THE PSYCHOTHERAPIST SITTING WITH A PATIENT WHO IS EXPERIENCING SHAME: AN EXPLORATION OF SHAME'S EMERGENCE, SUBTLETY, AND MEANING

Paula Branch Holt

THE PSYCHOTHERAPIST SITTING WITH A PATIENT WHO IS EXPERIENCING SHAME: AN EXPLORATION OF SHAME'S EMERGENCE, SUBTLETY, AND MEANING

A dissertation submitted to
The Sanville Institute
in partial fulfillment of the requirements
for the degree of
Doctor of Philosophy in Clinical Social Work

by

PAULA BRANCH HOLT

December 18, 2012

THE SANVILLE INSTITUTE

CERTIFICATE OF APPROVAL

We certify that the dissertation

THE PSYCHOTHERAPIST SITTING WITH A PATIENT
WHO IS EXPERIENCING SHAME:
AN EXPLORATION OF SHAME'S EMERGENCE, SUBTLETY AND MEANING

by

Paula Branch Holt

and that in our opinion this work meets the criteria for approving a dissertation submitted in partial fulfillment of the requirements for the Doctor of Philosophy in Clinical Social Work at The Sanville Institute.

Mary Coombs Ph.D. 9-28-12
Mary Coombs, Ph.D., Chair Date

Judith Schore PhD 9-28-12
Judith Schore, Ph.D., Faculty, Date

PhD 10/18/12
Jane Reynolds, Ph.D., External Member Date

PhD 12/18/12
Whitney Daly van Nouhuys, Ph.D., Academic Dean, Date

PAULA BRANCH HOLT, LCSW, ACSW, LCS 18043

2237 Fulton Street, # 103, San Francisco, CA 94117. 415-668 4736

January 2, 2013

Mr. Sheldon Harvey
c/o Yvonne Stokes
Andrews Pueblo Pottery
303 Romero NW,
Albuquerque NM 87104

Dear Sheldon Harvey,

I am completing a doctoral dissertation at The Sanville Institute, Berkeley CA entitled

The Psychotherapist Sitting With a Patient Who is Experiencing Shame:
An Exploration of Shame's Emergence, Subtlety, and Meaning.

I would like your permission to reprint with my dissertation a picture of your painting entitled "The Watchers" as an illustration of the depth, power, and sense of otherness of shame in a person's life.

The requested permission extends to any future revisions and editions of my dissertation, including non- exclusive world rights in all languages, and to the prospective publication of my dissertation by ProQuest through its UMI® Dissertation Publishing business. ProQuest may produce and sell copies of my dissertation on demand and may make my dissertation available for free internet download at my request. These rights will in no way restrict republication of the material in any other form by you or by others authorized by you. Your signing of this letter will also confirm that you own, or your company owns, the copyright to the above- described material.

My request is the result of my regard for your work. I will treat this permission with all my respect. If these arrangements meet with your approval, please sign this letter, where indicated below, and return it to me in the enclosed return envelope. Thank you very much.

Sincerely,

Paula Branch Holt

PERMISSION GRANTED FOR THE USE REQUESTED ABOVE:

Original signed by Sheldon Harvey Date: January 16, 2013
Sheldon Harvey

ABSTRACT

THE PSYCHOTHERAPIST SITTING WITH A PATIENT
WHO IS EXPERIENCING SHAME:
AN EXPLORATION OF SHAME'S EMERGENCE, SUBTLETY, AND MEANING

PAULA BRANCH HOLT

This research project explores the experience of the psychodynamically, psychoanalytically, or analytically oriented therapist sitting with a patient who is experiencing shame. It is a study of the therapist's recognition of shame, how shame is perceived, shame's influence within the countertransference, and the influence of clinical orientation within clinical space.

This research used the qualitative approach of grounded theory. The data was collected through interviews with seven seasoned therapists who had long been immersed in the study of shame. The findings were organized by the patterns and discoveries found occurring in the data. The findings were structured toward locating a coherent and more central consideration of shame in psychotherapy and theory.

These interviews revealed unexpected common patterns in three areas: (a) the therapists' subjective/empathic use of their own shame experience in therapy, (b) the therapists' similar immersion in the overt or subtle cues of the presence of shame, and (c) in the therapists' primary dependence on direct experience despite an understanding of shame's academic theory. It was significant that signs of positive shame emerged in the experience of empathic connections with patients enhanced by each therapist's own shame work and recognition of vulnerability. Toxic shame was found to be experienced as an intrusion that can range from unpleasant to painful.

Keywords: Countertransference, contagion, hidden shame, therapist's shame, positive shame, toxic shame, vulnerability, right brain connection.

DEDICATION

In gratitude for the steady, academic head and heart of my husband

The Rev. Dr. Joseph Holt Holt,
Episcopal priest and scholar.

ACKNOWLEDGEMENTS

In appreciation for those who helped in my struggle
toward a beginning understanding of shame.

My knowledgeable and supportive committee members:
Mary Coombs, Ph.D., Chair
Judith Schore, Ph.D., Committee Member
Jane M. Reynolds, Ph.D., External Committee Member

and the presence of the entire Sanville Institute faculty.

I am grateful for the timely reading and encouragement of
Allan N. Schore, Ph.D.

I am grateful for each of the open and courageous psychotherapists
who shared with me the understandings and discoveries made
while working with the difficult subject of shame.

I am grateful for the longtime ur guidance of
Florence L. Wiedemann, Ph.D.

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION

> And to my mind, [shame is] the core issue of people.
> It is the gatekeeper of self-acceptance. (Interview with Participant E)

This research used the qualitative approach of grounded theory to explore how psychodynamically oriented therapists think about and work with the problem of adult shame in a therapeutic environment. It is a study of the experience of therapists encountering the phenomena of shame in their clients, how they recognize and perceive the presence of shame in their clients, its influence in the countertransference, and how therapists' perception of shame in the therapeutic context influences their thinking about clinical issues.

Shame can originate from the society or from within an individual. Although shaming that targets a particular person or group has an effect on society as a whole, the shaming of the individual from outside has particular effect upon the shame felt by the individual. It reinforces existing shame areas and may cause a greater depth of shame. It is important to understand the societal aspect of shame, but I limited the research question to shame, whatever its source, encountered in the therapeutic field by the patient and therapist.

What do psychodynamically oriented therapists recognize as shame in sessions? Are there common characteristics to what they call shame? What commonalities and repeating patterns would clarify the clinical presence of shame? My goal was to find suggestions for answers, fresh questions, or new directions in this study.

The Problem and Background

Attending to shame is one of many focuses in therapy that may help the treatment reach a desirable result. A central question in a focus on shame is whether or not, and how, therapist recognizes shame as it emerges in sessions.

Shame is described as a painful and complex emotional experience marked by an acute loss of self-esteem, and, variously, by disturbing eruptions of despair, anxiety, disorientation, and fear of (or actual) loss of autonomic control (Schore, 2003b). The shame experience is not usually directly shared or always easily observable (Lewis 1971), even though it is an experience peculiarly in relation to someone or to something else. Does a therapist's attunement to the patient provide a unique position from which to observe this phenomenon? This is the aspect of the shame experience that I want to explore.

A state of vulnerability that exists in the therapeutic setting may intensify a potential for shame. Patients usually come to therapy in a state of emotional distress, but potentially open for help. When shame is triggered in the vulnerable condition present at the initial visit, confusing and painful emotions can erupt, disturbing the therapeutic milieu. A patient of mine I will call Sara came to me for an initial visit only after avoiding therapy for many months. I sensed a deep shame reaction and we devoted time to reassurance and close attention to her comfort zone until she was able to begin to open up. This was an example of shame that typically occurs at the beginning of a therapeutic relationship. Some patients encounter shame after more deeply exploring problem areas. Patients are often surprised by the shame they feel, and the context in which they feel it.

From an evolutionary perspective, shame is regarded as a prewired, genetically determined emotion (Van Vliet, 2008; Darwin, 1872/2009) that enhances the survival of the species by signaling that a person is in danger of offending the social expectations of the group. But, the distinct potentials of the affect shame occur along a continuum from mild to strong. A twinge of awareness, more like openness, is a sign of shame's mild presence. At this end of the spectrum, shame has a role in human civilizing, and when gently employed enhances positive human connection with caregivers and the broader community. A powerful occurrence of shame will flood the individual with pain and confusion, often to the point of freezing the actions of the person feeling it.

Teasing, in a gentle form, but often with a prick, helps to civilize human beings (Rogoff, 2003). At this mild end of the spectrum, a child is tuned and open to his connecting environment and thereby understands what a culture expects and rewards, what is commonly avoided, and what choices would be culturally appropriate. A state of vulnerability that is essential to the student's learning edge, whether the student is a child or an adult, contains the unfortunate possibility for toxic shame. When vulnerability and the potential for shame occur together with contempt, punishment, or violence, it can affect our ability to learn, our individual bonds, and the experience of culture. The concurrence of these events may be to the detriment of many aspects of growth, thus allowing shame to weave together with fear, hostility, and even brutality.

Patients and therapists alike feel shame. I have found that my own countertransference can provide a situational intrusion further complicating shame in session. I have found it necessary to monitor my own reactions in order to reduce the occasions for this kind of interruption. I have wondered how other therapists have

discovered shame in the countertransference, and what they discovered. The purpose of this research is to explore the problem of shame between and within patient and therapist in psychotherapy.

The Appearance of Shame in Session

What does a therapist note that indicates that a patient is feeling shame? I look for a tentative, cautious approach by the patient, which I treat as guarded behavior surrounding the openness the patient could be feeling when receptive to help. This is the sensitive edge that can turn into shame by an unexpected question or an emotion-laden memory. Touching unconscious material can carry the burden of emotional history into a present moment. As a therapist, I scrutinize what I identify as shame, or near shame, so that I will have less opportunity to confuse it with other affects. I need to be clear about what I am perceiving if I hope to produce a benign therapeutic environment keeping the open, trusting elements in the patient present.

I have found that shame may present as half-hidden, disguised, or projected in a variety of subtle manifestations. To identify a case of shame, I look for a subtle or even noticeable stiffening in the body of my patient and a psychological withdrawal, either from me or from a subject. A patient may look down (so frequently toward the left) and perhaps flush. A patient may begin to speak of hostile, contemptuous elements outside of herself; that is, she may begin projecting. A patient will often begin to employ defense mechanisms to aid avoidance of the shameful area or she may try to justify her own actions regarding the shame-laden subject. However, sometimes I can only faintly discern the presence of shame. I must depend upon a dim sense of its presence or nearness. Sometimes I find shame through my own bodily sensation of discomfort. I find that I

need to keep my own definition and understanding open, so they can be modified by new facts and consciousness so that I will not miss an incidence of shame.

I have found that in session I uncover shame in a way that is unique to the situation in the session and unique to the patient. That understanding has led me to wonder what exactly other therapists would discern in their patients that signals shame. I have wondered what in the unique interplay between this shame and a correspondingly unique response, or countertransference, in the therapist can be disclosed that is of clinical importance.

A patient, whom I will call Nora, is an example of the uniqueness and difficulties inherent in a shame reaction. We had been working very close to a central trauma in her life, one located early in her life, profoundly violent, and reinforced with shaming from her family. In a crucial session, she seemed quietly open as we discussed new possibilities for healing. We had found a matrix where she had confused being badly treated with love. She had traced out feelings of false fulfillment and false satisfaction she had found in being degraded sexually, controlled, and abused. She had begun to realize that she sought out such situations in her life and such perpetrators. A few days after this crucial session she called in a raging panic, accusing me of not wanting what was best for her, of not being a good therapist, of not wanting her to be "happy." The protective drama that had roots in the original trauma, the story she told herself that had explained the unacceptable horror of the trauma, had, in effect, reasserted its claim on her life. She had learned to be safe in unsafe situations by unconsciously ignoring her own best interests and finding perverse satisfaction in abuse. This was the survival technique that had maintained her original connections within her world, the limitations of which

were becoming apparent in therapy. A conflict between the possibility for change and her old morbid satisfactions had arisen. She had felt unconsciously "safe" with an abusive situation and wanted desperately to return to safety.

In attending to my own experiences of shame in therapy sessions, I have looked at my own theoretical understanding and how that influences how I perceive shame. I wonder how theoretical orientation influences other therapists in their perception of shame.

The subject of shame is complicated by its marginalized position in psychodynamic thought. The fact that clinical aspects of shame are not typically included in mainstream psychodynamic thought (Nathanson, 1987) or training (Frawley-O'Dea & Sarnat, 2001; Hahn, 2000, 2001), means it is likely that an understanding of shame has been developed independently by an individual therapist. This increases the chances that a therapist has found unique ways of perceiving shame. Shame as a universal human experience carries with it the assumption that we know what it is, and that the experience we have is the same as that felt by others (Nathanson, 1987). This may or may not be so. I must consider the valuing process employed by the therapist and how he or she ranks the importance of the shame itself, the therapist's own understanding of the importance residing in the countertransference, and what weight theoretical orientation has on this valuing process.

Research Question

This research uses the qualitative approach of grounded theory to explore how psychodynamically oriented therapists think about and approach the problem of shame in a therapeutic environment. It is a study of the experience of therapists encountering the

phenomenon of shame in their clients, how they recognize and perceive the presence of shame in their clients, shame's influence in the countertransference, and how therapists' recognition of shame in the therapeutic context influences their thinking about clinical issues.

Recognizing shame in sessions can be a unique event whose occurrence should be noted. Still, we are looking for common characteristics to shame, commonalities, and repeating patterns. I would like to clarify what is the clinical presence of shame, find suggestions for answers, fresh questions, or new directions in this study.

I limit this study of shame to what is found within the therapeutic relationship and within the individuals involved in the therapeutic session. I include three aspects of shame: the concept of shame, the feeling of shame (a benign sense akin to valuing), and an emotional sense of shame (from mild and controllable to a painfully disorienting flood of feeling). The emotional sense of shame includes the shame reaction and how that has become activated from the affective history living within the individual patient. The research looks at psychodynamically oriented psychotherapists in private practice.

Significance

I have found that given the persistence, potential for harm, and the debilitating impact of shame on adjustment and health, an understanding of this emotion as it is found in psychotherapeutic sessions can be central to effective therapy. I believe that seasoned therapists recognize and work individually and uniquely with what they find in the therapeutic session, and knowledge of the problem of shame can be fu0rthered if that knowledge is brought together, compared, and the elements studied.

This qualitative study is focused on the subjective experience of the therapist with the patient, using a grounded theory approach (Glaser & Strauss, 1967). The data consists of in-depth interviews with psychotherapists in private practice. The psychotherapists were asked to reflect upon and talk about their subjective experiences of discovering shame in the therapeutic session, how it was discovered, and how it impacted their work. The *constant comparative method* of qualitative data analysis as described by Strauss and Corbin (2008) was used to analyze the data from the study.

Given the difficulties that come with discovering and understanding the appearance of shame in the therapeutic environment, what is the psychotherapist's subjective experience of perceiving the shame and coping with the countertransference? How does the perception of shame influence their thinking about clinical issues? What have individual therapists discovered of clinical interest through taking notice of the emergence of a shame reaction?

Grounded theory together with the use of a constant comparative method of data analysis combine to make an effective method for exploring my research question and underlying assumption that shame is frequently encounted in psychotherapy and new ideas can be brought from the perspective of individual therapists to the whole of the subject.

What is it that psychodynamically oriented therapists recognize that leads them to identify the presence of "shame" in sessions? Are there common characteristics to what they call "shame"? What commonalities and repeating patterns would clarify the clinical presence of shame? In this study I am looking for repeating patterns, commonalities, and the possibility of new discoveries.

CHAPTER II: LITERATURE REVIEW

The questions explored are six: How do psychodynamically, psychoanalytically, or analytically oriented therapists think about and work with the problem of adult shame in a therapeutic environment? What is the experience of those therapists encountering the phenomena of shame in their clients? How do they recognize and perceive the presence of shame in their clients? What is its influence in the countertransference? How does a therapist's perception of shame in the therapeutic context influence therapeutic thinking about clinical issues?

In order to effectively interview therapists about the experience of shame in the therapeutic hour, groundwork was laid by a thorough literature review. In this literature review, shame is considered from the perspective of both theory and language.

Clear definitions of both the word itself and its history are the foundation for discussing the literature on shame. Also, two aspects of shame are examined: external shame as seen through the lens of society, as addressed by sociology and social psychology; and internal shame as seen through the lens of the individual, addressed in psychological theory and psychoanalytic theory. Within the individual, feeling shame is the conscious awareness of a shame state. An act of *shaming* represents shame coming from outside, targeting a particular person or group. Shaming from outside the individual, or toward a targeted group, can have an effect upon the felt shame, reinforcing existing shame, and intensifying shame's impact on the individual or group until the shame becomes toxic. Toxic shame can convert into toxic pride as an unconscious defense against the pain of shame. When speaking of shame, narcissism must also be considered

since the affect shame is centrally relevant to narcissistic process (Kohut, 1971; Lewis 1971; Morrison, 1989; Tangney & Dearing, 2002; Wurmser, 1972).

In this review I address the problem of an adequate definition for shame, and discuss how shame operates in social science as an overlap with psychology. I explore how the concept of shame in psychology and psychoanalysis occurs within the literature of psychological theory, in psychoanalytic theory, and in psychotherapy, and establishes a context for examining shame in session. Recognition of the emergence of shame in session is a question that requires identifying both subtle and obvious signs of its operation.

Defining Shame

Making a distinction between shame and guilt is a first task in many articles and books that discuss the subject of shame (Herman, 2007; Lewis, 1971; Nathanson, 1987; Tangney & Dearing, 2002; Tomkins, 1963; Zaslav, 1998). Any study of shame necessitates defining shame, differentiating it from guilt, and setting boundaries in order to establish a clear frame for exploration.

The word *shame* itself reflects the concept's complexities. The word *shame* is derived from an Indo-European root *skam* or *skem* that means to hide or to cover. The word comes to modern English through Old English, *scamu,* and is akin to similar words in Old Saxon, Old High German, and Old Frisian (Teutonic) which mean *to cover,* or to cover one's face. There is an informing English dialectical variation in the word *shame-faced,* which may be, in fact, be derived from *shame-fast*, that is, *held fast by shame* (as well as, intentionally or not, referencing the importance of the face in shame); and *sham* and *scam* which have come to mean trick or imposture (Partridge, 1961). Being held fast

by shame suggests the emotional overwhelm that freezes one in shame. *Sham* represents a judgment made upon some activity, and *scam* is the activity.

The Dictionary of Psychology (Corsini, 2002) defines the word shame in a manner that highlights some difficulties with definition:

> [Shame is a] painful feeling of humiliation associated with guilt, immodesty, dishonorable behavior, or not living up to personal expectations; disgrace. In psychoanalytic theory, Sigmund Freud (1894) interpreted shame as a fear of ridicule; G. Piers, as the response to the failure to live up to one's ego ideal. (p. 897)

In this definition shame is associated very closely with guilt. That highlights one of the problems with the concept of shame. Shame and guilt are not the same either as a concept or affectively, although they do commingle and influence one another. Conceptually shame and guilt have in common a sense of responsibility, blame, and stigma. In *Roget's Thesaurus*, shame is presented as having a close association with affect, guilt as having a close association with thought process (Kipfer, 1999).

In the references to Freud and to Piers in the above quoted definition from Corsini (2002), the description positions shame as originating in the environment and somewhat after infancy. This is not necessarily correct, nor does it exactly reflect Piers and Singers' (1953) or Freud's thoughts on the subject. Freud's grasp of the meaning of shame changed over the course of his work (Freud, 1905/1962, 1930/1962, 1933/1962). Shame is first noted (Freud, 1894/1962) as a result of the self-reproach a child can feel if his experimentation with sexual activity is discovered. Later, Freud (1905/1962) developed a theory of shame as a regulator controlling sexual impulse, exhibitionism, and voyeurism.

Subsequently, a sense of guilt in the developing person differentiated guilt from shame and became felt as an experience similar to vague anxiety, or, as Freud stated (1923/1962), "dread of conscience" (p. 63). With Freud, guilt is associated with the aggressive drives and shame is associated with the sexual drives. In 1930, Freud posited that shame was based on fear, and, in 1933 that the origin was a sense of inadequacy. Piers & Singer (1953) added that a sense of personal loss and cohesion is suffered in shame, as well as a feeling of threat from outside the self.

Distinguishing precisely between guilt and shame continued to be a question into the 1990s. From the phenomenological view, psychologist Zaslav (1998) has made a clear operative distinction for the psychotherapist between guilt and shame in his article, "Shame-Related States of Mind":

> In guilt, there is a concern about some action perceived to cause harm to another. This concern leads to regret over the guilty action and, usually, a motivation to make amends or apologize. The guilty self can be perceived as inordinately powerful because of its potential to harm others. The goal in psychotherapy with a guilty patient might be to help the patient to feel less omnipotently responsible, to forgive herself for her actions, and to feel more deserving of happiness and less deserving of punishment. In shame, the person goes beyond evaluating a set of actions to making a negative evaluation of the entire self. There may be a corresponding urge to hide or to blame others. The shameful self is experienced as small, weak, and bad. (p. 156)

In exploring the functional externalization of shame in blame and aggression, Stuewig, Tangney, Heigel, Harty, & McCloskey (2010) also distinguished shame from

guilt:

> Although shame and guilt are regarded as moral emotions that regulate social behavior, there are important conceptual differences between the two (Lewis, 1971; Tangney, Stuewig, & Mashek, 2007; Tracy & Robins, 2006). Both shame and guilt are "negative" or uncomfortable emotions. Shame, however, involves a negative evaluation of the entire self vis-à-vis social and moral standards. Guilt focuses on specific behaviors (not the self) that are inconsistent with such standards. Further, shame and guilt lead to different "action tendencies" (Lindsay-Hartz, 1984). Guilt is apt to motivate reparations. Shame is apt to motivate efforts to hide or disappear. (p. 91)

Scheff and Retzinger (2000) in an article, "Shame as the Master Emotion of Everyday Life," noted that recognition of the *spectrum of shame* could expand an appreciation of its nuances significantly. They said:

> Our definition is in conflict with vernacular usage, in which shame is defined narrowly, as an extreme crisis emotion, what might be called disgrace shame. But in our usage, most shame does not involve crisis or disgrace. It is rather routinely available in the interior theatre of the imagination [as] modesty, shyness, self-consciousness, or conscience. (p. 1)

With the understanding developed from these sources, the distinctions between *shame* and *guilt* can be further clarified. Shame carries a sense of deficiency, of being defective at one's core, and is often confused or conflated with guilt. Guilt carries an awareness of some transgression for which it may be possible to make amends, it carries a sense of concern for the other (development of a moral sense), appearing later

developmentally than shame (Morrison, 1989; Schore, 2003a). Thus guilt's development is thought to occur at the point of sufficient development of speech and the superego (Schore, 2003a) that occurs at about five years of age in the pre-phallic or separation-individuation phase (Mahler, Pine, & Bergman, 1973). Guilt can involve an empathic experience with the hurt suffered by another, whereas shame is focused on the self, is aligned with narcissism (Morrison, 1989), and seems to lack the dimension of empathy.

Shame, Narcissism, and the Social Sciences

The phenomenon of shame holds a position in the overlap between the social sciences and psychological theory. In the discipline of the social sciences, the elements of shame remain consistent with those found in psychology, but the emphasis is on shame as a social force and in overt manifestations of narcissism. Shame is the affect associated with narcissism (Morrison, 1989). A consideration of narcissism thus implies the presence of shame, as a consideration of shame implies the presence of narcissism. The self-interest that marks narcissism spans a continuum from normal to pathological, as the continuum of shame goes from mild to toxic. The power that the impact of shame can hold over an individual, its ability to instantly reduce a person's sense of his own worth, its tendency to disorient, and its painful, physical impact not only operate in the psychology of shame, but also function in society as a tool to civilize (Rogoff, 2003), control, or selectively devalue an individual or group (Crocker & Major, 1989). Recognition of the importance of the functioning of shame and narcissism in society and in psychology has increased since the late 1950s and 1960s (Tangney & Dearing, 2002; Zaretsky, 2008).

Emile Durkheim in *Suicide, A Study in Sociology* (1897/1951), made an early exploration of the social phenomenon of stigma, the mark of shame, and a shamed position in society. He considered stigmatization to be a permanent fixture in society. The social theorist Goffman (1959), looking at the operation of shame in society, held that all participants in social interactions are engaged in certain practices that function to avoid embarrassment. Based on his observations as a participant observer in a mental hospital, Goffman (1961) describes an example of such behavior. He noted that, "in 'progressive' psychiatric establishments, a deferential show of acceptance, affection, and concern may form a constant and significant aspect of the stance taken [by the staff]" (p. 59). Goffman reported that this conscious attitude by the staff represented "attempts to counter the social shame" (p. 59) attached to mental illness and is an acknowledgement that the patient had suffered from shaming. In his book *Stigma* (1963), Goffman, based on his reflective observation, noted that in the operation of stigma, the individual is "deeply discredited" (p. 41) by a characteristic (physical or other) attributed to him. He suffers assault upon his identity and rejection by society. This deep discrediting is intended to inflict shame upon the individual, or in the case of racism, sexism, or other collective identities, upon a group.

The sociologist Thomas Scheff, both in a 1988 article, and in the article co-written with Suzanne Retzinger (Scheff & Retzinger, 1991/2001), has recognized that shame cannot be discussed in social science without equal weight given to the psychological. Scheff and Retzinger (2000) in "Shame as the Master Emotion of Everyday Life," asserted that shame and its opposite, pride, are the "building blocks of interpersonal relations" (p. 1). In discussing shame and conformity, Scheff noted that

Durkheim in his 1897 work, *Suicide, A Study in Sociology*, had first stated the principal that "the force of social influence is experienced by individuals as exterior and constraining" (Scheff, 1988, p. 395). The force of shame and shaming was observed to be especially effective in delineating the *identity* of the individual (or group) in society (Goffman, 1963; Scheff & Retzinger, 2000).

Zaretsky (2008) found that a respect for *personal privacy* and *individual responsibility,* societal customs part of the cultural norm before the 1960s and within which shame could hide, had been protected in the psychoanalytic ethic before the 1960s, but the norm itself and its holding environment in psychoanalysis came under siege with the cultural shift of the 1960s. This cultural shift moved toward more open relations, toward easier personal disclosure, involved popular experiments in group living and blurred personal boundaries (Zaretsky, 2008; Storey, 2009. Attention to individual identity gave way to attention to group identity, and individual liberation to a group liberation. A new emphasis moved away from Freudian understanding of primary narcissism to a secondary narcissism that took the form of non-utilitarian artistry, personal display, and deliberate self-centeredness. Abstinence disappeared into indulgence and experimentation. The individual could lose himself into a group identity.

Most of the United States' psychoanalytic community resisted this societal shift (Zaretsky, 2008), but there was some movement that seemed to respond. Kohut's (1966) work suggested that narcissism had replaced sexuality as a defining issue. Attention to narcissism meant consideration of its affect *shame*. Kohut's (1984) theory found sex – that universal source for anxiety and shame – as a positive and legitimate need and a basis for self-respect, a position that, even though it may not have been Kohut's intent,

offered support for the freer sexual expression after the 1960s. Even so, free sexual expression and a fresh examination of narcissistic expression did not "cure" the presence of shame or shaming. Kohut's rethinking of Freud and his responsiveness to societal changes was not welcome in his orthodox American psychoanalytic community, and he was intellectually exiled for abandoning the primacy of sexual and aggressive drives in his developmental theory. Ego psychologists such as Kernberg (1974), in defending the previous psychoanalytic perspective, advocated Freudian moralistic positions for patients requiring that they *courageously face the truth, strive for mental health, strive for maturity,* and *employ abstinence* in pursuit of a fulfilling individual life (Zaretsky, 2008). The culture of the 1960s, on the contrary, declared that these positions suppressed a patient's legitimate narcissistic need for recognition and satisfaction, and ignored the oppression of individuals as members of certain groups, especially blacks, gays, and women. As the sixties passed into the seventies, however, writers such as Lasch (1978) spoke to the flaws inherent when an individual focus is folded into a collective identity, and he raised concerns about the emergence of narcissism as narrow gratification.

As noted by Storey (2009), Lacan also responded to the cultural change from an analytic standpoint. Lacan (1971/2001) maintained a running commentary on culture and psychoanalysis from his Paris seminars from 1951 through 1981, and had redefined narcissism in a way that was a reflection on emerging culture after the 1970s. Despite the fact that Lacan was broadly criticized and rejected by the psychoanalytic establishment, an experience that was repeated in the experience of Kohut, and had his work questioned generally by cultural critics (Zaretsky 2008), the influence of his understanding of the interplay between culture and the individual was accepted as a deeply insightful

comprehension by many important critical thinkers (Felluga, 2003). Lacan saw narcissism as the unavoidable center of the individual, and *desire* as its social expression. But, the desire Lacan described was not the property of the individual expressing it, but mixed by *imagination* with elements from the culture. For Lacan (1971/2001), there was no purity in either the individual expressing desire or the cultural components building it, each of which is co-constructed within the other. In a Lacanian sense, then, our desire is never properly our own, and the culture is not properly objective, but both are created through fantasies in the imagination.

Without, perhaps, consciously referencing Lacan, or his restatement of the nature of the exchange between culture and individual, a stage was set for a new understanding of the psychoanalytic and psychotherapeutic model. The new model assumed diversity and variety, and did not trust old moralistic verities. The new model emphasized relationship, presumed trauma, and gave weight to culture (Zaretsky, 2008). It reflected a need for empathic therapeutic relationship, recognized narcissistic wounds, and attended the patient's unique exchange with culture.

Shame in Mind and Body

The issues of definition, theoretical focus, relative importance, therapeutic intent, and meaning are points of contention throughout the literature on the psychology of shame. In these aspects, the consideration of shame changed over the history and spectrum of psychological thought.

The Psychological Concept of Shame

Darwin noted the universal nature of emotional expression in his book *The Expression of the Emotions in Man and Animals* (1872/2009): "The young and the old of

widely different races, both with man and animals, express the same state of mind by the same movements" (p. 362). Darwin pointed to a shared human and animal ancestry by calling attention to the fact that monkeys, dogs, and other mammals display recognizable shame reactions. The palpable presence of emotions such as shame were essential support for Darwin's theory of evolution and set a precedent for a modern exploration of the emotions generally, and shame specifically. Even so, Freud, although influenced by Darwin, dealt with shame (and all emotions) as secondary to drives in psychological importance. Freud, as a neurologist, had begun an exploration in 1895 of the neurological basis for his work. He was "directly linking functions of the brain and functions of the mind" (Schore, 2010)" while formulating the foundational concepts of his theory, but had abandoned this portion of his project before proceeding with the formulations of psychoanalysis.

Psychological focus on shame intensified after the mid-twentieth century with an emphasis on the relational in therapy and an expansion in object relations theory (Klein, 1948), the advent of affect theory (Tomkins, 1962) and self psychology (Kohut, 1971), relational theory, and attachment theory. A recognition of narcissism in the cultural landscape (Broucek, 1982; Goffman 1963; Lasch, 1978; Rogoff, 2003; Zaretsky, 2008) pointed toward its emotional element: *shame.*

The weight given shame in the history of psychological theory has varied. When drive theory was dominant, reflecting the influence of Freud, focus on shame was minimal, although Freud did give shame attention. His understanding of shame developed over the span of his work. As noted earlier, Freud (1894/1962) first observed the shame exposure a child can feel if his experimentation with sex is discovered.

"Exposure" is an important constant in tracing the concept of shame. With Freud, guilt was associated with aggressive drives and shame was associated with sexual drives. In Freud's drive theory emotions such as shame were not a determining factor in psychological makeup (Basch, 1976). The development of ego psychology (Kernberg, 1974) continued interest in drive theory and the secondary importance of the emotions, but that was to change.

With Erikson (1950), shame took an essential place in the second stage of development, the toddler's struggle with autonomy versus doubt and shame. Here the phenomenon of shame is seen to make a basic contribution to the development of identity. Each stage of life redefined and enlarged issues and problems through the reshaping of shame. Shame informed and helped to form a superego, an ego, and the expansion of self. The location of the struggle of the self is important in Erikson. Freud and the traditional psychoanalysts placed development in the mind of the individual who was impinged, denied, and limited by the culture and environment. For Erikson, social aspects and the mind were co-creators of the individual.

The focus of therapeutic attention on shame and other emotions came about as a result of the development of object relations theory in Great Britain. British object relations theorists Fairbairn, Winnicott, and Guntrip moved away from Freud's conceptualization of drive theory and toward consideration of the impact of relational interaction and internalized objects. Fairbairn (1963) shifted so far from drive theory that he denied the existence of the id – that portion in Freudian mind construction that contains the drives, and declared that there is no id, only ego structures. The move away

from drive theory shifted psychological examination toward the emotions, such as shame, as is seen in the subsequent appearance of affect theory.

Appreciation of shame took a sharp turn in the 1960s with the affect theory of Tomkins (1962). Tomkins developed affect theory as he observed the importance of emotions through contact with his own infants. Tompkins (1962, 1963) theorized that emotions comprised a biological system that functioned entirely apart from that of the drives, and that it was an important motivating force. This departure from mainstream psychoanalytic theory was not integrated into general practice and discussion. However, among those following Tomkins was cognitive-behaviorist Ekman (1991), who honored Tomkins' understanding of a central place for the emotions, carefully exploring their expression, but who did not treat shame as the *hard-wired* characteristic of humanity that Tomkins had. Ekman contended that shame did not exist without "the ridicule or disapproval of others" (p. 65). In *Telling Lies* (1991), Ekman stated, "If no one ever learns of a misdeed there will be no shame, but there still might be guilt" (p. 65). This distinction between shame and guilt is quite different from that found in other psychoanalytic or psychological theories. In Ekman's structure of shame and guilt the two phenomena are treated as having equal importance, neither existing at a greater emotional depth than the other. However, the cognitive reality of guilt is treated as if it had greater *substance* than shame. As described in *The Nature of Emotion: Fundamental Questions* (Ekman & Davidson, 1994), Ekman's conception of psychological structure does not include a fully developed unconscious dimension. Missing from Ekman's theory is some solid unconscious dimension that is structurally part of the infant from birth and

informed in very early infancy with preverbal experience, a base from which shame can spring.

Self-psychology, the work of Kohut (1971), provided a domain for a developing understanding of emotions and, therefore, of shame. Broucek (1982) in an article on shame in early infant development noted that Kohut had not exactly recognized the importance of the shame dynamic in his work. However, Kohut's exploration of narcissism (1966, 1971, 1972/2011), with its closest affect shame, provided a fertile field in which later theoreticians, such as Morrison (1989), did explore shame. In exploring narcissism, Kohut (1971) noted a bodily involvement in early emotional development, and maintained that the healthy mother/child bodily dyad provided the infant with the ability to self soothe and remain calm. This area of emotional regulation was more thoroughly developed by subsequent theoreticians such as Schore (2003a, 2003b) who extended exploration to include more specific details of the functions and elements of shame. Kohut described painful eruptions of affect (1971), and identified these eruptions as a manifestation of shame.

Sometimes an analytic tool is needed to locate shame. The Kohutian prime instrument of analysis is empathy (Kohut, 1959), especially as it operates in the transference/countertransference. This empathic connection with the emotional life of the patient opens a way for practitioners to recognize shame. Kohut understood empathy, however, as an unreliable tool. The problem is to maintain scrutiny of what is discovered through empathic connection, and make a careful interpretation to the patient.

Kohut's investigation of narcissism (1959, 1971, 1984) and his understanding of the tool of empathy opened two paths to an understanding of shame. The use of empathy

as a therapeutic tool lead to its later use as a channel through which to sense shame in a patient, and his examination of narcissism suggested further attention could be productively paid to the context for shame.

Attachment Theory

The complex and varied aspects of shame found a fitting domain in attachment theory, which empirically examined early childhood, asking "what" and "how" of that experience. *What* influence do early experiences have upon human development, and *how* are these experiences formed? John Bowlby (1959, 1969), founder of attachment theory, examined these early experiences and found his answers to the "what" and "how" in the influence of the quality of the child's emotional relationship with a primary caregiver, who carried to the relationship transgenerational experiences. He found this relationship the determiner of a child's response to his environment.

Bowlby's empirical studies, made in conjunction with Ainsworth, Boston, and Rosenbluth (1956), provided a broader sense for the theoretical understanding of shame. These authors emphasized the importance of the emotional quality of the primary bond of the child with its caregiver, and found in that bond the foundation of the child's relational world. The baseline importance of the emotional quality of this bond (Bowlby, 1988) was the matter leading to a further formulation of shame's aspects.

Nathanson (1987, 1992b) and Schore (1994, 1997, 2001, 2003a, 2003b), in their respective work, brought together the efforts of John Bowlby, Lewis, and Tompkins, considering, with Herman (2007), that shame was an attachment phenomenon occurring when the relational bond is disrupted. Nathanson (1992b) and Schore (1994) took the position that shame can be experienced directly, unmediated by abstract cognitive

processes, that it originated in earliest infancy, and therefore did not require the self-reflection of maturity (Mills, 2005). Nathanson (1992b) theorized that shame is a response to actions or attributions that may signal rejection by an *other*, and motivates unconscious efforts to prevent this. Nathanson (1992b) saw shame as triggered by interruptions in connectiveness, and then drew upon affect theory in that the function of an affect is to magnify the event that produced the affect. The affect shame operates to attenuate, or possibly reverse, positive affects of emotion in order to "save" one from loss of connection.

Schore (2003b) recognized the importance of shame as a regulatory phenomenon, calling his theoretical position *regulation theory*, and integrating neurobiological research, affect theory, and attachment theory. Schore (2001) observed that the immature being could be kept in an optimal state of alertness and positive affect, ready for learning and development, through the attunement of the nurturing caregiver. He asserted that misattunement triggers shame, requiring acts of repair (2003a). The work of Schore (1994, 1997) brought psychoanalytic theory back to its origins in the neurological grounding in which Freud began.

Schore's work (1994, 1997, 2003a, 2003b, 2005) has effectively revisited Freud and worked toward solving problems left by Freud in his model of early development, in explanations of the complexity of affect, in the place of the body in a mental life, and in the impact of real life trauma (Schore, 2010). This neuropsychological work returns to Freud and attends to psychoanalysis and neurology in a way that revitalizes and extends both. Schore (2005, 2010) has noted that the essentially private mental state of the individual, the state that is open in establishing the therapeutic alliance, is also open to

shared intersubjective processes, and is dependent upon right hemisphere resources. As Schore (2005) states, "Increases in implicit relational knowledge stored in the nonverbal domain . . . lie at the core of the psychoanalytic change process" (p. 832).

Shame in Session

The literature confirms that finding shame in session does not come only through a simple, straightforward observation. Shame is found through complex observation involving the visual, auditory, countertransferential, bodily, empathic, and right brain paths.

Identifying Shame in Session

Identifying shame in session is complicated by the fact that shame does not manifest clearly (Lewis, 1971). In addition, the signs themselves of the activity of shame may open up complex matters. Shame is prone to entangling itself with guilt (Lewis, 1971; Kohut, 1971; Hahn, 2000) presenting itself with several layers of overlapping phenomenon, and conflating several sources of shame into one emergence. It also springs from unconscious, preverbal sources (Schore, 2003b), adding to the difficulty of addressing it. It is "contagious" and a patient's shame may affect the therapist, and the therapist's shame may affect the patient (Hahn, 2000; Pitre, 2007).

Retzinger (1995) found various clues to shame in session:

> Numerous verbal, paralinguistic and nonverbal cues should alert the therapist to shame states. The vocabulary [used to express the presence] of shame is extensive: words such as "ridiculous, foolish, silly, idiotic, stupid, dumb, humiliated, disrespected, helpless, weak, inept, dependent, small, inferior, unworthy, worthless, trivial, shy, vulnerable, uncomfortable, or embarrassed" may

> indicate feelings of shame. Paralinguistic cues include confusion of thought, hesitation, soft speech, mumbling, silences, stammering, long pauses, rapid speech, or tensely laughed words. Nonverbal cues include hiding behavior such as covering all or parts of the face, gaze aversion with eyes downcast or averted, hanging head, hunching shoulders, squirming, fidgeting, blushing, biting or licking the lips, biting the tongue, or false smiling (Retzinger, 1995, p. 12)

To Lewis' (1971) three "difficulties" of shame in session – (a) identification of shame; (b) impaired functioning; and (c) discharging, or mitigating, the feeling of shame -- can be added the problem of hidden, unacknowledged, or unrealized shame, that Lewis called "by-passed shame" (p. 233). This hidden shame phenomena gave new dimension to understanding the problems of "seeing" shame phenomena and including it consciously in the treatment setting. These problems in the area of shame remain current issues.

The suggested causes for shame's effect upon a session are several. Shame is among the self-conscious emotions --shame, pride, guilt, and envy--which connect immediately to an anxious anticipation of threat to the self (Morrison, 1989; Tangney & Fischer, 1995). Shame draws the attention of the patient away from the work of the therapy, and back to himself as an object of negative attention (Stuewig et al., 2010). The emotional response may be noticed primarily as an intrusion and the therapist may feel called to "hold" the emotions that have erupted and/or redirect the session adding a dimension of tension (Lewis, 1971; Hahn, 2001). Shame may be overlooked (Lewis, 1971) until it erupts as an enactment, especially in the transference/countertransference. Shame may also trigger a response of anger or rage, or call up psychological defenses, all

of which must be considered (Morrison, 1989; Scheff & Retzinger, 1991; Hockenberry, 1995; Hahn, 2001).

The varied clues to the therapist of the presence of more subtle shame responses can be visual, auditory, in the content of speech, sensed in the body of the therapist, or can be known through the emotional connection between therapist and patient (Schore & J. Schore, 2008; Herman, 2007; Schore, 2001, 2005; Hahn, 2001). In the direct route of the visual, the therapist may see signs as listed above (from Judith Herman), or she may hear her patient stammer or search for words. Shame may also render the subject mute, and unable to think clearly (Herman, 2007). Shame is intimately connected to a sense of low self-esteem, and can be identified when self-deprecating references are made.

Lewis (1971) noted that this intrusion of shame into therapeutic work not only destabilizes the emotional state of the patient, but also is felt by the patient as if it were a direct attack, whether mild or intense. Therefore, although shame can be experienced subjectively as an initial shock, and a flood of painful emotion (Schore, 2003a) accompanied by physical responses such as blushing, (Darwin, 1872/2009; Zaslav, 1998; Herman, 2007), it more often involves quieter subjective feelings of being devalued, scrutinized, and found wanting (Zaslav, 1998). When the patient speaks, she may betray a lowered sense of her own worth by speaking in negative images, directing attention away from herself, covering her mouth, and lowering her voice (Zaslav, 1998). If the patient's efforts become focused on repair of self-esteem, the cost is to more solid progress in the therapy (Crocker & Park, 2004). Shame interrupts the essentially relational experience of the therapeutic session (Herman, 2007), perhaps even if the therapist is not working from a relational model (Ekman & Davidson, 1994).

Less apparent to an observer may be the pang of secret discomfort conveyed by themes of inferiority the patient alone feels, themes and words that may not be obvious to the therapist, contributing, again, to a loss of patient self-esteem (Zaslav, 1998). The patient may understand words or ideas through her own set of sensitive memories. This less apparent, but profound, self-conscious state must be translated by the therapist, according to Lewis (1981), into the fact that he is seeing shame.

When a therapeutic alliance is established, the patient is "held" (following the concept of theoretician Winnicott, 1972) by the mind of the therapist. Regulation theory (Schore, 2003a, 2003b) describes the patient as being held *within the mind* (especially the "right brain" mind) of the therapist. This holding function provides a two-way exchange of the emotional and developmental capacities between patient and therapist, but respects the differences in the function of each (Decety & Chaminade, 2003). That is, the therapist remains the "holding environment" for the therapy and the patient is primarily the receiver in the process. The therapist is reflecting both on the state that constitutes the holding environment and on the state of the patient. This reflective function's role is to understand the patient's mind, desires, and feelings, what has been called the patient's *mentalization,* as it is functioning (Fonagy & Target, 2005). According to Fonagy and Target (2005) and Lyons-Ruth (2000) an initial capacity for mentalization evolved out of the experience of interaction with the initial caregiver of the patient and continues evolving in the connection with the therapist.

The therapist enters the therapeutic space and understands the patient's mind again, as it was entered and joined with as an infant, and in that vulnerable and open space, a new opportunity occurs for extending the patient's capacities (Schore, 2003b;

Fonagy & Target, 1997). As Fonagy and Target (2005) have asserted, "Understanding of minds is hard without the experience of having been understood as a person with a mind" (p. 334).

Shame in Trauma

Trauma is a special case for the occurrence of shame. While active trauma occurs most frequently in two guises, that of physical abuse through pain, threat of death, and/or sexual violation, or emotional abuse through the undermining of a sense of worth or the loss of safety, an equally damaging injury can be caused by neglect. Inflicted upon the very young, especially by caregivers or family members in positions of trust, abuse will embed itself within the earliest memories and right brain functioning of an individual. The fact that traumatic events were not the fault of the patient does not affect the fact that the patient will blame himself for it and feel hopeless shame. An abuser is able to use self-blame and shame in the patient to control and further abuse the patient. Early abuse will often leave a reservoir of especially painful feelings of shame, recalling unconsciously the helpless state of an infant. This is difficult material to identify in a patient, and is usually "spoken" in acting out and in non-verbal communication.

Using drugs and alcohol are often connected to trauma and to shame; therefore, attending to the shame aspect of addiction is critical. The addiction that often results can usually be traced back to shame, and/or physical or emotional trauma. Drugs and alcohol numb the pain of both trauma and shame (Kueppenbender, Herman, Khantzian, & Albanese, 2008). Many therapists require the patient to be clean and sober before treatment begins, noting that using substances while in treatment holds little hope for success. A reason for the lack of success may be that drugs and alcohol offer immediate

escape for a patient and lures him away from the hard work of both grappling with the trauma and emotional abuse and maintaining the progress that has been made. Alcohol and drugs also mask the symptoms of trauma and prevent emotional growth.

A powerful trauma often results in post-traumatic stress disorder (PTSD), leaving the patient unable to tolerate stress and vulnerable to re-traumatizing by subsequent events. An initial trauma that does not result in PTSD may, however, set up a vulnerable location for a patient to be re-traumatized to the level of PTSD. In order to cope with such debilitating experiences the patient attempts to escape from threats by any means possible (Van Vliet, 2008). Emotional withdrawal, avoidant behavior, and use of drugs or alcohol, all compounded by shame, can mark a patient's retreat. Each re-triggering of the traumatic response re-wounds the patient and forms additional traumatic material, despair, and shame.

Re-traumatizing the same emotional injury leads patients to be ever more vulnerable to re-forming the kind of relationships surrounding a precipitating event. Self-destructive behavior often accompanies shame and feelings of low self-worth. Victims of sexual abuse are prone to choose environments that tend toward revictimization. Repeating traumatic behavior can be not only part of a repetition compulsion, but it also reinforces the meaning of the abuse. Donald Kalsched (1996) found that the complex narrative built around a traumatic event became an emotional/psychological zone of false unconscious safety for the patient, a personal, pseudo-protective zone. For example, a patient may feel a familiarity that seems "safe" to her when actually she is in danger of being abused. The meaning of the facts and behavior around trauma and shame must be

understood in therapy (Kueppenbender et al., 2008). This brings another question: What unhealthy needs are being met through the shame?

Sexual abuse victims have various ways of signaling their history of sexual abuse. They frequently exhibit the symptoms of PTSD. They may act out their woundedness, becoming either sexually promiscuous, or inflicting upon or allowing sexual abuse of others (Courtois, 1988). Signs of early sexual abuse can be seen, as well, in patients who choose to avoid all sexual contact.

Trauma, either physical or psychological, is particularly associated with a patient blaming himself, and treating himself as a shameful object. This redirection of the blame from the truly guilty toward the self can be understood in part as an attempt to take control of a situation. In abuse, the situation is, by definition, not controlled by the victim. Self-blame and shame are part of the core of trauma. However, this defense necessitates that the therapist lead the patient to untangle the self blame from the real situation while proceeding with therapy.

Transference/Countertransference

In reviewing Courtois' (1988) work with incest survivors, Judith Herman (2007) noted the difficulty in addressing shame directly because of the effect of transference/countertransference issues. Herman pointed out that when the patient had difficulty trusting her therapist's positive regard, as is common in incest survivors (and other trauma survivors), the difficulty could be related to damaged esteem that can be projected as *contempt coming from the therapist.* To complicate matters further, the patient's shame may trigger the therapist's shame (Herman, 2007), pushing the therapist toward action that may not further the therapy. The right brain connection between

patient and therapist provides a field within which shame can be triggered in either person. The therapist's challenge is to hold and mitigate the self-contempt of the patient, and simultaneously to examine her own shame.

Connection, especially as it operates in the transference/countertransference between therapist and patient, offers not only opportunities for healing, but also opportunities for confusion (Orange, 2008). W. K. Hahn (2000) found that defensive reactions to shame – which include withdrawal, attacks on self, avoidance, and attacks on others – particularly affect shame in the transference and countertransference. The irruption of defenses adds barriers to clarity and understanding, as well as, conversely, offering opportunities to probe for clarity and understanding.

Shame Perceived Through the Body

The mindfulness that surrounds our lives does not restrict itself to the brain, but occurs throughout the body. Every psychological event has its interaction with the body. It is not just in psychosomatic illness that the body is engaged with the psyche, but mind and body are wholly involved in every experience. In a psychosomatic eruption, we can become aware of hidden emotions that require our attention. Somatic theory includes this mind-body dichotomy and has coincided with research in neuroscience (Schore, 2003b), and the embodiment of consciousness. In somatic theory the unconscious mind "speaks" through the language of the body.

When shame develops in the mother/infant dyad, the child is open emotionally and attuned for the mother's guidance, and the body and the unconscious realms are engaged simultaneously. Here it must be recalled that a capacity for shame is present at birth and is the path through which the child is socialized. The body, too, is wholly

present at this stage of development (Karen, 1994). Shame, the emotional life, the body's interaction, and the right brain engagement are all in open attendance during these early stages. The differentiation between guilt and shame is apparent. Guilt develops after the age of five and represents a cognitive and verbal involvement, while the capacity for shame is present at birth. Recognizing the body's essential part in very early psychological development was central in the work of Reich (Raknes, 1971), and has been taken up in the bioenergetic work of Lowen (1975) and Conger (1988, 2001). A therapist must maintain an attunement to the body of the patient, and not just the words of the patient.

Conger wrote (1988), "In written clinical cases, body awareness tends to be absent, with the exception of [with] a few writers" (p. xvi). This void has continued since 1988 despite the observation that emotions, such as shame, have visual, bodily manifestation. The few psychoanalytic writers mentioned by Conger were Jung, Kahn, Winnicott, and Reich. Winnicott's awareness of the importance of the body was rooted in his practice as a pediatrician. In clinical case reports, Carl Jung described his patients in close physical detail, including somatic symptoms. Reich's analysands were disrobed to their underwear in order to observe bodily reaction. Reich's radical insights concerning the body's sexuality and healing was no doubt a major contributor to his alienation from the traditional psychoanalytic community. Kahn is described by Conger (2001) as having an "embodied attention . . . [that] extended to body process, mixed with traumatic feeling [in] an early childhood relationship" (p. 3). In his insightful introduction to Winnicott's *Holding and Interpretation* (1972), Kahn described Winnicott as having a similar ability to place his whole body into listening to his patient.

In the therapeutic alliance we *feel* each other in both meanings of that word (Damasio, 1999), which are physical and emotional. Schore (2005) has said that from the perspective of the clinician, a subjective/empathic immersion in the session allows access to knowledge about a human being that one cannot have through other paths. McWilliams, (1999), in describing how she makes initial formulations about a patient, says that she depends upon the "feeling presence" (p. 31) of the whole person, suggesting a very broad, sensitive, engagement. The recollection by Kahn (1972) of Winnicott's listening posture also fits this immersion model.

Appearance, Signs, and Process

The therapist sitting with the emergence of shame is observing a complex situation. The therapist must identify the appearance of shame, interpret its signs, and follow its process in the very space that shame is trying to hide. The overarching thrust of a response to shame is the wish to escape the shame and its cause. All of this contributes to the experience in which the psychotherapist must locate and interpret what is subtle or hidden, precisely because the human response to shame is to hide it, and hide from it. *Appearance* and *signs* are that which signal the presence of shame in the session, what the psychotherapist hears or sees that makes shame's presence apparent. The *process* is the dynamic movement of symptoms, complexes, or health through the therapeutic space. One immediate sign of toxic shame in a patient is *denial*. This may signify that the shame is verging on consciousness, and that it can then be followed by awareness and recognition.

The basic text regarding the markers for shame is from Helen Block Lewis in *Shame and Guilt in Neurosis* (1971). Paralinguistic signs (Retzinger, 1991) are also

factors that play an important role in human speech communication of emotion. Speech requires a paralinguistic voice that encompasses the non-verbal elements accompanying speech, modifying meaning and conveying emotion. This would include pitch, volume, and intonation.

Additional signs that accompany the words and process of shame include hesitation, interrupting oneself, long pauses, and fragments of sentences, confusion, or jerky speech. Lewis (1971) described the psychological process that follows an appearance of overt shame in session, as "[a] rage, or taking offense, followed by [b] concern about what the therapist thought of him/her, [c] a wordless depression, [d] a feeling of tension, and/or [e] recollection of other instances of overt shame" (p. 304). These are the movements and changes wrought by an overt occurrence of shame. Lewis found that the process of unconscious shame, or what she called "by-passed shame" (p. 233), is marked by a jolt or wince followed by silence and/or a plague of obsessive, guilty thoughts. In my practice I have discovered a process in the direction of healing that is long, and that begins with an initial recognition, continues with examination of root causes, incorporates a thorough understanding of the wounds incurred, moves into acceptance, with a continuing recognition of the impact of toxic shame in one's life. All these processes do not occur in a straight line, but move back and forth between progress, regress, and recollection.

Questions

The core questions raised in this review are those I noted earlier by Lewis (1971). The questions concern identifying shame, managing the disordered functioning of a shame experience, holding the pain evoked by the experience, and holding the confusion

and mystery of an unrealized or unperceived preverbal shame experience. I would also add that the quality and focus of the attention to the patient is an open question to be explored. Within the description of how the individual therapist works with these problems, I hope to find new insight into the problem of shame.

In identifying shame, the cues described in the previous section may be augmented by the experience of therapists who have found unique signs of shame. How, in fact, does the therapist perceive shame? How is that manifested? What does the absence of shame mean? What is it about shame that determines treatment approaches?

Functioning in the midst of a shame experience in session is particularly difficult. Most therapists have methods to attend to the patient, attend to the shame emergence, and attend to its importance. What are these methods and what can they tell us about the shame experience? What does maintenance of a therapeutic environment tell us about the experience of shame? There also is the reassurance and comfort of a well-established therapeutic alliance. How is that judged? How does the therapist maintain a listening posture, or return to a posture, that provides a flexible ability to respond.

How does a therapist "know" that the therapeutic alliance is holding? If both the therapist and the patient are engaged through an unconscious avenue, the right brain, how does the therapist judge or test the knowledge received through this avenue? How does the therapist use his own, tacit knowledge? How does the therapist describe how and what he or she *knows*?

John Bowlby (1988) made his discoveries about attachment theory through the direct observation of children in a nursery school setting. Tomkins (1962) discovered the importance of emotion through observing his own children. Goffman (1961, 1963)

examined stigma in his direct experience in mental hospitals. In all these cases, social interaction with others was involved as well as direct involvement with the persons suffering shame, underlining the importance of a direct observer. For the purposes of this study, the therapist is the observer.

The above questions of how shame is known, how it is interpreted, and how it is an influence will be considered in examining the findings of the interviews with therapists. The question of additional findings will be always open.

CHAPTER III: METHODS AND PROCEDURE

The purpose of this research was to learn from psychodynamically oriented therapists their experience of encountering the phenomenon of shame in the therapeutic session, their recognition and perception of the presence of shame in session, and their perception of the existence of shame in the countertransference, and the influence of their therapeutic orientation in the way they think about shame in the context of clinical issues. The consideration of the study is restricted to shame as it is found within the therapeutic context, between or within adult patient and therapist.

Methodological Approach and Design

This research is qualitative and based on grounded theory (Glaser & Strauss, 1967; Corbin & Strauss, 2008). Qualitative research relies on interpretive rather than on statistical procedures; data collection is designed to preserve context; therefore, pre-established categories, which reduce the data prior to interpretive analysis, are avoided. The research process is designed so that explanatory concepts emerge from the data, thus theoretical concepts are "grounded" in the data. Describing their approach, Corbin said in the preface to the 2008 edition:

> Though there are multiple interpretations that can be constructed from one set of data . . . generating concepts is a useful research endeavor . . . for increasing understanding [of problems], and . . . build[ing] these elements into a professional body of knowledge and enhanced practice. (p. ix)

This approach is particularly conducive for exploring therapists' experience within the shifting environment of practice.

Qualitative research does not rely on statistical or quantifiable procedures or hypothesis testing, but uses, instead, other systematic methods and procedures to collect, code, and analyze data and to generate theory from data. In the more traditional, quantitative research, the researcher sets out to prove or disprove a hypothesis and approaches the participants with a pre-set, structured set of questions, asked in an identical sequence and manner. Mishler (1986) criticizes this method as suppressing the discourse rather than encouraging spontaneity. He recommends an interview style that generates a more organic process, where the interviewer and interviewee co-create the context in which the data emerges, with the researcher being very much an instrument in the data collection process. This interview method, using open-ended, semi-structured interview questions, fits well with the grounded theory approach.

Using the "constant comparative" method of data analysis (Corbin & Strauss, 2008), each participant's responses were individually analyzed and interpreted for contextual meaning and compared with the responses of the other participants. The analytic process began as the first interview was completed, thus, data collection and analysis proceeded concurrently. This allows the researcher the option of revising interview topics as deemed appropriate by the material.

In qualitative research, the researcher is the instrument. According to Corbin and Strauss (2008), one reason for choosing this method is the preference, experience, and temperament of the researcher. This approach fits my goals as a psychotherapist and here as a researcher. They list 10 characteristics of a qualitative researcher (p. 13):

1. A humanistic bent
2. Curiosity

3. Creativity and imagination
4. A sense of logic
5. The ability to recognize diversity as well as regularity
6. A willingness to take risks
7. The ability to live with ambiguity
8. The ability to work through problems in the field
9. An acceptance of the self as a research instrument
10. Trust in the self and the ability to see value in the work that is produced.

These characteristics are compatible with a psychotherapist's skills. For my part, this approach felt comfortable with my professional goals and standards, making it a good fit for this research.

Validity and Reliability

Qualitative research, in contrast to quantitative research, requires different standards by which validity and reliability are judged. Reliability relates to the accuracy of the measuring instrument or procedure; validity addresses whether or not the study measures what the researcher intended. In more traditional research, validity and reliability are judged by "significance, theory-observation compatibility, generalizability, consistency, reproducibility, precision, and verification" (Corbin & Strauss, 2008, p. 266), the assumption being that traditional statistical and analytic methods will reveal one valid truth. These methods, however, fail to adequately judge the validity, reliability, and scope of qualitative research.

In this research the analysis of the data was interpretative because the researcher was the primary instrument of validity and reliability. Patton (1990) argues that validity

and reliability depend on the skill, sensitivity, and integrity of the researcher; "Validity in qualitative methods . . . hinges to a great extent on the skill, competence, and rigor" (p. 14) of the researcher. Following this same argument, Mishler (1986) contends that the validity of a qualitative study is in direct relationship to the care and quality of the research process. Patton (1990) points out that through the process of open-ended interviewing, the researcher takes in "the world as seen by the respondents . . . enabl[ing] the researcher to understand and capture the points of view of other people without predetermining those points of view through prior selection of questionnaire categories" (p. 24).

Participants

Qualitative research differs from quantitative research in its sampling method. In qualitative research, there is an in depth focus on a small sample that is "selected *purposefully*" (Patton, 1990, p. 169). Participants are picked who have the greatest capacity for adding to our knowledge of the subject under investigation. Patton advocates maximizing the sample variation in order to achieve "the central themes or principal outcomes that cut across a great deal of participant or program variation" (p. 172), and by selecting a sample of "great diversity" (p. 172).

In order to add the most to this research topic, I interviewed participants who identify as psychodynamically or psychoanalytically oriented, who are knowledgeable about shame, have practiced psychotherapy for 20 years or more, and whose practice included adult clients. Data was obtained from open-ended, semi-structured interviews with seven psychotherapists. The sample size was large enough to maximize the variation in the phenomena that I studied (Corbin & Strauss, 2008) yet small enough to provide a

data field that was manageable. I continued interviewing until saturation was reached (Corbin & Strauss, p. 143), that is, no new material emerged from the interviews.

Criteria for Selection

My participants were psychodynamically or psychoanalytically oriented psychotherapists in private practice with adults. Since my interest was how therapists identify shame in adults, I chose those therapists who demonstrated an interest in shame by their participation in the shame group from The Psychotherapy Institute, or who were referred by colleagues who knew of the psychotherapists' interest in shame. Three of the participants were referrals from colleagues, and four of the participants were from The Psychotherapy Institute shame group.

I was open to the widest variation possible and I did not control for gender, age, race, or other demographic variables. To maximize variation I recruited from professionals who are licensed in California to practice psychotherapy – social workers, psychologists, psychoanalysts, and marriage and family therapists.

Recruitment

In order to recruit participants, I contacted several colleagues directly who, I knew, had many years of experience in the field. In addition, I advertised (see Appendix A) in the newsletter of the San Francisco Jung Institute, briefly describing the research and asking interested therapists to contact me by phone or email. I contacted Jane Reynolds, Ph.D. who had conducted the shame group at The Psychotherapy Institute, to ask for her suggestions.

Six of the therapists' to be interviewed were initially contacted by telephone and one by email. Upon expressing interest in participating in the research, each was emailed

the title of the dissertation and the research question (Appendix B), a recruitment letter that expands upon the topic (Appendix C), and the Informed Consent Form (Appendix D), to be read and signed.

The Interview

Data for the study was collected through open-ended, semi-structured interviews involving two people: the interviewer and the interviewee. Together, as Mishler (1986) explains, they form a mutually constructed discourse. This form of interviewing lends itself well to a study about personal responses and subjective observations, as it allows for exploring the research topic in considerable detail.

Procedure

I conducted 60 to 90 minute interviews in a mutually agreed upon place. Each interview was audio taped and then transcribed. Before beginning the tape-recorded interview, I reviewed the purpose of the study and issues of confidentiality and had the participants sign the Informed Consent Form (see Appendix D), a copy of which they had received prior to the interview. I used an Interview Guide (see Appendix E) to guide me during the interviews, covering important key and probe questions. However, I did not rigidly follow this guide, using it only as a reminder of topics, thus, allowing the participants to speak more spontaneously. Using the "constant comparative" approach of Corbin and Strauss (2008), as data began to emerge from the interviews, I added or subtracted interview topics accordingly, with the Interview Guide as a framework for further discussion and elaboration.

Interview procedure

I began the interviews, almost as I would as a therapist, asking participants to share thoughts they had about the research topic. Following the lead of the participants, I raised questions as they came up in the interview rather than asking them in a pre-conceived order. I was more interested in letting the material flow spontaneously than in controlling the material.

I considered the following topics to hold in mind as I was interviewing:

1. The difficulty of identifying shame
2. The influence of a theoretical orientation
3. Methods of managing the disorientation brought about in the shame experience
4. What patient needs are being met by a shame attack
5. The unique problems of unrealized or preverbal shame experiences
6. Perception and management of shame in the countertransference

Data Analysis

I analyzed material from the interviews using Corbin and Strauss' (2008) constant comparative method. This method is useful as a systematic method for generating hypotheses from the themes and patterns that emerge organically as participants talk about their experience with the topic. Donald Polkinghorne (1987) proposes that the constant comparative method is best suited for research that is looking at subjective experiences.

In order to immerse myself in my participants' experience, I began my data analysis by taking notes of my feelings and thoughts following each interview. I listened to the audiotapes of each interview, paying close attention to the common and unique

themes as they arose. Each interview was transcribed for additional review. As more interviews were conducted and the tapes reviewed, new themes emerged, requiring collecting more data until saturation was reached.

Corbin and Strauss (2008) suggest that data analysis is a fluid process in which the researcher goes over the data, line-by-line, culling out the various themes and meanings. The context from which each subject worked is examined to determine the structural conditions that shapes the situation, and the problems to which the subject therapists have responded. Using the "open coding" method and "axial coding," each thought, idea, and meaning is broken down and re-ordered by relating the concepts found in similarities and differences.

In this research, I examined each transcript, identifying concepts and their relation to one another in order to develop a schema for context, as well as categories and their properties and dimensions. The data was integrated by linking categories around a central category. A core category identified by the researcher is the primary phenomenon that best describes the data.

Presentation of Findings

In qualitative research, findings are presented in a narrative overview and then by presentation of the thematic categories within a format that suggests their relationships to one another. Data from the interviews is used to exemplify the categories. In presenting my findings in Chapter V, I took precautions to protect the anonymity of my participants by only revealing enough information to address the common features and variations of the categories and subcategories that have emerged from the data.

The final chapter is devoted to a discussion of the data in terms of the research question. In order to clarify the overall findings about the characteristics of shame, the process of shame is compared to Navajo Shapeshifter witchcraft. A systematic presentation of the elements of shame are presented as the Rules of Shame.

There was an unexpected discovery of the common element of the therapists' use of their own shame reactions in the therapeutic field in order to connect, inform the therapeutic process, and further the healing of the patient. The hypotheses generated by the data are discussed in relation to existent theory and to the literature on the subject. Variations, deviant cases and limitations of the study were discussed.

CHAPTER IV: FINDINGS

> [I have found that patients with shame difficulties] feel they are extremely defective, which is more about failure, not good enough. [They feel themselves] not competent, not capable, not whole, or feel unlovable, unlikeable, disgusting, or just "outside." (Interview with Participant G)

The purpose of this research is to explore the experience of shame in the therapeutic session. This study explores the following questions: How do psychodynamically, psychoanalytically, or analytically oriented therapists think about and work with the problem of adult shame in a therapeutic environment? What is the experience of those therapists encountering the phenomena of shame in their clients? How do they recognize and perceive the presence of shame in their clients? What is shame's influence in the countertransference? How does a therapist's theoretical orientation influence thinking about shame in the therapeutic context? In this chapter I will relate findings from seven interviews based on these questions.

Participants

The participants selected had practice experience that ranged from twenty-two years to more than forty years. The therapists described themselves as generally psychodynamically oriented. Two participants, one man and one woman, had Ph.D. degrees, one participant was a psychologist, three had MFT licenses, and three had LCSW licenses. Two were men and five were women. Six participants were in practice in the San Francisco Bay Area, and one participant in southern California. The participants will be referred to in the text by letters A-G in order to protect anonymity and keep the confidentiality of the interviews intact. In the following paragraphs each of the participants is described by length of practice and their depiction of their theoretical orientation.

Participant A has been in practice for more than forty years, considers herself a close adherent of bioenergetics, and was originally grounded in systems theory. She has lectured and taught somatic analytic psychology internationally, as well as being a practicing psychotherapist.

Participant B has been in practice more than thirty years, is the author of books and articles, and in addition to a psychotherapy practice, teaches somatic analytic psychology [bioenergetics] at a graduate level, and integrates psychodynamic, humanistic, interpersonal, somatic, Jungian dream work, and a Kleinian perspective into his work.

Participant C has been in practice for twenty-three years, and is influenced by relational theory, inter-subjectivity, self psychology, and attachment theory.

Participant D has been in practice for twenty-two years, and is a lecturer and author of books and articles. Her theoretical orientation is attachment theory, attachment somatic elements, emotional considerations, family systems, interpersonal process, and relational theory.

Participant E has been in practice more than twenty-five years and considers himself very broadly psychoanalytic, but he is specifically focused on object relations, ego psychology, and self psychology. He does not consider himself a Jungian, but is influenced by archetypal considerations.

Participant F has been in practice 40 years. Her first training was in systems theory, to which she has added a psychodynamic approach integrating object relations, Kleinian and neo-Kleinian, Lacanian, and Jungian perspectives, and an understanding of shame. She considers current neuroscience a compelling source of information.

Participant G has been in practice 40 years. Her orientation is psychodynamic and relational, which she feels facilitates working with the shame she finds in session. She considers the subject of shame a central clinical concept in her work.

The participants responded thoughtfully with material from their practices. I found that each presented a unique style developed from their years of practice, and characteristically revealed a deep reflection on the subject of shame in session. Participant A described what signs and indications led her to presume the presence of shame, but did not choose to present a case illustration. The remaining six used specific cases to illustrate their experiences. Each of the participants indicated that shame was a central consideration in their understanding of symptoms that were observed.

There were seven therapists who submitted to the audio recorded interview of a just over an hour. The interviews were designed to be open ended but directed, intensive but allowing for the emergence of the unique experience of each therapist, and were constituted to permit flexibility within the interview. I used a semi-structured interview guide (Appendix E) that, although not followed rigorously, was used as a check to see that I had covered relevant questions. Six of the interviews were made in the offices of the participants, a deliberate decision that used the therapist's familiar space for the setting. One interview was conducted in a confidential space in the office of The Sanville Institute at the request of the participant. An hour and a half to two hours had been allowed for the interviews, but the interviews lasted about 60 minutes or a little more. I had allowed for the interview to open, to unfold as seemed natural, and be contained within a one-hour span within which our work was brought to conclusion. I contacted five of the participants subsequent to the interview in order to confirm or request

information. Two of the participants contacted me subsequent to the interview, and those contacts will be discussed as part of the findings.

Findings From the Data

In sorting the data and considering how therapists' think about and work with the problem of adult shame in session, I looked for what groupings became prominent. My findings emerged in five categories: (a) the therapists' recognition, perception, and response to the presence of shame in a patient; (b) the therapists' framing of shame and hidden shame; (c) the influence of the therapists' theoretical orientation; and (d) shame's impingement on the countertransference. An unexpected idea surfaced that was connected to the elements uncovered in the fourth category and from the therapists' responses. That produced a fifth category: (e) the emergence of the therapist's shame as a contagious and interfering element, or informing element. After a discussion of these five categories, I offer some concluding remarks and a note about discovery.

The Therapists' Recognition, Perception, and Response to Shame in Session

The participants were thoroughly knowledgeable about the cues to shame that they would find in their patients. Each of the participants B through G spoke about their familiarity with the work of Lewis (1971), Herman (2007), and Retzinger (1991), which listed, examined, and discussed the signs of shame in the patient. Participants A and B were most familiar with the work of Reich (1933/1990), Lowen (1975), and Conger (1988), and had specific training to read bodily signs of emotional history. Each participant had found particular shame clues that they recognized as signaling the presence of shame in session.

Recognition and perception of shame.

Participant E saw in initial shame clues a suggestion of what more would be found:

> So what we might call shame, or my awareness in a clinical hour that my patient was feeling shame or that I was feeling shame, is just the tip of the iceberg. What I see is a blip, a wince, downcast eyes, any of the shame clues.

Participant A would notice an array of shame clues; "physical manifestations, like sitting on her hands, or looking away, or not looking at you," that would together show the presence, depth, or source of the shame.

Several of the participants mentioned other specific clues in which they found shame. Participant E heard shame in eruptions of "rapid speech, aggressive behavior, [which] especially [occur] between men in a clinical setting." Participant G found, "Whenever I hear 'should,' my ears perk up. It usually is an experience of oneself as 'not good enough.'" Participant F found shame in a patient was often marked by the patient obsessively returning to certain material, " right away . . . there [in returning to the material] . . . I knew it was about shame," and she also found, "there was an inconsolable quality" in the patient's return to material. She would find that the repetition itself compounded the shame, "because usually when somebody continues to talk about an incident over and over again, there is something we aren't getting to. That [in itself] would evoke a certain amount of shame." Participant E noted recurrences in relation to trust issues: "In a way he was feeling, well, not exactly like I was the enemy, [but] I was not to be trusted and so kept at arm's length. I had [had] that experience with him before and we [had] debriefed about it [but I knew] it [was] going to happen again."

Participant E would look for any "shame clue [occurrence as] a particular manifestation of a kind of disturbance in the field, a rupture in the bond between two people that produces this fairly extreme [emotional] reaction." Participant E also sensed the distancing of a patient, "He descended into a kind of rabbit hole of shame and I wasn't really able to make good contact with him." This therapist also traced less severe manifestations of shame in his patients such as "changing the subject" or turning the shame away by "shaming me by projective identification." Projective identification is a defense mechanism in which a person misattributes an emotion or trait he is uncomfortable with in himself onto another person, and identifies that trait as belonging to that other person (Corsini, 2002).

Participant G attributed a sudden change in the patient's direction as a way she could see shame as an aversive reaction, "We are going a little deeper, and then suddenly we are somewhere else, [then] I am wondering about shame. So, that is another way shame comes up." Shame can also influence the patient's delay in sharing known incidents in his history: "One person, one man I worked with, took some time to tell me he had been a Peeping Tom as an adolescent. Well, that was very important clinically, it turns out, but he took a long time to share that with me."

Response to the appearance of shame.

The therapists addressed the position of their own responses to the appearance of shame in the therapy session. Regarding the therapeutic space provided for the patients, Participant C remarked, "Only if they [patients] are feeling safe can they really expose those pieces of shame." Participant C found her role in the therapy was to provide containment and safety by "being fully present and attuned." Participant D recognized

that patient shame often resides in, "a hidden place," that must be uncovered by the therapists' skill so that she could see, "how much shame was there, [and that the] shame wants to be seen."

Several participants noted the disconnection that is part of the shame reaction. Participant C sees patient mistreatment of himself in the disconnect, in the distancing, "I feel they aren't being compassionate with themselves [when withdrawing]." In one case, Participant C followed the shame operating in her patient's psyche: "Shame didn't allow her to connect with [a] piece of herself, and mourn some of her childhood, and [allow herself to] feel compassionate [with herself]." Participant G also interpreted lack of self compassion with a disconnect of the patient with herself, "I talk a lot about that compassion for the self. When you think, 'I shouldn't have those feelings,' you aren't showing a lot of compassion for yourself."

A connection between therapist and patient was seen as becoming possible through the intense vulnerability that occurs in shame. Participant C uses this vulnerability as a path through which a patient, "[can allow herself to] feel that I [have] connected with that vulnerability." Participant D found herself linked with her patient's vulnerability through her own vulnerability, "I never thought about this until this moment, [that] making myself vulnerable was making myself allow his vulnerability, which he was fighting against in his own shame." Despite the best efforts of the therapist, sometimes vulnerability is realized only upon reflection, as mentioned by Participant E, "He was vulnerable in a way that I did not quite see at that time." The importance of therapists' reflection upon their own vulnerability was vital for Participant B: "It [vulnerability] goes with being able to self-reflect, to live and try and grow. I think of

these things as essential to growth itself . . . self-reflection, and that we work in a profession that encourages vulnerability."

One therapist noted that his response to the appearance of shame in session was one of stunned confusion. Participant B described,

> You [are unable to] think about it, and it traps you in a box, without any way of getting out. Finally, if it persists, then it is just a defense about itself and keeps us from thinking about it at all. Because it too awful, thinking about it. Also, beneath it, is a kind of anger, resentment that, "It shouldn't be happening to me, I shouldn't be having this experience," so it goes with [blocking the ability to] self-reflect.

Participant G perceives shame confusion as a fog that descends over both patient and therapist. She describes, "The fog rolls in and you don't know where you are anymore. It is shared, [patients] lose their train of thought, they don't quite remember." Participant G called this fog a 'brain freeze,' and related a particularly graphic therapeutic incident:

> The [patient] would come into the room and completely "freeze" both of us, and he would say he had this image of himself naked, which was a big issue for him, and in a freezer room, frozen unable to move, naked and exposed and frozen. This is what he felt.

Participant D felt her shame confusion was like being tossed in the sea, "I just felt like I was tumbling in the waves, tumbling, tumbling."

Participant D felt fear with her patient: "He [the patient] would say, 'You are really afraid of me, aren't you?' And I would say, 'Yes I am.'" As Participant D explained her understanding of the confluence of shame and fear, she said:

> Shame and fear are tightly woven together. In the beginning, pre-verbally, it is the same thing. Fear, as I look at it, is a threat to life and limb, and shame is the threat to the connection we have that is, I think, just as important [to life].

The Therapists' Framing of Shame and Hidden Shame

In listening to the participants, I noted that they had framed the shame they found in session in particular ways that furthered their work. Participant B had framed a narrative understanding of working with shame for himself, patients, and other therapists. Participant D found a central insight. Other participants emphasized other particular aspects that helped in framing shame for them.

Framing shame.

Participant B had the longest exposition of how he framed shame. He called this his "rant." Participant B spoke of "pride" as knowledge one can have of one's real worth and competence.

> There is no shame without pride. We have shame because it is a social phenomenon; it is read on the face. It is the "autobiographical self," as Antonio Damasio (1999) calls it. So I find it helpful to remind people that they have pride as well as shame. The two go together, they are brother and sister. When you feel shame, you don't have pride. In a way, you've lost your pride, but [actually] instead, it is connected.

> I have been doing this work for years. Sooner or later, something shows up [and] I say something wrong, I don't do it right, so I will feel humiliated. It just comes with it. And I tell them [students] that, "Shame smells like a smelly dog, with fleas . . . in the kitchen . . . and [it has] adopted me. So . . . when you first feel [it, it's] catastrophic, you know. It [feels like it is] an attack on yourself. You don't exist [because of] some defect, something fundamentally wrong with you and me. The issue with me is: How long does it take me to go from catastrophic [to] just a pain in the ass, you know? When things are catastrophic, you can't really think about them. You lose symbolic thought, you are swallowed up in it, you can't stand outside the experience, [a position that] makes it available for symbolic thought, and you [are able to] compare it to other things. You can't reduce it to something manageable. As long as it is in a catastrophic stage you are trapped in a box and you can't get out. So, you can't really think either. So this thing has to do with surviving the catastrophic stage of shame, and not to do anything until you can recover something normal. [You] survive the painful experience so you can stand outside it and compare it to other things. . . . I am on the path of humiliation, there is no other. (Interview with Participant B)

He understood that one can resume reflecting and thinking when he has recovered enough healthy pride to stand outside the shame experience and compare it to other experiences. His observation that he was "on the path of humiliation" pointed to the discipline he found in accepting the inevitability, pain, and reality of shame. Participant B continued his framing of shame, his "rant," his "whole way of thinking about it," as he said, and his pursuit of the way of shame.

> There is one other image I like, in which life is a trap [or] the world is a prison, and I say, we are in this cell, and down someplace, and shaking at the bars, yelling, "Let me out, Let me out" And, way in the corner, with the chamber pot, we notice there are a couple of rats there. So we say, "How did they come in?" So then we see, right by the chamber pot, we see a slimy long hole there, and if we are proud, too proud, we [only] stand shaking at the bars. But actually the way to get out is to get down into the slime, and see if you can slip through that hole where the rats came in. And that is the path of humiliation. (Interview with Participant B)

Participant D worked through aspects of the shame she encountered and found a unique, deep way of using the painful vulnerability that comes with shame. She found, "I didn't know how to handle it. I couldn't talk to my supervisors." Her supervisors had not understood that she needed help with her own process. She said:

> I would go to my supervisors, but they couldn't hear me. All they could do was to focus on him, "He's this, he's that, he's the other thing." What about me? Here I am struggling with this situation that I have never been in before.

She found her own way, her own frame, by following her instincts and matching her patient's vulnerability, "And I made myself more and more and more vulnerable, [even though usually] in shame you hide all vulnerability, but I just let it come out." She framed what she was doing as, "I kind of went by shame." That is, she used the movements and elements she found operating in shame. Participant D, in a summarizing this case, said, "He came to trust me, he was the best teacher of psychotherapy I ever had in my life."

Participant E framed shame as aversive. He pointed out that, "Shame is so aversive that we want to get away from it as soon a possible." He followed the aversion through his patients: "He was kind of more and more resistive, and not liking my interpretations. I was not able to be trusted and so kept at arm's length." Participant G understood, in her frame, that the "brain freeze" she experienced was shared with her patient, and that it was an aversive reaction indicating shame: "Reading that as shame helps me to realize something. It is not [just about] me being a therapist, which is about my shame, but that we are in a shame state together."

Participant F reported that a frame she uses to identify shame is the frequent repetition of material by the patient: " right away . . . there [in returning to the material]...I knew it was about shame," and she remarked on the tone she found, "there was an inconsolable quality" in the patient.

Hidden shame.

Three participants noted that some forms of shame were instrumental in concealing what was most important in the therapy, and which was the source and structure of the origin of symptoms. Unconscious shame can also distort or obscure the use of the therapist's self as a tool. Unconscious shame affects another tool essential to locating the origin of the symptoms, which is the therapeutic relationship. Helen Lewis (1971) so framed "by-passed shame" (p. 234) as to call attention to the fact that this shame positions itself so that it can be ignored.

Participant E discovered that uncovering hidden shame revealed what had prevented relationships for his patient and what would open up an ability to reflect in his patient, "[I came] to realize [that patients had] repudiated [that] shame but [that] it then

prevented reflecting, [and affected] their basic relatedness to other people." Participant E also saw shame in projective identification, and that it was hiding the unbearable aspect of shame; as in, "The 'evacuated shame' [evacuated into the therapist] that is by-passed, shame that was a feeling for an instant [in the patient], but it was unbearable."

Participant G disclosed how well shame could be hidden, despite her best understanding of a patient, when in a discussion of the mysteries uncovered in therapy she said:

> Like you know that patient pretty darn well, but ultimately you can't [know the patient] and [of course] I don't. I [necessarily] have blinders on, and [although] it is unlike me I can say it is also true, that if they are ashamed about a particular feeling, or event, and they are hiding that from me [and maybe themselves], they may have hidden that pretty well. So, I blunder upon it and follow that thread, and then there we are and we are both caught there. And that person may be flooded in shame or in a lot of pain, and I feel a lot of shame, of course, having unexpectedly caused that pain, that shame. Depending on the issues. I am not sure if that is a mystery. *It is just you don't know it until you step into it* [italics mine].
>
> The unconscious can erect a lot of barriers, if you, the therapist, let's say, are a little way "in," but don't know that is the way "in," but sort of blindly following thru that maze and are unaware of the "hole" there, you end up getting into that place that has previously been locked away. Sometimes it is terrific, it is kind of an "ah-ha," and, oh it is good to have that out in the open. But, sometimes that is when the shame is evoked. The dreadful, and horrifying has been revealed. Exposed is a good shame word [here].

Participant G had found that in the process of uncovering the patient's psychological processes unexpected areas of hidden shame surfaced, and that in that incident a mutual shame emerged.

Participant D found a blocking aspect in hidden shame:

> That unacknowledged shame really blocks the healing process. If we can acknowledge our shame, bring it into the open, that is where healing occurs. [Lack of acknowledgement of shame leaves us] pretty much . . . helpless, vulnerable, and paralyzed.

The Influence of the Therapists' Theoretical Orientation

There were no simple demonstrations of the influence of theoretical orientation to the experience of shame, but there were allusions to the influence of theorists upon the work. Most of the participants acknowledged a variety of theories that resonated in their practice. A constant presence was the participant's awareness of the movement of shame in the psychology of their patients, and theory was a lens to further highlight what they found.

The somatic or bioenergetic theory provided, particularly, a visual lens through which to see shame. The two therapists (A and B) who were adherents of bioenergetics were immersed in the bodily/emotional aspects of the emergence of shame. As Participant A noted,

> We look at the body, as well as the mind, and it manifests shame, as in an embarrassment. And so it is easily identifiable. It is manifested in facial expressions, in behavior. It is easily identifiable. It is not something that can be really hidden.

Participant B described addressing his students, "So . . . if you want me to look and tell you something about how you are standing or your body, and psyche, I will tell you." Participant B started from the point of bioenergetics for visual clues, but moved from the visual to the cause and effect of shame.

> But I was thinking of a patient describing being looked at by his grandfather and [that effect on] his self-awareness. And it created a false sense of self . . .. The discrepancy between how we appear and who we are creates a kind of shame. It is a discrepancy because we want to appear a certain way to please other people. That creates this discrepancy between a false self and true self.

Participant D looked for visual clues, also, but from the aspect of her own psychology: "I can see it visually, actually, I am a visual person, so I do better visually."

One influence cited was social theory, in which systems theory is prominent. This was an obvious influence on the social work therapists, but was also a strong influence upon the work of other participants. Systems theory supported several therapists in understanding the movement and change that appears in the therapeutic hour, and the influence of the process of shame. Participant D was concerned with interactions between the people in the environment, "So that is the interpersonal dynamics [which] for me are really important," and the patient's world, "I always look at the person as in context to their whole. And, what is happening in their world." Participant E saw couples in his practice, and he saw shame appearing in the couple's family system, "Whenever you see it, that manifestation [of shame], it is an upsurge of something that is a commentary on the ongoing state of the relatedness between two people. In other words, it doesn't come out of nowhere." Participant F observed the system within which the patient she

discussed was formed, "Recently we have had another thread which has been about her family history, which certainly is a layer underneath the sense of shame with these experiences." The family and social systems the patient operated within were a part of the environment for Participant F, "Although I would say you think about shame as a break in the bond, in the connection, in the relationship, which is one of the standard ways of conceptualizing it." Her mentioning of *bond, connection, and relationship* refers to elements from relational theory, attachment theory, interpersonal theory, and object relations.

The analytic tool most described, and which was a focus of development with the participants, was empathy, the appreciation of which is linked to Kohut (1971) and self-psychology. When Participant F spoke of the "break in the bond, in the connection, in the relationship," it was within her empathic sense of the patient. Participant C also used empathic connection as she describes, "So I really want them to know I am with them, and I am trying to reach out, trying to connect. I'm trying to help in a non-judgmental way, understand what their experience was, tapping into their experience." Participant G's sense of the mutual "brain freeze" signaled the onset of patient shame in her empathic sense of the therapy. Participant E commented on aspects of this mutuality when he noted, "What is coming up in you, frequently, is the patient's disowned shame. You may be a good target for it. You have hooks there, [in] your own shame, you really need to know those as well."

For Participant E, the lens of object relations highlighted and enhanced his understanding of shame.

This is the whole point of object relations theory: you have to monitor the whole

> relationship, on both sides. . . . This study [I have made] of shame has been most illuminating, and the most clinically useful aspect of my training, but it has been on the job training. It has been really important to put [shame] into an object-relations framework because you need to conceive [the treatment] in terms of the patient pathology and vulnerability.

Object relations theory was the holding environment for his work with shame, which initially frames the psychological history of the patient in terms of the initial mother/child dyad.

The influence of theory upon the participant therapists was subtle and woven into their work. For example, certain words and phrases in the interviews suggested ideas derived from Jungian and Lacanian theory. Jungian ideas appeared in Participant E's referral to psychological "hooks" when he says: "You have hooks there," meaning the characteristics or "hooks" in the human object that capture a patient's projection. Participant E also suggested a Jungian concept in a summation of his understanding of shame as a barrier to wholeness, with the characteristics of Jungian individuation:

> Shame is the primary barrier to their consciousness, in fact. It is a hugely important phenomenon, and to my mind, the core issue of people. It is the gatekeeper of self-acceptance. To the extent to which it is unbearable to be divided, you can't accept it. But, you can't fully integrate yourself, be whole, if you have too much pathological shame. But also at a core level, whatever they are hiding from themselves, is the thing that divides themselves, un-whole, un-integrated.

Suggestions of Jungian thought also appeared in Participant F's interview, with the

concept of *symptom as goad*: "It is a shame that doesn't go away. It just serves as a signal, an opportunity to learn something," and from Participant G:

> So one of the things to do when you recognize shame is to try and [instigate] a shift. [Shame can be] a kick in the butt [and can facilitate fulfilling] the desire to have what you really want. It is amazing, they [patients] don't think about that. They have no idea. They never know their desires.

Participant G's appreciation of *desire* follows Lacan's theoretical understanding that narcissism is an unavoidable central personal attribute, that desire is its expression, and that desire is basic. A suggestion of Lacan also surfaced in the work of Participant F in her description of her patient's insistence upon some specific word or diagnosis to fit her mother's pathology:

> What [she wants] is a name, a diagnosis, for what happens. It was very disturbing to her that I couldn't answer that question. I would ask her questions, "Why is it important to you, having a name? Sometimes people have lots of problems without fitting into a diagnosis." I talked to her in all different ways about it, but it still kept coming up again and again as her need.

The patient's needs for a name to attach to her agony and for the association of specific words for some phenomenon are particularly emphasized in Lacanian theory.

Above quotes from all of the participants could be seen as related to interaction occurring in the therapeutic field, which suggested the domains of interpersonal theory, relational theory, and intersubjectivity. This was commented upon by Participant D, "The interpersonal dynamics for me are really important."

Shame's Impingement on the Countertransference

Countertransference is never without its own complexity. In this data, much of the material that is associated with countertransference was also associated with hidden or unexpected shame. Therapists found it difficult to make distinctions among the facets of the countertransference, and what may have begun as only semi-conscious, or what emerges from a hidden, unacknowledged place, or makes an unexpected appearance may later be recognized as countertransference material. These therapists found the overlap between unconscious elements and the countertransference, with the first influencing the other and the latter becoming part of the other.

Participant G found countertransference a shared state. "We could talk about my countertransference, certainly. When the room goes foggy I am usually feeling as foggy as they are." Participant F addressed distancing experienced in the countertransference in a long, difficult treatment:

> I did distance [consciously or unconsciously] from her at certain times when I was having a reaction to her complaining, even though I understood it [the complaining] as a shame reaction, and I [also] felt some shame that I wasn't being helpful. Now, that is partly a normal response to somebody who just complains, complains, complains, about the same sort of thing, but I had something of my own. I had a mother who complained all of the time.

In this case with Participant F, the complex countertransference was made up of (a) the patient using complaint to cover her own shame, (b) an irritable therapist reaction and distancing, (c) the psychotherapist's countertransferential memory of her mother's

annoying complaints, and (d) the psychotherapist's need to hold herself to her professional standards.

As an example of complexity, participants considered the problem of unseen or unacknowledged shame, also called by-passed shame as conceptualized by Lewis (1971). In the context of the countertransference, that shame must be watched to be sure it is not passed over. What can seem to be countertransference is often a manifestation of patient shame. Vigilance is necessary, according to Participant E, "otherwise you will by-pass it, you will by-pass it yourself," unless you can hold both the state of yourself and your patient's state in your conscious mindfulness. Said Participant E, "You need to work . . . dialectically," and make careful distinctions because, "what is coming up in you, frequently, is the patient's disowned shame." Participant G pursued distinctions: "Is that my stuff or is that something I am picking up? You have to sure, but chances are, it is something between you, not just [the therapist or the patient], not always."

The Emergence of the Therapists' Shame

Aspects of therapists' shame, as it emerged from the data, fall into four categories: (a) maintaining professional pride and standards; (b) personal emotional history; (c) emotional connection to the patient's shame; and (d) a general sensitization to the presence of shame. These therapists had a preoccupation with how professional standards, personal history, and accurate mirroring have an effect on their work, and this gave the work a dimension of alertness to the signs of shame. Five of the therapists, Participants B, C, D, F, and G, had specifically mentioned being aware of anxiety about the professionalism of their work.

Participant C had reflected deeply about her own shame interfering with her work:

> I can feel shame around my professional competence. I should know what to do. So, I try to soothe myself by saying, "You know, just be there. Just be with this person. You don't have to know [everything]." So there are things I say to myself around that. I notice that [shame] interferes. I get into that place [where] I am not really present. [I am] paralyzed by it, not really able to stay connected.

Participant E recalled a specific case that singled out for him a concern about professional competence, "I'm immediately thinking about a session with a couple that I had last week. I am still feeling shame about the way I handled it, which [I feel] was not particularly well." Participant G had questions about the use of shame as a judge of her work when she said, "I feel ashamed, or anxiety, like shame that I am pushing too far, am I going to hurt them?" Participant F noted the inevitability of her shame/self protection trigger. "I am trying to protect my core vulnerability. There is always shame about that. There is shame about that complex." Participant E also mentioned response to core vulnerability, "And to my mind, [shame is] the core issue of people. It is the gatekeeper of self-acceptance." Participant D described her search for her professional stance in the midst of a difficult case encounter, "Here I am struggling with this situation that I have never been in before."

Three incidents of shame emerged during, or just after interviews, or transferred from other sessions, demonstrating a contagious characteristic of shame. In these episodes the therapists seemed to suffer the shame, or something like the shame, for what we had been discussing, or they were carrying over feelings from a session. A theme throughout these interviews was the shame-as-exposure that affected the interviewee, as well as affecting myself as interviewer, as it also affected the interview.

The experience of Participant C, which occurred early in our interview, was a shame attack having to do with professional competence. The record of that incident from the interview follows:

> [After a silence]
>
> PH: Yes please, keep talking . . . uh . . . What happened to you just then? I mean, [but] I don't want to sound like your therapist.
>
> C: I am feeling, "Am I really qualified, right now, to be talking now? Am I able to talk to you about this?"

Participant C expressed how she had been made to feel vulnerable by the subject of shame, and had momentarily lost her professional self-confidence. Participant E expressed a similar feeling of professional self-consciousness. At the time of our interview, he was thinking about how he had handled a session, and graciously permitted our interview to open up his current work and his professional misgivings. He had become angry with a patient: "In essence I got my back up, and I would hope I would not be that insecure professionally, but . . . there it is . . . there it was."

Participant B contacted me shortly after our interview to express concern about an intrusion into the interview. He had answered a phone call during our interview and commented, "I generally consider answering phones with others present as rude, maybe shameful . . . I want to apologize." This illustrates being sensitized to shame, respecting its mild form, and possibly a subject of its contagion.

Concluding Remarks

Holding shame in the forefront of a therapist's mind presents a complicated challenge. The task of understanding shame's elusive nature was primary in the

therapeutic stance adopted by the participant therapists. In addition, the therapeutic stance of each therapist combined the tool of empathy with a clinically objective mindfulness. At its most useful, a clinically objective mind interprets and holds therapeutic goals, as well as monitoring psychological process.

Discovery

There were important discoveries apparent from this data. One discovery was that each of the therapists had worked with his own shame, and each discussed how that inner work affected his own functioning as a therapist. Another discovery was that shame could act beyond the control of not only the patients, but also the therapists. The therapists had learned to be immersed in the overt or subtle cues of the presence of shame during the therapeutic hour, and employed a primary dependence on direct experience rather than academic experience. Each of the therapists pursued the task of therapy in his own way, incorporating the experience, skills, and theory gathered in their unique histories, and bringing that to bear on the affective field present in the therapy.

CHAPTER V: DISCUSSION

In order to convey the strange otherness that is introduced into a therapeutic situation by toxic shame, the story of the Navajo Skinwalker, the Shapeshifter (Kluckhohn, 1944), offers a metaphoric analogy. In Skinwalker, or Yenaldlooshi, witchcraft, there is a sense of invasion by a unique dynamic. Toxic shame introduces a similar sense of sinister otherness.

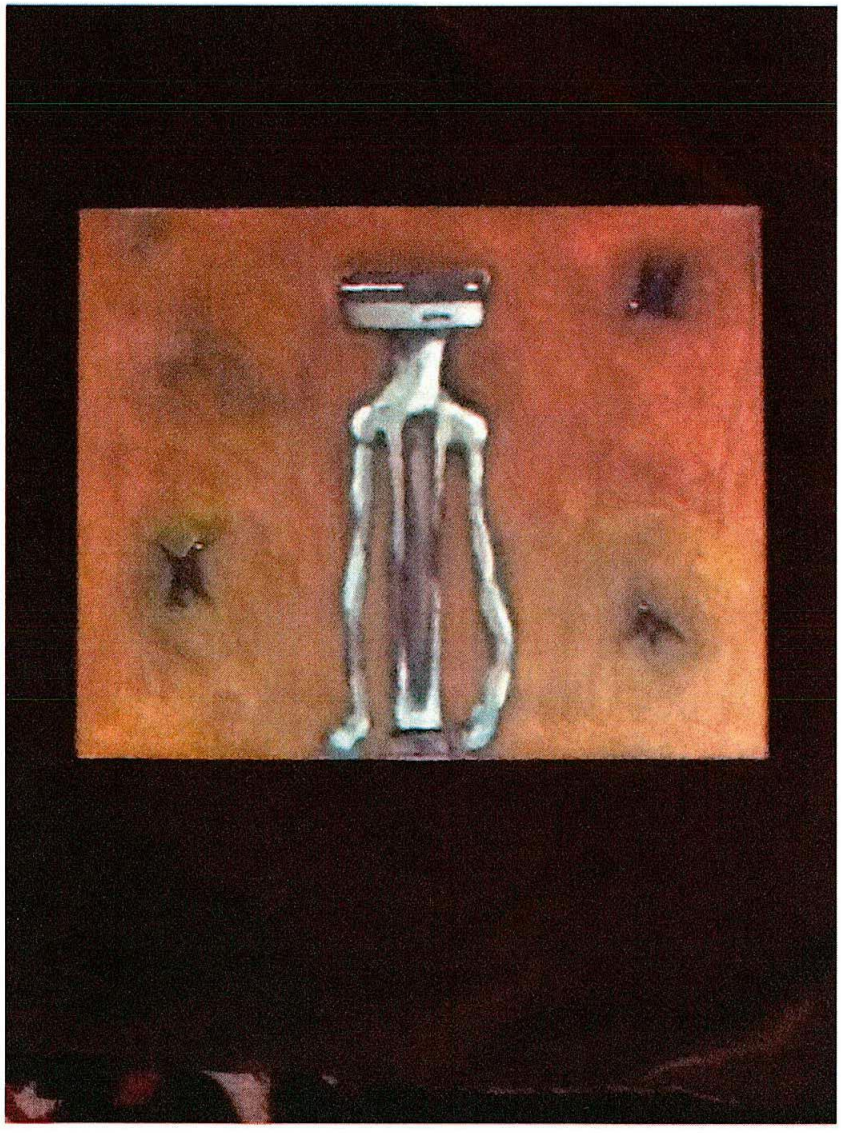

Figure 1. "The Watchers" by Sheldon Harvey, Navajo artist Shiprock, Navajo Nation. The central figure represents a Skinwalker. Reprinted with permission of the artist.

The Navajo Shapeshifter, the Skinwalker

Neither the Shapeshifter nor toxic shame is governed by the presence of an ethical respect for the humanity of the patient or for the authority of the therapist. Toxic shame moves through the therapeutic field by its own rules, and then disappears underground, still making its powerful presence known by the presence of disorientation and distortion. To move into the open, the Shapeshifter uses the skins of the animal whose power it wants to borrow.

In therapy, a psychotherapist seeks to really know a patient. She tries to get "under the skin" of the patient to find out how it is to be that patient. Of course, it is really not possible to be another person or know his exact experience, but the psychotherapist tries to get as close as possible in order to gain as much information as possible. It is almost like inhabiting the skin of another.

"Skin" is an apt metaphor. To be "under the skin" of another person is to be next to a special kind of nakedness. To be without the covering protection of skin is to be truly exposed and without safety. However, to be without skin is also to be able to assume another skin to hide or change beneath. In the Navajo community, the blackest, most volatile, and unpredictable of the witches is the Yenaldlooshi, the Skinwalker (Kluckhohn, 1944). The Skinwalkers can don animal skins to take on the shape and characteristics of animals, especially wolf, coyote, and raven. But the animal shape assumed is a very large version. If it is wolf, it is a two-hundred-pound wolf. The footprints left behind by the Yenaldlooshi are hugely overgrown. If one sees eyes, they are prominent eyes of an odd light color and are particularly calculating and intelligent. This black witchcraft has the power to influence the health, mind, and emotions of others.

It is disorienting. It seems to emanate from another sphere.

An attack of intense shame affect can equally disorient. It can surprise its victim and have its own feeling reality that insists that this dire and frightening situation is the fault of the victim himself and threatens life itself. It has the quality of feeling that says, "I have done something to deserve this awful situation. Intentional or not, it is my fault." At the same time, it can overwhelm, like the very large size of the wolf, and it moves through the moment by its own rules and processes. Shame is not controllable.

The Yenaldlooshi engage in their witchcraft involving shape shifting with animal skin, but they also have other special powers. They are able to travel at great speed, change direction suddenly, walk through walls, appear and disappear, and leap over tall ridges. Their very presence brings with it a field of fear and loathing. They frighten their victims and then possess them, using a victim at will. A Yenaldlooshi victim may be unable to act in his own best interest. He may harm himself or even take his own life.

Similarly, persons dominated by shame do not seem able to act in their own best interest. Often a person in the grip of shame will be unable to escape his fear long enough to chose another path. He will seem caught in a maze of bad choices. He will seem imprisoned by the pain of shame, enhancing a depressive state. Persons in a depressive state are in danger of taking their own lives in the same way the victims of the Yenaldlooshi are in danger of taking their own lives.

Shame hides itself and will not sit still to be examined, just as the Yenaldlooshi will move suddenly away from an observer. Shame's quality of avoidance makes it very quick to evaporate, just as the Yenaldlooshi are described as fading away suddenly. The quality of "disappearing into a rabbit hole of shame," that one of the interviewees

(Participant E) mentioned, mirrors the Skinwalkers ability to vanish. Yenaldlooshi only appear to vanish, but actually they just become invisible to the eye.

The Skinwalkers travel in secret to deliver their poisons suddenly, just as toxic shame will suddenly materialize in a moment. The Yenaldlooshi and shame share an ominous quality that is not quite human, it is unmitigated by mercy. The Yenaldlooshi and shame also share the desire to be hidden and not be discussed or opened up in polite society. Often Navajos are reluctant to discuss this witchcraft for fear of being accused of being a witch or incurring the wrath of a witch. The antisocial element in shame often makes a person reluctant to talk about his own shame issues because he will expose his shortcomings and faults to his society and he will become vulnerable to contempt and bad treatment.

The perverse witchcraft of the Yenaldlooshi nonetheless has a societal function. It can provide a focus to relieve responsibility, provide cautionary instruction, direct behavior, and provide an explanation for hardship, illness, and even death. Yenaldlooshi send out curses, invade, cause illness, trick, and kill. Yenaldlooshi are accused of terrible crimes that flaunt Navajo tradition. They are very difficult to kill, but if they are killed there is no penalty. No guilt is incurred by disposing of a Skinwalker. A bad witch forfeits his right to life and humanity.

Discussion of the Dissertation Question and the Relevant Findings

This study was designed to explore the question of how psychodynamically oriented therapists think about and work with the problem of adult shame in a therapeutic environment. It was intended to draw out the immediate experience of therapists encountering the phenomena of shame in session with their clients. It was meant to elicit

how the immediate recognition and perception of shame is experienced. The study considered the countertransference and the therapist's theoretical orientation in the context of therapy sessions.

Preliminary questions in Chapter I asked what commonalities and patterns would be revealed, and what the impact might be of shame being intermittently ignored or marginalized in mainstream psychoanalytic thought. There was also the hope that the study would uncover unexpected findings about therapists and shame. These questions were in mind as I listened to the interviews and when analyzing the data.

The following sections of this chapter will discuss the impact of the experience of finding participants for the research; how initial, failed attempts to recruit interviewees changed my choice of participants; as well as how potential participants were approached. Subsequent sections will incorporate the preliminary questions, the research question, the literature, and the findings in a discussion of the patterns in the findings and the influence of theory. The discussion will continue with the countertransference, contagion and response, and how those components led to an unexpected discovery.

A consideration of the rules of shame will reiterate findings about shame and its source and formation, development, dynamic, and characteristics, as well as issues of positive shame, which together contribute to the process and implications for healing. This chapter will conclude with implications for further study and concluding notes.

The Experience of Finding Participants

Shame is a sensitive and complex subject clinically. Initially, I planned to draw from California licensed participants who had had at least ten years' experience in the field. However, the therapists I actually found to work with had at least 20 years'

experience, and three participants had had more than 40 years' experience.

The sensitivity of the subject matter was confirmed with my first attempts to recruit interviewees. I placed an announcement calling for interviews in the newsletter of a professional society (Appendix A). This call brought forth no response. I approached two therapists known to me to have had long experience, and whom I felt would be open to an interview. I learned a great deal from these attempts.

When I contacted these two potential participants, I started by volunteering information about the project and asked each if he or she would be interested in being interviewed. The first potential subject did not respond to the request. I did not repeat the request. The second potential subject looked startled and said she needed to leave. Upon reflection, even considering the possibility of miscommunication, I was still puzzled. Upon further reflection, I felt that, although I might have misinterpreted the reactions, the subject of shame could also be an important disorienting element.

As I reflected upon these experiences, I took my concerns to a colleague, an experienced psychotherapist, hoping to talk my discoveries through with a neutral person, but she immediately began to talk about her own, then current, struggles with being overwhelmed by feelings of "not quite good enough." She could not at that moment seem to escape her own web of shame. I was convinced that the subject of shame itself needed a different approach.

I decided to modify my approach by seeking subjects who already had established a deep interest in the problem of shame in psychotherapy. I was led to members of the "shame group" formed in the 1990s by Jane M. Reynolds at The Psychotherapy Institute in Berkeley, California. Other colleagues referred me to therapists that they knew had

worked with shame.

The participants I eventually was able to chose from were not only seasoned therapists, but were therapists who vitally attended to and appreciated the shame dimension in practice. These therapists had overcome shame's marginalization as psychological phenomenon through their particular sensitivity to what they found happening in session, and through their own curiosity that led them to persist in the face of mainstream indifference. In the interviews, I learned that the participants were relieved to talk about their interest and discoveries about shame, especially because it is a subject so often avoided or ignored.

An Overview of Therapists' Recognition of the Presence of Shame in a Patient

There was a depth to the participants' immersion in the cues and indications for the presence of shame in the session. In considering the interviews as a collective body of information, it was evident that in order to function in session with the degree of sophistication that these participants exhibited, it was necessary that each therapist thoroughly absorb the cues signaling shame in patients, in addition to a thorough understanding of their own personal psychology in relation to shame. Knowledge of shame cues is just the beginning of an involved process of learning. The therapists had learned to tolerate the pain of shame, and then had reflected upon the material presented in session until therapeutic understanding developed.

Evidence of the individually developed approaches to shame emerged in the emphasis of each of the therapists. Participant B had developed a long description of the characteristics of shame, his "rant," using simile ("smelly dog, with fleas"), evoking a direct emotional portrayal ("it's catastrophic"), and colorful exhortation ("just a pain in

the ass"), which succinctly drew attention to the elemental units of shame that required attention and understanding and defined a field in which to successfully work with shame.

Participant D uncovered a powerfully effective tool that would disarm shame through a careful and difficult employment of tolerance, along with her courageous openness and vulnerability. Participant D, in effect, sacrificed her own safe harbor of professional distance in order to reach an ultimate objective for the patient. In that process, she had learned her craft. Participant C maintained her reassuring connection with her patient throughout her work. Participant F monitored her sessions for a possible disconnect between herself and her patient, her signal to probe deeper. Participant G followed the thread of the therapeutic process, allowing an unfolding to operate in its own way until she would come upon the discovery of shame, locating with shame what required therapeutic attention. She "followed" and "allowed," trusting the process. Participant E was willing to struggle with the intricacies of working with the complex defenses of a patient, using himself to retrieve a connection to the patient. Each of these therapists was prepared to sacrifice emotional distance in order to further the therapy, and pushed beyond conventional limits of the engagement in the therapeutic process. Central elements operating in these sessions were immersion in right brain connection with the patient, holding the connection within a safe holding environment, and trusting the process to unfold for the patient's healing.

The rant of Participant B, the vulnerability of Participant D, the struggle of Participant E, the connection of Participant C, the monitoring for a break in the bond of Participant F, the tracing of the thread of shame to its source with Participant G, all had

allowed shame to inform the work of psychotherapy.

Considerations on the Influence of Theory

Theory, in this study of shame, has two recurring themes: direct experience and marginalization. The preponderance of the theorists cited in the literature review, as well as by the participants, had developed their theories through their own direct experience, or their observation of what was occurring in society. Like the participant therapists, most of the cited theorists who were central contributors to the literature on shame were open to a fresh contact with patients or to societal changes.

A thread running through the study of shame's theoretic history was the importance of direct experience. Kohut in the 1960s noticed that narcissism had replaced sexuality as a culturally defining issue. Lacan had similarly responded to the societal shifts he observed taking place in the 1950s, 1960s, and 1970s, and to which he provided a running psychological commentary from his seminar. The object relation theorists (Fairbairn, 1963; Klein, 1948; Winnicott, 1972) shifted clinical focus to an examination of the relational. Tomkin's affect theory (1962, 1963) was the result of his direct observation of his own infants. Bowlby, Ainsworth, and colleagues (1956) based attachment theory on direct observation of the reaction of children in new situations. The fresh return to a focus on a primary object, the patient or the society, injected essential vitality in these theories.

The second theme, marginalization, was repeated in the professional experiences of many of the major theorists: Kohut suffered rejection by his colleagues, Lacan's rejection by the French psychological establishment; Jung's rejection by Freud; Winnicott's and Fairbairn's experience with Klein and the Kleinians' rejection; and

Tomkins' isolation. Marginalization allowed space to define a new idea, new insight, and in most cases gave it room to develop. However, as in the case of Tomkin's exploration of affect, the problem of shame has never quite taken its place in the mainstream of psychological theory.

The therapists interviewed in this study were unique in their ability to pay attention to a difficult and shunned subject, and in their ability to integrate and use theory. The discovery and employment of the many qualities required to access shame and work with shame clinically demonstrates why that may be so.

Countertransference, Contagion, Response, and an Unexpected Discovery

Three areas of inquiry in this study led to an unexpected discovery of the importance of the therapist's use of their own shame. Those areas were the operation of the countertransference, the element of contagion, and the therapist's response to the direct experiences in the therapy session. The therapist's own emotional response in these three areas of inquiry, especially attention to the response of shame, found the central point of pain emerging in the therapeutic field. The therapist used his own shame to find the pain of the patient.

Countertransference.

The countertransference and the therapists' responses to the countertransference gave them significant information about the connection between the patient's shame state and the therapist's own shame state. Four of the participants – D, E, F, G – made specific reference to elements in the countertransference that led them to note the connection of their own shame responses with the shame of the patient. Participant D spoke of the activation of her own vulnerability, that was her countertransference, and how she used

that vulnerability to connect with the patient's shame. Participant E struggled with a sense of professional ineffectiveness as he came into touch with his patient's defenses. His struggle mirrored his patient's agony. For Participant F, the patient's complaints triggered her own distancing response, a distancing that was the patient's defense, a way to hide and deny her own shame. Participant G had shared a "brain freeze" with her patient, which told her that she and her patient were in "a shame state together." The overlap of the patient's state and the state of the therapist is significant. The patient and the therapist are sharing the discomfort and pain of shame. It is not just the experience of the patient.

Contagion and response.

The process of the study is permeated with the problems of the contagious and toxic nature of shame. The activation of shame in the patient triggers shame responses of pain in the therapist, a recall of therapist's shame history, and defenses from the therapist. The pain of shame has the potential of closing off communication with the patient and imposing distance.

Shame operates in hidden, subtle, unconscious ways that are hard to anticipate and detect. The therapist holding an objective stance while in the midst of a shame state was a notable challenge for the participants in this study. In consciously recovering balance at crucial points in the process I became aware of what the participants had learned about their own shame processes. It was evident by their sensitive understanding of the patients and their openness to disclosing their own responses that the *participants had established a relationship to the toxicity of shame within themselves.* This was another piece of unexpected discovery.

Part of the discovery of the crucial relationship of the participants to their own shame was a result of this investigator's reflection about her own processes. As I became increasingly aware of the possibility of contamination of the study process itself, I became aware of the impact of this study on myself. This was not easy to grasp because it was painful and full of shame.

There is a difficult rawness in shame states that is both helpful and toxic. To begin to understand this discomfort required intense reflection. Immersion in shame brought up strong responses of being overwhelmed by personal pain, regression, fear, anger, and vulnerability. In the process of writing I had to push through a fear that my writing would "never be good enough." I found myself intermittently hypersensitive to criticism, and confusing critique with rejection. The process brought up defenses, and I found myself fighting rather than accepting. All these troubling responses would occur within a sense of drowning in my own feelings. At each occurrence, I had to carefully work though the psychological defense and its presentation.

The struggle with my own shame was deeply valuable for me as a therapist and as a human being, even though the struggle set up obstacles to the completion of the study. The process mirrored some of the intense shame experiences encountered by me and by my patients in session, experiences that became an invaluable therapeutic tool.

The unexpected discovery.

The core of the unexpected discovery in this study was the importance of the therapist's use of his own shame. These therapists and I had learned the significant importance of a connection between the patient's shame state and the therapist's own shame state. I noticed that the therapist participants could not talk about shame in their

patients without referencing their own emotional state. I noticed how significant it was that the participants were able to be open about their own process and emotional work. I noticed that there was a back and forth between the participants' discussion of the patients' states, and a reference to the participants' own states. A sensitive understanding of the patients and openness to disclosing the therapist's own responses had established a relationship to the toxicity of the shame within themselves.

Another part of the unexpected discovery was that the patient and the therapist shared the discomfort and pain of shame. It was not just the experience of the patient alone. It called to mind a mother holding an infant that is in pain; both infant and mother are holding the pain. A therapist's ability to hold more than one thing in his consciousness is present. The therapist is mindful of the emotional state of the patient and all that that state contains, and a therapist holds both the patient's processes and his own processes. This points toward a healing by providing an experience of wholeness, which uses a therapist's ability to be immersed and, at the same time, objective in his work with his patient, to be vulnerable as well as detached.

The Rules of Shame: Structure and Operation

"I kind of went by shame." This compelling statement by Participant D described how she proceeded in her work with her demanding patient, the patient she identified as "the best teacher of psychotherapy I ever had in my life." What, then, does "going by shame," mean? Could this be Participant B's "path of humiliation" that he named in his "rant?" Could shame be organized into *rules of shame* in its formation, development, dynamic, and characteristics? Considering the clinical literature concerning shame and

considering the interviews with the participants, certain commonalities and patterns emerge.

Source and formation.

The formation of an individual's emotional life begins early. As described by Schore (1994), the neonate arrives equipped with a potential for complex shame, fear, and vulnerability in which is also embedded the ability to develop and change, reflect and learn. As explored by Retzinger (1991), there is a dimension of rage in this formation. Physical reactions of the infant are intimately involved in this complex; the whole body and mind of the child responds. It is in relating to the first caregivers through a right brain connection and the body (Schore, 1994) that the infant accesses his world. The infant picks up cues that help him navigate the social world that protects him (if he is protected), teaches him what is expected of him, and molds him as a functioning human being. The early dyad, usually mother and child, provides a psychological space to which a person can return to learn. However, if a very early memory is traumatic, the touchstone can be encapsulated with physical and mental pain in a psychological complex that retards emotional growth. It is a state that may mimic safety (Kalsched, 1996) in the patient's mind but is not safety. The "safety" that a traumatized person has learned from that state is more a defensive attempt to "normalize" what is horrific. An individual's understanding is distorted by the condition of the early environment.

Development.

The shame/fear/vulnerability/rage composite begins early and continues out of the preverbal period. This period is marked by intense connectiveness with a primary

caregiver and sensitivity to feelings of safety and comfort. The elements in this connectiveness profoundly affect how the person continues to function for life.

The infant's early distinctions are quite gross and simple (Kohut, 1966); as simple as black and white, good and bad, reject or accept. Nuanced distinctions develop slowly, acquiring richness as the boundaries of safety, comfort, and necessity expand. Early trauma, repeated trauma, or extreme trauma can affect a person's ability to tolerate nuance and abundance, as well as an ability to hold multiple aspects of a situation in the same psychological space. Living within an emotionally stunted environment or with neglect will influence infant development and ultimately the adult's ability to tolerate certain aspects of the environment or to tolerate even emotional change and growth.

Dynamic.

I discovered the elements of the shame dynamic in reflecting on my own experience and the experience of the participants. I saw three aspects: aversion, attraction, and containment. The dynamic is a very quick reaction and process triggered by the pain that occurs when shame is activated. Participant D noted that she found evidence of the unbearable nature of this pain in the quick reaction that marks the avoidance of this pain.

The aversion associated with shame is particularly strong. Participant G was conscious that this aversion would push away any suggestion of a person, place, or thing where shame is associated. This tends to happen very quickly, and the trigger and pain can pass almost without notice because of its speed in passing; what is evident is the aversion. Consider a person who has an aversion to crossing over bridges. The avoidance of bridges can be directly observed, and can even be interpreted as a symptom with an

underlying cause, but by not crossing over bridges the pain of the original experience is not completely called up by the patient. If a person can avoid crossing bridges, any reference to the original experience can be hidden from full consciousness.

The attraction element is associated with the defenses that build up around shame. We could say the shame attracts the defenses. The core issue, the origin of the shame response, is guarded by the defenses that are lined up around it. Participant E noted that patients tended to repeat the same defenses, or group of defenses, to a particular shameful complex. For example, various defenses may be called up in a case of fear of bridges. A person might *deny* by saying, "Oh, it's not a problem, I just do not cross bridges," or may *rationalize* it saying, "Bridges are dangerous," or may make up a story to explain why it is superior to avoid bridges, such as, "If I walk to the edge of the water and cross in a boat I see many things and build my body and skills."

The original experience of the shame reaction, the whole area that has been touched by the shame, its origin, its history, and its development are also guarded by containing all of it in an enclosed psychological space. This compartmentalizes the experience and attempts to isolate its effects. This compartmentalizing removes the pain and its effects from directly interfering with everyday life and reduces consciousness of the event and its ongoing effects. I have particularly noted this compartmentalization in the case of abuse victims.

Characteristics of Toxic Shame

Before I began this study I had become convinced, over years of practice, that identifying toxic shame occupies a central position in the treatment of patients. I had watched characteristic occurrences in the therapeutic hour that, when traced out, pointed

to toxic shame. In order to help me in my practice I developed a list, a rule of thumb, to help me recognize and work with shame. My interviews with seasoned therapists helped confirm and fill out this list. Toxic shame, as it moves through the affective field between therapist and patient, will demonstrate these traits:

1. Shame exists in a spectrum with pride.
2. Pride can be false and inflated, or healthy and grounded.
3. The duration of a conscious shame attack is limited.
4. Shame is preceded by a high expectation of positive response.
5. Shame is accompanied by tension.
6. Chronic toxic shame is the result of repeated, unrepaired exposure.
7. Repeated exposure to unrepaired shame results in hyper vigilance and a greater general sensitivity to shame.
8. Shame is often experienced as a sudden deflation.
9. Shame is accompanied by anxiety.
10. Shame resonates in the body as shock and exposure.
11. Shame can be seen in the body as the blush of exposure.
12. Shame is often felt in the body as a chill.
13. Shame is sensed as vulnerability.
14. The emotional pain of toxic shame can be overwhelming.
15. Shame is intimately connected with clinical depression.
16. A shame attack is often accompanied by cognitive distortion.
17. A shame attack is often accompanied by confusion.
18. Defense mechanisms hide and distort shame.

19. The characteristics of shame cannot be controlled consciously.
20. Toxic shame feels like a loss of control.
21. Toxic shame interferes with reflection.
22. Toxic shame functions as a barrier to relationship.
23. Toxic shame will prevent growth and progress.
24. All of these characteristics are dynamic.

Any defense mechanisms can occur with toxic shame from the most primitive denial and dissociation, through to more semiconscious defenses such as avoidance, distancing, hiding, reclusiveness, withdrawal, aversion, humor, or paranoia. More sophisticated defenses connect with rational functioning and "explain" a defense as a choice or may "explain" a response to an inquiry that triggers shame as an "inappropriate intrusion." Anger and rage are connected to shame (Scheff & Retzinger, 1991/2001), and this connection is not only a primitive emotional response, but is also an effective defense that deflects, frightens, and distances from a person or situation that is perceived as threatening.

The pride that is a positive part of the shame spectrum is not a false pride, which is arrogance and could result in bullying. It is the quiet pride one feels when knowing one's strengths and solid accomplishments. It is akin to the identification with the loving caregiver, a supportive family, or recognition within society for real contributions to that society. However, false pride, an inflation of oneself, can associate with a shame attack and act as defense.

Toxic shame is a shame that has become poisonous in its manifestation. A modicum of shame guides conduct and helps us feel with others. Overwhelming toxic shame paralyses movement, thought, and feeling; it renders one helpless and subordinate.

Positive Shame

The term "positive shame" is a difficult concept. It may seem an oxymoron, but is not. Shame occurs in a spectrum from the very mildest form to overwhelming. The "mildest form" adds nuance to relationships through an act of sensing shame, and respecting what it is guarding. An internal sense of mild shame in oneself signals that a private, guarded area has been touched. As quoted by Nathanson (1992a) Herbert Marcuse was clear on this point. He was asked, "if shame and guilt cut us off from our sensitivities, doesn't it follow that a revolutionary form of therapy would have to de-shame the individual?" (p. xix). He answered:

> I think you have brought up the decisive point. I would say that shame is something positive and authentic. There are qualities and dimensions of the human being that are his own possessions and I mean that in a non-exploitative and non-acquisitive way. They are his own and he shares them only with those whom he chooses. They do not belong to the community and they are not a public affair. (p. xix)

In the German, Yiddish, and Russian, as in other languages, there are several words for shame representing precise and varied distinctions in meaning. We have very few ordinary English words for the whole spectrum of shame. We have words for the toxic part of the spectrum, such as humiliation, disgrace, dishonor, ignominy, and infamy, but not so many words for the simply slightly uncomfortable end of the spectrum. For

this feeling of discomfort we do have embarrassment, but the word *embarrassment* is still too strong for a meaning that is less than an embarrassment, and is merely a prick that is a signal. All of this reflects a fact that many cultures appreciate shame as a nuanced experience. Shame has many subtle aspects such as varying amounts of shame, shame that reflects our attachment to individuals, shame that signifies our place and function in the larger society, and somewhat appropriate or somewhat inappropriate shame. The missing links, in English, are these common words for the positive features of shame associated with positive attachment and civilized behavior. Shame is widely understood in popular American culture only in its toxic manifestation, a "bad" feeling we would be better off without.

Positive shame is a combination of respect, connection, and place-in-society (Schneider, 1987). Positive shame holds a boundary to the integrity and cohesiveness of the individual. It is a mature ability to hold the self and some other in the same psychological space. Scheff & Retzinger (2000) proposed modesty, shyness, self-consciousness, or conscience as further positive aspects of shame.

Societal bonds, national identity, honor, ethics, and duty are guided by pricks to consciousness that is a mild form of shame. This mild shame can even be felt through the warmth of caring. It can be felt many times a day. It is a kind of societal guide, professional guide, or familial connection to what is appropriate. There is a precise English word available for this, it is *compunction*, but it is little used. Compunction's subtlety can be described through a translation from the medieval monk Thomas à Kempis (c. 1418-1467/1952) in Book I of *The Imitation of Christ*; "I would rather feel compunction, than know how to define it" (p. 27).

The Process and Implications for Healing

Implications for healing toxic shame began in an observation by Participant D concerning hidden or unacknowledged shame. She noted, "Unacknowledged shame really blocks the healing process. If we can acknowledge our shame, bring it into the open, that is where healing occurs." Participant G reflected that patients are "healed by moving toward rather than away from, something," and that when a patient "recognized his own desire" healing could begin. Healing depends upon the therapists' own depth of understanding. A process for healing begins with the patient acknowledging the shame, opening it up to scrutiny with a therapist who has deeply understood her own shame issues, respects the process of the patient, leading the patient to recognize her own deep desires, and moving toward realizing those desires.

Healing uses a therapist's ability to be immersed and at the same time objective in her work with her patient. The participant therapists followed the process of shame to uncover an exact emotional location for a toxic shame complex. This is the "hole" that the patient can disappear into, but that can also be used to locate the center of the patient's shame. The healing depends upon an established connection between the therapist and patient, the therapeutic alliance. The strength of the holding environment of the therapeutic alliance in the right brain makes available a growth potential and allows the vision of the therapist to become available to the patient. The alliance provides a place of trust and rest for the patient. Despite the difficulty involved, shame seems to require cooperation and close examination to be disarmed, and to allow the possibility for growth.

The therapeutic space, in a right brain connection, enhances a patient's ability to grow toward seeing and accepting the inevitability, pain, and reality of shame. This allows a patient to see and understand at least two sides, the limiting elements and the growth elements that are present in shame. The ability to hold more than one aspect of a situation at once marks a strong impulse toward health.

Recovery most probably begins when one can resume reflecting and thinking, having recovered enough pride to allow a stance outside the shame experience. This stance allows the beginning of comparison to other experiences. Shame is a limiting, closed experience that references only itself. Healing begins when a place once shrouded in shame can be opened up to wider consideration.

Implications for Further Study

> He got through. When he got through he sit back over there where his place is (south). He says, well, mens [sic], this might be truth; may not too.
>
> A Navajo Medicine Man speaking after a Blessing Way Ceremony to remove a curse.
> (as cited in Kluckhohn, 1944, p. 200)

The fact that this study was focused on the experience and perceptions of the individual practitioner, and how the practitioner shaped his or her own work, opens the possibility for discovery through further exploration using seasoned therapists. Our psychotherapy work is ultimately idiosyncratic. We are using ourselves as the instrument of healing for the patient. We use our history and knowledge of our craft and our knowledge of our own processes to help and support our patients.

I have noticed how often, when a patient makes a breakthrough in therapy, I am surprised by what of myself has accompanied this breakthrough. Being thoroughly prepared and then willing to back away and give room to the patient's change is useful,

as is something unexpectedly spontaneous, or some simple technique; but also it is true that we cannot always predict or know what will help our patients.

The area of positive shame, mild shame, is a field that has not been sufficiently explored, researched, or reflected upon and has rich possibility for further study. Healthy shame adds depth to a complex psychological picture of a patient. How does one see it, respect it, or use it in session? Positive shame involves the concept and understanding of *privacy*. It begins in social psychology, but points back toward individual psychology. Long and focused experience as a psychotherapist can yield wisdom about the simple and complex elements of psychotherapy. This study has had the gift of interviews with seasoned, wise therapists. Probing that experience for what long- practicing therapists have learned could be a constantly renewable source for a body of knowledge about psychotherapeutic work. Periodically mining the work and wisdom of practicing therapists holds rich implications for further study.

It was my own direct experience, in dealing with myself and in doing therapy, which led me to this work on shame. I had found shame a central affective issue in therapy that came in the door with every patient, and guarded a vulnerable component of the individual. I had found that I needed to offer fresh openness to shame each time a patient started with me, and I needed to create unique ways to approach each patient's toxic shame. This openness and creation were beyond words. As with the participants in this study, I find it difficult to describe what I do, successful or not. In my experience, toxic shame always occurred in conjunction with key therapeutic issues in a patient. I have put together some *rules of shame* to point toward a more complete formulation of how toxic shame works and what it means. It was astounding to talk to seasoned

therapists who also worked closely with shame, and who kept an open, always searching, mind for what can be found in toxic shame. A new concept for me was the concept of positive shame. Probing work in this area could lead therapists into a more subtle understanding of patients.

Concluding Notes

How did this study open the subject further? The attempt was to explore the inexactness of shame in the context of the inexactness of psychoanalytically oriented psychotherapy. But, this is psychotherapy through the considered experience of seasoned therapists who were steeped in the complexity of shame. The task was complicated by the fact that while holding carefully prepared maps, a therapist following shame could still become lost. However, the lostness can open the therapy to the discovery of new material and new insight. The new insight here was the psychotherapist using his own experience with shame as an additional tool for exploration.

When I am lost in a session, I am in the company of a similarly lost but probably more anxious patient. I am prepared to investigate a mysterious object, but the shame object I find very often bleeds all over the therapeutic space while still shifting, growing, and moving. Shame appears as a substantially insubstantial touchstone that points us toward the underlying conflicts we are treating, while it still has the potential of obscuring the conflict the patient is suffering.

The interview participants were expert in the subject of shame, but still maintained the process of learning about shame in an ongoing training without a precise beginning or end. Their expertise appeared to be governed by limits of the tolerance of their bodies and defenses of their minds whose boundaries were flexible because they

were open and learning. Questions had to be asked again and again for each patient, in each situation.

Shame is unavoidable and determining; it is rich, but not comfortable; it is at once ephemeral and emotionally grounded in the body. An aware experience of shame seems to hold promise as a character-building experience, absolutely real but indeterminable. No boundaries seem to apply. Subtle, hidden, larger than any mental structure it accompanies, shame is most present when it does not seem to be present. Shame is not an avoidable life experience.

A fitting assessment of shame encompasses shame's subtlety, its uniqueness, and idiosyncratic nature. We may have a glimpse of holding our shame still for objective evaluation, but it will not sit still for examination.

This is the primary limitation to further study; this is the difficulty of describing in words what is not experienced in words. I have struggled with this factor. This suggests that we will need a new vocabulary. We are also limited by the fact that we are exploring shame phenomena with therapists who employ the tools and methods unique to them. It is hoped there will be new approaches to shame study not yet discovered, but determined by fresh insight into these phenomena

APPENDIX A: NEWSLETTER RECRUITMENT REQUESTS

Recruitment requests to be submitted to professional newsletters:

1. SEEKING PARTICIPANTS FOR RESEARCH STUDY. *The Psychotherapist Sitting With a Patient Who is Experiencing Shame: An Exploration of Shame's Emergence, Subtlety, and Meaning*. I am seeking psychoanalytically, analytically, or psychodynamically oriented psychotherapists with at least 10 years of practice, interested in relating what they, as experienced therapists, through their own unique perceptions, have seen in client shame as it emerges in the therapeutic session. The research study will involve a 60-120 minute time period in which to narrate the experiences. If you are interested in helping me explore this complex subject, or would like more information, please contact me: Paula Holt LCSW, doctoral candidate at The Sanville Institute. 415-378-5973, vm 415-289-6990, or paulaholt35@gmail.com (designate "Research" as the subject).

2. SEEKING participants in a research project: Bay Area licensed psychotherapists practicing 10 or more years who are interested in relating what they, as experienced therapists, through their own unique perceptions, have seen in client shame as it emerges in the therapeutic session. Paula Holt, LCSW, doctoral candidate The Sanville Institute, paulaholt35@gmail.com (designate "research" as subject) 415-378-5973, vm 415-289-6990.

APPENDIX B: RESEARCH QUESTION

The Psychotherapist Sitting With a Patient Who is Experiencing Shame: An Exploration of Shame's Emergence, Subtlety, and Meaning

My research question is: How do psychodynamically, psychoanalytically, or analytically oriented therapists encountering the phenomena of shame in the therapeutic session recognize and perceive the presence of shame in session? How is shame found or perceived in the countertransference? How might therapists' therapeutic orientation influence thinking about shame in the context of clinical issues? The consideration of the study is restricted to shame as it is found within the therapeutic context, between or within adult patient and therapist. The influence of these factors on treatment will be considered, but treatment techniques will be considered as secondary.

APPENDIX C: RECRUITMENT LETTER

Paula B. Holt, LCSW, ACSW
2237 Fulton Street, #103
San Francisco, California 94117
415.378-5973. vm 415-289-6990
email: paulaholt35@gmail.com

Re: Research Project on Shame in the Therapeutic Setting.

Dear Colleague:

I am currently involved in the dissertation phase of the doctorial program at The Sanville Institute, Berkeley, C I will interview psychotherapists who have ten (10) or more years of clinical practice and are interested in relating their experiences with, reflections upon, and concerns about shame as they find it in the therapeutic session. The research title is *The Psychotherapist Sitting With a Patient Who is Experiencing Shame: An Exploration of Shame's Emergence, Subtlety, and Meaning*. If you or any colleague you know is interested in helping explore this subject I would like to be contacted. I would be so pleased if you pass this letter on.

There has been much interest in the subject of shame in the professional literature since 1990, but I want to know what has come to the attention of seasoned therapists in their private sessions. Confidentiality will be conscientiously preserved. The purpose of my study is to explore the actual experience of therapists, whatever their theoretical orientation, as they are encountering the phenomena of shame in the therapeutic session. Specifically, I will be listening to whatever psychotherapists' wish to explore, relate, and reflect upon in his/her professional experiences with shame in session.

I will be conducting one 60-120 minute interview with participants. The place and time will be arranged for the convenience of the participant.

If you, or someone you know, is willing to participate or interested in this research project, I can be contacted by phone (415-378-5973) or by email (paulaholt35@gmail.com. Please put "Research" in the subject box). I will then be in contact about participation in this research.

Please call me at the above telephone number (leave a message) if you have any questions. I am open to comments and inquiries. Thank you in advance for your cooperation and participation.

Sincerely,
Paula Holt, LCSW
Doctoral Candidate, The Sanville Institute, Berkeley, CA

APPENDIX D: INFORMED CONSENT FORM

I, _____hereby willingly consent to participate in a research project, *The Psychotherapist Sitting With a Patient Who is Experiencing Shame: An Exploration of Shame's Emergence, Subtlety, and Meaning.* Paula B. Holt, LCSW, investigator, will conduct this study under the direction of Mary Coombs, Ph.D., Principal Investigator and faculty member at The Sanville Institute. This work is done under the auspices of The Sanville Institute.

I understand the procedures to be as follows:

1. Voluntary, self selected participation in a screening telephone interview of 15 minutes or less, or in person with the Investigator.
2. Voluntary, self-selected participation in a recorded interview of 60-120 minutes in a convenient location with the Investigator.
3. A follow-up call or email requiring not more than 15 minutes after completion of the interview with the Investigator.
4. A voluntary decision on my part to receive, or not to receive, a summary of the research results after completion of the study.
5. When the study is completed, the recordings will be deleted so that they cannot be recovered, and all hard copy will be shredded.
6. If any part of the study is published, my anonymity and the confidential nature of my material will be preserved. Such publication would exclude references to my name, personal identity, or any identifying references in my material.
7. I am aware that I may terminate my participation during the interview or withdraw from the research process at any time I choose up to the time that the dissertation be accepted.

I am aware of the following potential risks and benefits of my participation in the study:

1. I might feel vulnerable, and/or concerned for my clients, speaking on record about the experiences of shame that have occurred in sessions despite the agreed upon safeguards.
2. This material might possibly bring up, in self-reflection, difficult experiences with my clients or of myself that could trigger anxiety, vulnerability, negative self-thoughts, or past traumatic events.
3. Even sometime after the interview, I may have uncomfortable recollections and concerns that could be troubling. I can contact the Investigator to express my uncomfortable recollections or concerns.
4. In reviewing the summary of the research, if I have elected to receive it, I may have questions and concerns that I may need to address with the Investigator. I understand that I may contact her at the contact addresses I have received.
5. There is the possibility of benefit to my practice and professional knowledge base through relating my experiences with shame as I have experienced it in sessions.

6.I will be contributing to the knowledge available to my profession concerning shame and shame as it is found in session.

Provisions to be made in case of emotional discomfort:

1.The Investigator and I will be monitoring my stress level, and I can request a break at any time during the interview or withdraw from the study.
2.My participation is voluntary, and I may withdraw from the study at any time during the interview or after, up until the time the dissertation is accepted, at my own discretion and without an explanation.
3.I can contact the Investigator at the address and telephone numbers provided to me, to express any uncomfortable recollections, questions, or concerns at any time during, or after, the interview. The Investigator can refer me to further help if appropriate.
4.If I have questions or concerns about confidentiality or any part of the protocol, I may contact the Investigator at the address and telephone number provided to me at any time.

I am aware that Paula Branch Holt, LCSW, will make every effort to preserve the confidentiality of my clients and myself. I will receive a follow-up telephone call of no more than 15 minutes within two weeks after completing the interview. My signature below indicates that I have read the above explanation about my participation in this research study, that I understand the procedures involved, and that I voluntarily agree to participate.

Signature: _____

Date: _____

If you would like a summary of the results of this study, please provide your name and address:

Name_____

Address_____

_____

Investigator: Paula B. Holt, MSW, LCSW
office 415.378-5973, vm 415-289-6990, email paulaholt35@gmail.com

APPENDIX E: SEMI-STRUCTURED INTERVIEW GUIDE TO ENABLE DATA COLLECTION

Thank you so much for agreeing to this interview and for being a part of a shame research project. I am interested in hearing your unique experience of the emergence of patient shame in session. I want to understand what it was like for you to discover a patient experiencing shame. Let's begin with your recounting an episode of shame that you witnessed in session. As we move through the story, express yourself however you need to communicate all your thoughts and feelings.

What is it like to sit with an emergence of shame? What do you see and experience that identifies shame? How is your own experience of the patient's shame? What meaning have you discovered in this experience? What have you become aware of through a shame experience, and what do you learn from it or still wonder about. What does the shame experience suggest about its importance to the potential of the therapy? How has your awareness of patient shame developed over your years of practice?

While talking about your recollections of experiences with shame in session, can we explore how you may have experienced:

1. What you see or experience as the shame is emerging?
2. What surprising complexities and mysteries in the experience of shame?
3. Holding and helping a client manage a shame emergence?
4. What have you seen as the impact on therapy?
5. What have you seen of shame through or in a countertransference?
6. What is it like to discover unconscious shame, unacknowledged shame, unrealized shame, or preverbal shame?

APPENDIX F: PROTECTION OF RESEARCH PARTICIPANTS APPROVAL

THE SANVILLE INSTITUTE

PROTECTION OF RESEARCH PARTICIPANTS APPLICATION

(Submitted by candidate to the Institute Office if the Dissertation Committee has determined that the research proposal requires it. Most do.)

Title of Research Project: The Psychotherapist Sitting With a Patient Who is Experiencing Shame: An Exploration of Shame's Emergence, Subtlety and Meaning

Principal Investigator: Mary Coombs, Ph.D.
(print name and degree)

Investigator: Paula B. Holt, MSW
(print name)

I have read the *Guidelines, Ethics, & Standards Governing Participation & Protection of Research Participants* in research projects of this Institute (in Appendix D of the *Student and Faculty Handbook*), and I will comply with their letter and spirit in execution of the enclosed research proposal. In accordance with these standards and my best professional judgment, the participants in this study (check one)

_____ Are not "at risk."

_X_ May be considered to be "at risk," and all proper and prudent precautions will be taken in accordance with the Institute protocols to protect their civil and human rights.

I further agree to report any changes in the procedure and to obtain written approval before making such procedural changes.

Mary Coombs, Ph.D. 8/25/2011
signature of Principal Investigator/date

Paula B Holt, MSW 8-22-2011
signature of Investigator/date

Action by the Committee on the Protection of Research Participants:

Approved ✓ Approved with Modifications _____ Rejected _____

Whitney Ve Nunez, PhD 8/25/2011
Signature of representative of the Committee on the Protection of Research Participants/date

Approved

Whitney Ve Nunez PhD 8/25/11
(signature of Dean & date)

REFERENCES

Basch, M. (1976). The concept of affect: A re-examination. *The Journal of the American Psychoanalytic Association, 24*, 759-778.

Bowlby, J. (1959). Separation anxiety. *International Journal of Psychoanalysis, 41*, 1-25.

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment.* New York, NY: Basic Books.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development.* New York, NY: Basic Books.

Bowlby, J., Ainsworth, M., Boston, M., & Rosenbluth, D. (1956). The effects of mother-child separation: A follow up study. *British Journal of Medical Psychology, 29*, 211-247.

Broucek, F. (1982). Shame and its relationship to early narcissistic development. *International Journal of Psycho-Analysis, 63*, 369-378.

Conger, J. (1988). Jung and Reich: The body as shadow. Berkeley, CA: North Atlantic Books.

Conger, J. (2001). *The body of shame.* The Analytic Somatic Training Institute. Retrieved from http://www.analyticsomatictherapy.com/articles/the-body-of-shame.pdf

Corbin, J., & Strauss, A. (2008). *Basics of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.

Corsini, R. (2002). *The dictionary of psychology.* London, England: Brunner-Routledge.

Courtois, C. (1988). *Healing the incest wound.* New York, NY: Norton.

Crocker, J., & Major, B. (1989). Social stigma and self-esteem: The self-protective properties of stigma. *Psychological Review, 96*(4), 608-630.

Crocker, J., & Park, L. (2004). The costly pursuit of self-esteem. *Psychological Bulletin, 130*(3), 392–414. doi:10.1037/0033-2909.130.3.392

Damasio, A. (1999). *The feeling of what happens: Body and emotion in the making of consciousness.* New York, NY: Harcourt.

Darwin, C. (1872/2009). *The expression of emotions in man and animals.* New York, NY: Penguin Classics.

Decety, J., & Chaminade, T. (2003). When the self represents the other: A new cognitive neuroscience view on psychological identification. *Consciousness and Cognition, 12,* 577–596.

Durkheim, E. (1951). *Suicide, a sociological study* (G. Simpson, Ed., G. Spaulding & G. Simpson, Trans.). New York, NY: Free Press. (Original work published 1897)

Ekman, P. (1991). *Telling lies: Clues to deceit in the marketplace, politics, and marriage.* New York, NY: W. W. Norton.

Ekman, P., & Davidson, J. (1994). Afterword: Can emotions be nonconscious? In P. Ekman, & J. Davidson (Eds.), *The nature of emotion: Fundamental questions* (pp. 298-299). New York, NY: Oxford University Press.

Erikson, E. (1950). *Childhood and society.* New York, NY: Norton.

Fairbairn, W. (1963). Synopsis of an object-relations theory of the personality. *International Journal of Psychoanalysis, 44,* 224-225.

Felluga, D. (2003). Introductory guide to critical theory. Retrieved from http://www.purdue.edu/guidetotheory/psychoanalysis/psychintroframes.html

Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self organization. *Development and Psychopathology,* 9, 679-700.

Fonagy, P., & Target, M. (2005). Bridging the transmission gap: An end to an important mystery of attachment research? *Attachment & Human Development, 7*(3), 333-343.

Frawley-O'Dea, M., & Sarnat, J. (2001). *The supervisory relationship.* New York, NY: Guildford Press.

Freud, S. (1962). Further remarks on the neuro-psychoses of defense. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 13). London, England: Hogarth Press. (Original work published 1894)

Freud, S. (1962). Three essays on the theory of sexuality. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 7). London, England: Hogarth Press. (Original work published 1905)

Freud, S. (1962). Analysis of a phobia in a five year old boy. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 21). London, England: Hogarth Press. (Original work published 1909)

Freud, S. (1962). The ego and the id. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 19). London, England: Hogarth Press. (Original work published 1923)

Freud, S. (1962). Civilization and its discontents. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 21). London, England: Hogarth Press. (Original work published 1930)

Freud, S. (1962). New introductory lectures on psychoanalysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 22). London, England: Hogarth Press. (Original work published 1933)

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Chicago, IL: Aldine.

Goffman, E. (1959). *The presentation of self in everyday life.* Garden City, NY: Doubleday Anchor Books.

Goffman, E. (1961). *Asylums, Essays on the social situation of mental patients and other inmates.* Garden City, NY: Anchor Books.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity.* New York, NY: Simon and Schuster.

Hahn, W. (2000). Shame: Countertransference identifications in individual psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 37*(1), 10-21.

Hahn, W. (2001). The experience of shame in psychotherapy supervision. *Psychotherapy: Theory, Research, Practice, Training, 38*(3), 28-37.

Herman, J. (1997). *Trauma and recovery: The aftermath of violence from domestic abuse to political terror.* New York, NY: Basic Books.

Herman, J. (2007, March 10). Shattered shame states and their repair. The John Bowlby Memorial Lecture. Victims of Violence Program, Department of Psychiatry, Cambridge Health Alliance, Harvard Medical School, Cambridge, MA. http://www.challiance.org/Resource.ashx?sn=VOVShattered20ShameJHerman

Hockenberry, S. (1995). Dyadic violence, shame, and narcissism. *Contemporary Psychoanalysis, 31*, 301-312

Kahn, M. (1972). Introduction. In D. Winnicott, *Holding and interpretation: Fragment of an analysis* (pp. 1-18). New York, NY: Grove Press.

Kalsched, D. (1996). *The inner world of trauma: Archetypal defenses of the personal spirit.* New York, NY: Brunner Routledge.

Karen, R. (1994). *Becoming attached: First relationships and how they shape our capacity to love.* New York, NY: Oxford University Press.

Kernberg, O. (1974). Further contributions to the treatment of narcissistic personalities. *International Journal of Psychoanalysis, 55,* 215-240.

Kempis, T. (c. 1418-1467/1952). *The imitation of Christ* (L. Sherley-Price, Trans.). London, England: Penguin Classics.

Kipfer, B. (Ed.). (1999). *Roget's 21st century thesaurus* (2nd ed.). New York, NY: Dell.

Klein, M. (1948). *The writings of Melanie Klein and other works, 1921-1945* (Vols.1-3). London, England: Karnac.

Kluckhohn, C. (1944). *Navajo witchcraft.* Boston, MA: Beacon Press.

Kohut, H. (1959). Introspection, empathy, and psychoanalysis: An examination of the relationship between mode of observation and theory. *Journal of the American Psychoanalytic Association, 7,* 459-483.

Kohut, H. (1966). Forms and transformations of narcissism. *Journal of the American Psychoanalytic Association, 14,* 243-272.

Kohut, H. (1971). *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorders.* Chicago, IL: University of Chicago Press.

Kohut, H. (1984). *How does analysis cure* (A. Goldberg, Ed.). Chicago. IL: University of Chicago Press.

Kohut, H. (2011). Thoughts on narcissism and narcissistic rage. In P. Ornstein (Ed.). *The search for the self: Selected writings of Heinz Kohut* (pp. 615-658). New York, NY: International Universities. (Original work published 1972)

Kueppenbender, K., Herman, J., Khantzian, E., & Albanese, M. (2008). "Narcotics helped, I thought." Recurrent traumatization and recovery from drug dependence. *Harvard Review of Psychiatry, 16,* 308-317.

Lacan, J. (2001). *Ecrits* (B. Fink, Trans.). New York, NY: Norton. (Original work published 1971)

Lasch, C. (1978). *The culture of narcissism.* New York, NY: Norton.

Lewis, H. (1971). *Shame and guilt in neurosis*. New York, NY: International Universities.

Lewis, H. (1981). Shame and guilt in human nature. In S. Tuttman, C. Kaye, & M. Zimmerman (Eds.), *Object and self: A developmental approach* (pp. 76-92). New York, NY: International Universities.

Lowen, A. (1975). *Bioenergetics: The revolutionary therapy that uses the language of the body to heal the problems of the mind.* New York, NY: Penguin Compass.

Lyons-Ruth, K. (2000). "I sense that you sense that I sense. . .": Sander's recognition process and the specificity of relational moves in the psychotherapeutic setting. *Infant Mental Health Journal, 21*(1-2), 85-98.

Mahler, M., Pine, F., & Bergman, A. (1973). *The psychological birth of the human infant.* New York, NY: Basic Books.

McWilliams, N. (1999). Psychoanalytic case formulation. New York, NY: Guildford.

Mills, R. (2005). Taking stock of the developmental literature on shame. *Developmental Review, 25*, 26-63.

Mishler, E. (1986). *Research interviewing: Context and narrative*. Cambridge, MA: Harvard University Press.

Morrison, A. (1989). Shame: The underside of narcissism. Hillsdale, NJ: Analytic.

Nathanson, D. (Ed.). (1987). *The many faces of shame*. New York, NY: Guildford.

Nathanson, D. (1992a). Introduction. In C. Schneider (Ed.), *Shame, exposure, and privacy* (pp. xiii-xxii). New York, NY: Norton.

Nathanson, D. (1992b). *Shame and pride: Affect, sex, and the birth of the self.* New York, NY: Norton.

Orange, D. (2008). Whose shame is it anyway? Lifeworlds of humiliation and systems of restoration (or "The analyst's shame"). *Contemporary Psychoanalysis, 44,* 83-100.

Partridge, E. (1961). *Origins: A short etymological dictionary of modern English*. New York, NY: Macmillan.

Patton, M. (1990). Qualitative evaluation and research methods. Thousand Oaks, CA: Sage.

Piers, G., & Singer, M. (1953). *Shame and guilt*. New York: Norton.

Pitre, H. (2007). *Dealing with countertransferential shame, A phenomenological study* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 3305711)

Polkinghorne, D. (1987). Phenomenological research methods. In R. Valle & S. Halling (Eds.), *Existential-phenomenological perspectives in psychology* (pp. 41-60). New York, NY: Plenum.

Raknes, O. (1971). *Wilhelm Reich.* New York, NY: Penguin

Reich, W. (1990). *Character analysis*. New York, NY: Farrar Straus and Giroux. (Original work published 1933)

Retzinger, S. (1991). *Violent emotions: Shame and rage in marital quarrels.* Newbury Park, CA: Sage.

Rogoff, B. (2003). *The cultural nature of human development.* New York, NY: Oxford University.

Scheff, T. (1988). Shame and conformity: The deference-emotion system, *American Sociological Review, 53*(3), 395-406

Scheff, T., & Retzinger, S. (2000). Shame as the master emotion of everyday life. *Journal of Mundane Behavior, 1*(3). Retrieved from http://www.mundanebehavior.org/issues/v1n3/scheff-retzinger.htm

Scheff, T., & Retzinger, S. (2001). *Emotions and violence: Shame and rage in destructive conflicts*. Lincoln, NE: iUniverse. (Original work published 1991)

Schneider, C. (1987). A mature sense of shame. In D. Nathanson (Ed.), *The many faces of shame* (pp. 194-213). New York, NY: Guildford.

Schore, A. (1994). *Affect regulation and the origin of the self.* Mahweh, NJ: Erlbaum.

Schore, A. (1997). A century after Freud's project: Is a rapprochement between psychoanalysis and neurobiology at hand? *Journal of the American Psychoanalytic Association, 45*, 841-867.

Schore, A. (2001). Effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*(1-2), 7-66.

Schore, A. (2003a). *Affect dysregulation and disorders of the self.* New York, NY: Norton.

Schore, A. (2003b). *Affect regulation and the repair of the self.* New York, NY: Norton.

Schore, A. (2005). A neuropsychoanalytic viewpoint, Commentary on a paper by Steven H. Knoblauch. *Psychoanalytic Dialogues, 15*(6), 829-854,

Schore, A. (2010). Interview: Allan Schore on Freud's work: It's all in "the right mind." Retrieved from http://simplycharly.squarespace.com/allan-schore-on-freud/

Schore, J., & Schore, A. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. *Clinical Social Work Journal, 36*, 9–20. doi:10.1007/s10615-007-0111-7

Storey, J. (2009). *Cultural theory and popular culture: An introduction* (5th ed.). London, England: Pearson Longman.

Stuewig, J., Tangney, J., Heigel, C., Harty, L., & McCloskey, L. (2010). Shaming, blaming, and maiming: Functional links among the moral emotions, externalization of blame, and aggression. *Journal of Research in Personality, 44*(1), 91-102.

Tangney, J., & Dearing, R. (2002). *Shame and guilt*. New York, NY: Guildford.

Tangney, J., & Fischer, K. (Eds.). (1995). *Self-conscious emotions: The psychology of shame, guilt, embarrassment, and pride.* New York, NY: Guilford.

Tangney, J., Stuewig, J., & Mashek, D. (2007). Moral emotions and moral behavior. *Annual Review of Psychology, 58*, 345-372.

Tomkins, S. (1962). *Affect, imagery, consciousness: Vol. 1. The positive affects*. New York, NY: Springer.

Tomkins, S. (1963). *Affect, imagery, and consciousness: Vol. 2. The negative affects*. New York, NY: Springer.

Van Vliet, K. (2008). Shame and resilience in adulthood: A grounded theory study. *Journal of Counseling Psychology. 55*(2), 233-244

Winnicott, D. (1972). *Holding and interpretation: Fragment of An analysis*. New York, NY: Grove Press.

Wurmser, L. (1972). *The mask of shame*. Baltimore, MD: Johns Hopkins University Press.

Zaretsky, E. (2008). Narcissism, personal life and identity: The place of the 1960s in the history of psychoanalysis. *Psychoanalysis, Culture & Society, 13*, 94-104.

Zaslav, Mark R. (1998). Shame-related states of mind in psychotherapy. *The Journal of Psychotherapy Practice and Research*, *7*, 154-166.