to repeating a harmful act or something that would be hurtful to me or to someone else...”

14. How do you think shame develops in an individual?
Nine of the twelve counselors said that shame usually develops in childhood. Five LPCs indicated that shame is externally imposed. Four LPCs stated that shame is internalized. Three mentioned that shame is the result of another’s disapproval or disappointment. Three suggested that shame is part of the socialization process. Four said that shame occurred in the family system. Two talked about an early disturbance in ego development.
“I think it develops when we experience something where there’s a certain sense of: we disappointed somebody, we feel we’ve failed somebody, we’ve done something wrong.”

“From the outside in. I think it develops because other people have pressed them to feel shame.”

“Certainly parental influence, societal influence, disapproval from lots of different sources. I don’t think we’re born feeling shame. I think that comes through our external contacts.”

“My experience is that it develops in a particular system, in a family system. ....”

“I think we socialize it into everybody shortly after birth.”

“...I think shame is the result of the wounding of a normal ego development without nurturance and support on the outside to understand life experiences...”

“That’s where you often engage people, at least adults, in therapy because they’ve internalized this stuff (shame) for years...”

15. From your perspective, does shame play a function in the behavior of people: If so, how?
All counselors said that shame played a function in the behavior of people. Seven participants discussed the variability of the behavior in terms of polarized behavior, passive vs. aggressive, submissive and dependent vs. hostile, schizoid versus social aversion, timid vs. acting out. Two counselors talked about how people with shame try to hide their behavior. Other answers varied, but the overall theme is that shame produces self-destructive behavior.

“My experience of it is that it can go in one of two ways. Either they become incredibly passive and submissive or they become aggressive, not assertive, but aggressive.”

“...for some people, shame has resulted in their being extremely dependent. For some people it’s resulted in their being helpful all the time. For other people, it’s resulted in their being hostile and acting out. so yeah, I think, for some people it has very wide-reaching consequences.”

“I think that it takes an incredible amount of energy for most folks to hide their sense of shame, that kind of internalized sense of their own badness or inadequacy, and that most folks spend an awful lot of time and energy protecting that, creating personas and creating artificial parts of themselves. compensating, overcompensating, undercompensating.”
“I think people who feel an awful lot of shame are self-destructive. I’m not necessarily talking about acting out with suicide and things like that, but I can see them getting into bad job situations or make bad choices in life, to unconsciously get into a good relationship, then get out of it very quickly because they don’t feel like they deserve it.”

16. From your theoretical perspective, does shame play a role in the development of conscience?
Ten participants said that shame played a role in the development of conscience. Six counselors stated that it played a negative role. One said that it possibly could have an impact on the development of shame. One had no answer for the question. Two participants said that an appropriate sense of shame played a positive role in the development of conscience. An unusual answer was that shame plays a role if one is a spiritual person.

“I think there’s an attempt in our culture to use shame as a way of developing a sense of conscience. I don’t think that it produces a healthy sense of conscience. I think it produces a fear-based, shame based sense of conscience.”

“Yes, I think it does. It lets us know in some way or another when we’ve really transgressed something important to us, some value. I think that is part of our personal and social conscience.”

“Yes, if you’re a spiritual person. ... It’s when I feel what I’ve done or having trouble doing is separating me from my higher power which I would call God.

17. Does shame play a role in identity formation?
All 12 counselors agreed that shame plays a role in identity formation. The most common answer (6 counselors) said that shame was feeling bad about who one is, feeling worthless or inadequate. Three discussed that shame was how one viewed oneself that stemmed from others’ opinions of disapproval.

“Yeah, I’d say it does because when somebody is told that they’re pretty worthless, that they really are stupid, or this or that over a period of time, and there’s no other place where some other possibility of self is available for affirmation or redemption in some way, they are going to believe that.”

“Again as kids are shamed about themselves, about the behavior and about themselves, that they develop a sense of themselves as being inadequate, fundamentally inadequate and bad and therefore begin to develop a persona, an identity based on that, often seen in body concept.”

“If I perceive that other people are disapproving of me, and maybe again that’s a distinction, they’re disapproving, not just of my act but of me, then, yeah, I think it could well affect your identity formation, how you view yourself.”

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18. Do you think there is a connection between psychological problems and shame? If so, what?
Eleven counselors said “yes,” and seven of these answered with either the word “absolutely” or “definitely.” One counselor stated that it was possible that shame was connected to psychological disorders. The explanations as to what the connection shame had with psychological problems were diverse, but all, except one, agreed that shame was a contributing factor to psychological problems.

“Absolutely. ... I think if you see yourself as a shameful person, I think that’s going to dictate how you function.”

“Absolutely.... Shame is an internal process. It’s usually a cognitive process, and that cognitive pain, if it’s an unhealthy sense of shame or guilt, does externalize itself in different ways, either self-defeating behavior or relational conflict.”

“I think there could be, but I think it would have to be a situation in which these feelings of shame had been imposed over a long period of time and in a very intense way.”

19. Are there specific psychological disorders that people have that you think are connected to shame?
Eight LPCs said that anxiety or anxiety disorders are linked to shame. Seven LPCs identified depression as being connected to shame, and seven counselors listed chemical dependency or addictions. Four mentioned post-traumatic stress disorder as being associated with shame. Three stated that abuse is connected to shame, and three said that mood disorders are linked to shame. Two counselors identified personality disorders, adjustment disorder, and dissociative disorder. Other disorders that were mentioned by counselors were agoraphobia, eating disorders, obsessive-compulsive disorder, avoidant disorder social aversion disorder, low self-esteem, perfectionism, compulsions, sexual dysfunction, attention-deficit hyperactive disorder, and attachment disorder. Four counselors said that all or almost all psychological disorders have a connection to shame. One counselor said that none of the psychological disorders are linked to shame.

“Well, I think, the population I see the main problems are depression and anxiety. I would say that and psychoanalytic theory says that anxiety is oftentimes based on guilt so a lot of anxiety, excessive anxiety, would probably be connected to shame, but I think that depression would, too.”

“I wouldn’t see a specific psychological disorder arising because of shame imposed from someone else.”

“I think they’re all connected to shame in some way, all of them. ... Most of the DSM, with the exception of schizophrenia and bipolar, those kind of things, I think, really have their origins in trauma. ... Part of that trauma process is the induction of shame.”

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20. Have you had any clients in which shame has played an integral part in their problems: If so, please discuss a couple of examples.
The most common examples were those in which clients revealed sexual abuse (4), homosexuality (3), depression (2), obesity (2), and chemical dependency (2). One counselor talked about a client who had been shamed by a counselor about becoming histrionic when talking about being sexually abused as a child. One counselor said that she had not had any clients in whom shame played a significant role. Two counselors said that either all or most of their clients had problems in which shame played a major part.

"...but the women and the men that I've worked with, actually, who have a sexual abuse history, feel like it was their fault that they didn't say 'no' when they were seven..."

"With one of my clients who now who is actually not out to his family, his mother announced not all that long ago at a family dinner.... She said, 'Well, I can tell you this, if any of my children ever told me that they were homosexual, they would be immediately disowned.'"

"He was shamed deeply at one point in a session with somebody some years back. He was telling me that he had just broken down, crying and rageful, and was told to stop, that there's no need for that kind of histrionics."

"Not in my view. ...I don't think I've ever had a client use that word. I cannot remember ever having a client say, 'I have these feelings of shame.'"

"That's a very hard question because I truly believe that most of my clients come in with a big shame issue."

21. Tell me about your understanding of the construct of shame.
There was a wide range of answers to this question. No two were the same.

"...it's really a big issue where it comes up, that it's labeled differently as low self-esteem, problems from childhood, relationship problems. I was talking to people about their internalized critical person or parent or whatever—that even if they're not around, they're still there, those early messages." (Spruce)

"How I see it is an intense kind of experience of dis-ease with oneself at a core level. It incorporates some sense of incompleteness, badness, wrongness, and folks will do whatever they need to do in order not to feel that way. Depending, I guess, on their own make-up or proclivity, they begin to develop defenses about that that may prove to be very dysfunctional as they move into adulthood. Those may range from macho acting out to obesity to sexual acting out to sexual avoidance. Helping those folks to address how much they eat won't get at those kinds of things or helping them be on a better diet won't help them get at that pain, get at those things. Helping them understand that women are human beings and deserve respect won't help them get at that. Those are the symptoms that you are addressing if you do that. There has to be some remedial work
around where the shame occurred for them. Often there are shaming events, shaming times in their lives and help them to wrestle with that in a way that’s pretty difficult to do sometimes.” (Oak)

“I see shame as a deeper level of embarrassment and just a real defect in the ego development around the time, and the superego development, around the time of the phallic period, 4 to 6, thinking in Freudian terms. I think of it as overdevelopment of the superego and somehow getting messages that ‘I’m not good enough as a person,’ and that “when I do things, I am to blame,” and I have a strong sense of judging myself and certainly judging in a very negative way. I think that’s how shame develops. Then usually what happens with these people is that either consciously or unconsciously, they continue to reinforce that concept throughout their lives so they’ll, consciously or unconsciously, put themselves in situations where they’ll do things to reinforce the idea that they are shameful people, that they’re not working, that they have less value. I think that that develops a strong belief and fits into the self-concept.” (Ash)

22. How is the construct of shame meaningful to you in the practice of counseling?

Five of those interviewed stated that the construct of shame helped them to understand their clients’ behaviors. All except one thought that shame was helpful to them in their practice of counseling.

“I think it’s useful in helping me and helping clients understand where certain behaviors come from. And again, once they understand what the automatic thoughts are or the core beliefs or the unconscious beliefs, then they can choose whether or not they want to do something about it.” (Willow)

“I think it’s a way of helping to understand and organize ideas about behavior, what we’re presented with, like any theory, any way of trying to put a way of understanding around a series of behaviors that clients present to us. I think it’s a useful one because it helps to explain just like when I first began to read stuff about family systems. It made sense to me at some kind of level, some kind of core level. It made perfect sense to me. You know it’s like those ahas. It’s like the first time I ever read Gestalt literature, was exposed to it, I went, “Wow, this makes sense. This really does help to understand what I’m seeing in terms of human behavior.” It’s that kind of concept. I think it’s one of those concepts that helps to make sense out of what you see in front of you as a therapist, as a counselor.” (Oak)

“I think it gives us a basis to be able to understand a little bit more about personality development and certain problems in people’s lives. If you understand the whole concept of shame and how it develops and where it comes from and how it affects the person, then I think it can give you a good springboard in working with a lot of cases.” (Ash)
“Really, it has not been (meaningful to me in the practice of counseling). ...Well, to my counseling field, “the construct of shame contributes) nothing, but I am aware that there are counselors who are very big on this issue.” (Hickory)

23. How frequently is shame a factor in the problems your clients present?
Two participants said that shame was a factor in 100% of the problems their clients present. One said 90 to 95%; one said 80%; one said 75%; one said 50 to 60%; four said between 20 to 30%; one said zero; and one stated that he did not know.

Almost a half of those interviewed said that for 75% or more of their clients shame was an issue for their clients. A quarter of the participants stated that for somewhere between 20 to 30 percent of their clients shame was an issue. One participant said that shame was an issue for 50 to 60 percent of his clients. Only one individual said that shame was not an issue for any of her clients.

“I would say probably at least 25%.” (Willow)

“What percent? I’d say probably a good three-fourths of the people I see are struggling with shame issues.” (Cypress)

“I would say that shame probably is an element in most all of people’s experience to some degree. I know that where it becomes more of a named or kind of addressed focus of therapy; it probably would be about 50 to 60% of the time.” (Elm)

“It varies. I think again about 20% of my clients, somewhere in that range. Those folks are dealing with that kind of intense, long-term experience of shame as a primary kind of experience for them internally.” (Oak)

“Frequently, I don’t see it, and I freely admit, perhaps it’s because I don’t look for it. I don’t go back and look at the client’s childhood. I don’t have time. It isn’t that it wouldn’t be interesting.” (Hickory)

24. How do you address shame in counseling sessions?
Eight participants included in their responses the act of exploring feelings and thoughts or asking questions about thoughts and feelings. Five of those interviewed mentioned helping clients rewrite their scripts or reconstruct cognitions. Three also said they would use a Rogerian approach with clients. Two included working with the clients’ core beliefs. An uncommon answer was to teach clients a toolset. Another unusual answer included the use of hypnosis.

“What I do is go one step below thinking because I think a person’s core values and beliefs impact their thinking. If their core values and beliefs are not healthy, then it’s going to eventually work itself all the way up to the relational level. That’s why a lot of time with clients, we go to the basement and say, “Let’s look at what’s impacting your thinking, including thoughts about their shame-based thoughts because shame-based thoughts come from somewhere. They come from that person’s core values and core
beliefs. Those shame-based thoughts are going to produce some anxiety, some depression, and that depression is going to result in certain behaviors, difficulty in concentration, difficulty functioning at work, greater conflict or avoidance or withdrawal or isolation behaviors, and in turn, are going to impact relationships. People come in, and there’s a problem in a relationship. I see that as the presenting problem, but not necessarily the real problem. It’s just what the manifested problem is.” (Cypress)

“It’s usually through a lot of Rogerian things presented first. Then I still think what people talk to you about at that level-- are talking about things that are truly personal. You’re pretty careful when you’re talking with them. Clinically or technique-wise, it’s a combination of helping them express their feelings, realistically sort of rewriting their story, maybe narrative approach and also cognitive-behavioral stuff, you know, thought-stopping or techniques, things that they can do.” (Spruce)

“When it comes up? In the beginning, I usually try to, as I said, develop as trusting of an atmosphere as I can. I’m extra careful about being nonjudgmental. What I find that’s most helpful in the beginning is not disputing it so that if a patient says, “I feel ashamed of this,” or “I’m just a bad person because that happened,” I think going back to more of a Rogerian approach at that point and a supportive approach that says, “I can understand what it’s like for you, and I feel for you” because I think in the lay world most people would just say, “That’s no problem. You’re not a bad person.” I think that’s the kind of thing that they can get from anybody. I think that what most people need at that point in the beginning is for them to be able to make contact with somebody who really understands the depth of what they feel. If you can communicate to them, if you do, first you have to feel it, and then understand it. If you can communicate to them that you do understand what it’s like to feel that way, then I think it gives you the basis. From that point, if the person has the capacity, then you can go back and try to explore some of the reasons why the person developed this concept, what makes them feel shameful and to be able to reconstruct some of the cognitions and reframe some of the ways that they look at themselves. You can’t really do that in the beginning unless you’ve been able to empathize and develop a real sense of rapport with that patient.” (Ash)

“I need to teach them an approach to the ongoing living of their lives and not promise the resolution of those trauma effects because it’s a lifelong process. Now I’m focused on teaching a toolset. I teach people how to use specific techniques and methods that they can learn in my counseling work to get through a particular crisis which has evolved or emerged for them. My orientation is-- these are techniques for better living. I call them that, techniques for better living, and I hope that they will continue to use these tools long after counseling is finished because life goes on.” (Maple)
“With some people, I do very direct kind of hypnosis or even a script. I’m working with a couple of individuals now who either didn’t want to do hypnosis or were hesitant about it. We started out doing this to make a script that they can read to themselves once or twice a day, and they are really positive affirmations about “I am confident in social situations. I feel comfortable. The words come easily. I know that I’m likeable. People enjoy being around me.” And so that’s one very direct way that I help people change the way they think about themselves.” (Willow)

25. Can you give me an example of an experience of working with a client who is experiencing shame in a counseling session?

27. If you become aware that your client is experiencing shame during a session, do you acknowledge that in the session? If so, how?
Nine participants said that they do acknowledge shame in therapy sessions. Two said that they did not always address it, one because of time constraints, the other, because she often does not directly address it; instead, she said that she addresses it indirectly by exploring core beliefs.
Four participants said they address shame by exploring the client’s feelings. Two said that they did not use the word “shame.” Two talked about how identifying shame gave great relief to clients. One said that he would first establish trust by not being judgmental and then use a Rogerian approach and empathy.

28. Do you think it happens that counselors inadvertently shame their clients? If so, how?
There were multiple answers to this question. The most common answer (3) was that clients become shamed around not doing their homework. Other shared answers by two participants were: counselors suffering from burn-out and stress would tend to inadvertently shame clients, and, counselors with unresolved shame issues would be inclined to shame clients. Two participants said that it was difficult for them to conceive that counselors would actually “shame” clients; they stated that perhaps counselors could “embarrass” or “guilt” clients. Other responses included the following:

“I think clients get triggered around financial issues about payments.”

“I may ask about parts of their lives that I think might raise that or touch those issues for them.”

“I think one of the main places it’s been done is in the substance abuse field.”

29. What connection, if any, is there between counselors’ own shame issues and how they provide counseling to their clients with shame issues?
There were a variety of answers to this question. The most common answer (4 participants) was that if a counselor had not worked through her or his own shame issues, she or he would tend to avoid addressing shame issues with their clients. Other answers included the following: If counselors had not worked through their own shame issues, 1) they do not see shame in their clients (2 participants); 2) they bring their own
shame issues into the therapy session (2 participants); 3) they project shame onto their clients or inadvertently shame them (2 participants). Two participants said that counselors who have worked through their own shame issues tend to be more perceptive of, sensitive to, and compassionate with clients who have shame issues. Uncommon answers were that counselors who have not worked through their own shame issues, must ethically inform their clients or refer them to another counselor (1 participant). One participant said that counselors should go through their own counseling, and one participant said that counselors may tend to overfocus or “luxuriate” in an issue if she or he has not worked through their shame issues.