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## WORKING WITH SHAME IN THE THERAPY HOUR: SUMMARY AND INTEGRATION

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It's ironic that it took 40 years from the publication of Helen Block Lewis's (1971) *Shame and Guilt in Neurosis*, in which Lewis laid out the self versus behavior distinction (as described in this volume's Introduction), for a clinicians' "handbook on shame" such as the present one to appear. Lewis was the quintessential scientist-practitioner—a collaborator on Witkin's classic research on field independence/dependence and a psychoanalytically trained clinician (Witkin et al., 1954; Witkin, Lewis, & Weil, 1968). *Shame and Guilt in Neurosis* was at heart a clinically oriented book, examining in detail the dynamics of shame and guilt in a series of clinical case studies. Yet it is in the domain of empirical research that Lewis's book has thus far had its greatest impact. The past 20 years have seen a virtual explosion of empirical research on shame and guilt, the majority of which has been directly or indirectly inspired by Lewis's groundbreaking differentiation between these often confused emotions. Two decades of research by social, personality, and developmental psychologists have confirmed Lewis's basic distinction between shame and guilt and her clinically informed speculations about the dynamics—both intrapersonal and interpersonal—of these distinct emotions. But surprisingly, comparatively little has been written to guide the clinician on how best to recognize, manage, treat,

or capitalize on shame in the therapy hour. In this sense, this edited volume brings Lewis's influence full circle back to the therapy room.

What can master clinicians tell us about the effective management and treatment of shame? As it turns out, plenty. In developing this volume, we purposely sampled a broad range of clinicians in terms of theoretical orientation and clinical population of interest. What strikes us most are the many similarities among the suggested approaches for managing shame in the therapeutic context. In this final chapter, we summarize common themes that emerged across chapters, highlight intriguing and unique insights and treatment suggestions, and outline what we see as important future directions for clinically relevant treatment research.

## COMMON THEMES AND INTRIGUING INSIGHTS

The following paragraphs describe themes and insights that appear across the chapters in this volume.

### **Shame Is Ubiquitous in the Clinical Context**

One common theme emanating from the chapters is that although it is rarely mentioned in standard clinical training texts and articles, shame is ubiquitous in clinical settings. Shame may arise from at least three sources: the client, the therapeutic interaction, and the therapist himself or herself.

First, there is the shame that clients bring into the therapy room, shame born of experiencing psychological and behavioral problems—or symptoms of mental illness—that are a source of stigma and shame born of unsuccessful attempts (often over a period of years) to resolve such problems. Given the vast empirical research linking shame proneness to a range of psychological problems (Harder & Lewis, 1987; Tangney, Wagner, & Gramzow, 1992), it stands to reason that clients entering therapy are likely to be prone to shame from the start.

Second, the therapeutic process is, by its very nature, shame inducing. Clients who have unsuccessfully attempted to resolve problems or symptoms are expected to lay bare their failures and shortcomings before a therapist who is often imagined to be a paragon of psychological health. Greenberg and Iwakabe (Chapter 3) wrote:

Shame operates everywhere in therapy because clients are constantly concerned about what part of their inner experience can be revealed safely and what part must be kept hidden. Clients' struggles with shame may start even before the therapy begins. . . . Seeking help from professionals about personal matters thus can evoke a sense of humiliation.

Herman (Chapter 11), too, observed the following: “Because of the power imbalance between patient and therapist, and because the patient exposes his or her most intimate thoughts and feelings without reciprocity, the individual therapy relationship is to some degree inherently shaming.” Moreover, the process of psychotherapy, especially insight-oriented therapy, encourages an acute focus on self—especially the feared, problematic aspects of self. Not only is the reality of the therapeutic context likely to induce feelings of shame, but clients’ experiences in therapy are often complicated by the process of transference, which elicits feelings typically associated with painful relationships from their past. In their quest for help, clients are apt to import more shame into this already shame-laden situation, and some of this shame may arise from envying the positive qualities (e.g., perceived emotional stability) of the therapist.

Third, as Ladany, Klinger, and Kulp (Chapter 13) and many others noted, the challenge of providing therapy, with all its uncertainty, can engender shame in a therapist who, rather than being a paragon of psychological health, brings to the therapeutic encounter very human limitations and vulnerabilities. In short, shame is apt to be found in all corners of the therapy room.

### **Shame Is Nonetheless Easily Overlooked (or Actively Avoided!)**

Clients rarely spontaneously announce that they are feeling (or have felt) shame. In Western cultures, especially, shame is an emotion rarely discussed outside of academic circles and a few shame-focused methods for treating addiction (e.g., Bradshaw, 1988). Many authors in this volume noted how easily shame is overlooked by both clients and therapists in the therapeutic encounter. Greenberg and Iwakabe cautioned in Chapter 3 that “therapists need to be attuned and responsive to nonverbal as well as verbal indicators of shame-related experience in the session.” To make matters even more complicated, as discussed by Teyber, McClure, and Weathers (Chapter 6), clinically relevant shame is easily disregarded because it is often actively avoided by the client, the therapist, or both. Thus, several master clinicians emphasize that it is important, from the outset, for therapists to be vigilant and probe for client shame. It is incumbent on therapists to be alert for nonverbal or therapy process-type cues of shame lurking beneath the various veneers that clients may present. (The trick, of course, is to probe carefully without inadvertently provoking additional feelings of shame.)

### **How to Recognize Client Shame**

Our master clinicians were remarkably consistent in describing a common set of verbal, nonverbal, and paralinguistic cues that may signal underlying experiences of shame, including physical or emotional withdrawal

(mentioned by Morrison, Chapter 1, among many other authors in this volume), decreased eye contact, slumped or rigid posture (Rizvi et al., Chapter 10), avoidance of “here-and-now” material (Shapiro & Powers, Chapter 5), freezing, stammering, tightened voice, self-deprecating comments that expand into hilarious monologues, and an “infinitesimal flash of irritation” before apology for a missing or incomplete homework assignment (Koerner, Tsai, & Simpson, Chapter 4). Similarly, Greenberg and Iwakabe (Chapter 3) cite downcast eyes, squirming or writhing in the seat, laughter or shrugging off that covers embarrassment, and indications that it is somehow degrading to be in therapy. In addition, as Gilbert (Chapter 14) described, shamed clients “may go blank, show submissive crouched body postures, avoid topics (e.g., talk around topics but not clarify them), become anxious or angry, or point-blank refuse to reveal” relevant clinical material.

Herman (Chapter 11) noted that client shame is frequently disguised by other emotions—most notably anger and rage, but also envy, contempt, and expressions of grandiosity. Such emotions are often prompted by initial feelings of shame, emerging as defensive reactions that serve to cover over the pain of shame. Herman also noted that “the vocabulary of shame is extensive.” Code words for shame include “*ridiculous, foolish, silly, idiotic, stupid, dumb, humiliated, disrespected, helpless, weak, inept, dependent, small, inferior, unworthy, worthless, trivial, shy, vulnerable, uncomfortable, or embarrassed. . .*” Recalling Helen Block Lewis’s clinical observations, Herman further identified paralinguistic cues of underlying shame, including “confusion of thought, hesitation, soft speech, mumbling, silences, stammering, long pauses, rapid speech, or tensely laughed words.” Yet in spite of such varied hints, many instances of client shame are overlooked or ignored by therapists not trained to recognize the many hidden faces of shame.

### **Common Causes of Shame**

Client experiences of shame can arise from events both inside and outside the therapy session. Regarding shame arising from causes and events outside the therapy room, chapters by Rizvi et al. (Chapter 10); by Epstein and Falconier (Chapter 7); and by Brown, Hernandez, and Villarreal (Chapter 15) each advocated that, early in treatment, therapists routinely take a survey of the topics and situations that cause the client shame in the course of day-to-day life (i.e., domain-specific assessment, as discussed in Introduction and later in this section). Clinicians may also find it beneficial to assess clients’ overall tendencies toward shame proneness and guilt proneness (i.e., dispositional shame and guilt), especially because of the differing and often clinically relevant outcomes associated with dispositional shame and guilt. Reviews of instruments for the assessment of dispositional shame and guilt can be found

in Tangney and Dearing (2002) and Robins, Nofhle, and Tracy (2007). For clinicians who are interested in dispositional assessment, we recommend use of the Test of Self-Conscious Affect, Version 3 (TOSCA-3; Tangney, Dearing, Wagner, & Gramzow, 2000), as suggested by Brown and coauthors (Chapter 15) and by Epstein and Falconier (Chapter 7).

Methods for domain-specific assessment are discussed in several of the chapters in this volume. For example, Rizvi and coauthors (Chapter 10) assessed clients' profiles of "shame triggers" using their Shame Inventory, composed of 98 situations or characteristics that might cause people to feel shame, to get an idiographic sense of client's personal areas of shame vulnerability. Brown et al. (Chapter 15) similarly assessed clients' idiographic shame triggers using 12 categories of potentially shame-inducing domains: appearance and body image, money and work, motherhood or fatherhood, family, parenting, mental and physical health (including addiction), sex, aging, religion, speaking out, surviving trauma, and being stereotyped and labeled.

Potter-Efron, in Chapter 9, suggested five sentences that convey different ways in which shame may be experienced: "I am not good," "I am not good enough," "I do not belong," "I am unlovable," and "I should not be." Clients may resonate with one or more of these if the therapist presents them as possible underlying themes (and then connects them with shame). Similarly, Gilbert (Chapter 14) emphasized as central to the shame experience feelings of being alone, disconnected from others, and in need of rescue but with no one there to help.

In addition, Shapiro and Powers (Chapter 5) and Sanftner and Tantillo (Chapter 12) expanded on the idea of the body as a potent source of shame. Shapiro and Powers noted,

Whether it is sexual arousal, flatulence, or the loss of hearing, there is something deeply personal about bodily functions. A primitive vulnerability is awakened by these situations, and a profound threat to one's sense of bodily integrity and personal cohesion can be experienced.

Episodes of body-related shame often lead to a desire to hide or avoid on the part of both clients and therapists. Because avoidance is apt to lead to even greater shame, it is important for therapists to make use of encounters that focus attention to the body—the therapist's or a client's. Shapiro and Powers also point out that client efforts to (apparently shamelessly) reveal or put on display shame-provoking aspects of the body can be seen as a defensive maneuver to disguise more profound and troubling aspects of the self.

Regarding shame arising from the context of treatment itself, Koerner and coauthors (Chapter 4) identified four common classes of shame-inducing clinical material that may help the therapist anticipate when problematic shame responses are apt to occur in therapy: shame related to purpose (e.g.,

feeling ashamed of desires, dreams, fantasies, or sense of purpose), shame related to affect (e.g., regarding specific emotions such as anger or pride or regarding intense emotional experience), shame related to sexual drives and hunger drives, and shame related to interpersonal needs.

As described by Sanftner and Tantillo (Chapter 12) in their discussion of the treatment of eating disorders, some clients secretly wish to be “the perfect patient,” which sets the stage for inevitable failure and attendant shame experiences. In such cases, it may be helpful for the therapist to reassure the client directly that he or she does not want a “perfect client.”

We were surprised to find that only two chapters mentioned money and billing issues as a potential source of shame between clients and therapists (Koerner et al., Chapter 4; and Shapiro & Powers, Chapter 5). Enforcing fee policies (e.g., dealing with cancellations and missed sessions) and addressing late payments can be shame inducing for both client and therapist, whether in the context of individual therapy or (especially) in the context of group therapy. For the therapist, enforcing fee policies—explicitly asking for money—may seem incongruous with the role of therapist as other-oriented, empathic helper; the notion of not only expecting but also requiring money in exchange for caring and concern may be shame inducing. More generally, both therapist and client may share a widespread societal discomfort with owing or being owed money.

### **Shame’s Insidious Impact on the Therapeutic Process**

Many chapters echoed Helen Block Lewis’s observation that shame can wreak havoc on the therapeutic process. Most obviously, to the extent that clients are inclined to hide shameful thoughts, emotions, and behaviors, important material is missing and the therapeutic process is adversely affected (see, e.g., Sanftner & Tantillo, Chapter 12). As Gilbert (Chapter 14) observed, shame can “hinder accurate formulation because clients are inclined to narrate their stories to minimize shame.” Even worse is the shame-based anger and rage that can be directed toward the therapy work and/or the therapist. This dynamic is eloquently demonstrated in a clinical vignette in which a client storms out of an appointment because his therapist arrives for the session a few minutes late (Morrison, Chapter 1). Morrison explained that the incident of the therapist arriving late confirmed the client’s feelings of being small and insignificant. Not only does client shame pose a challenge to the therapy work—so, too, does therapist shame. As Ladany et al. (Chapter 13) noted, “identifying therapist shame, and then working through the therapist’s experience, can be critical given its potential influence on the therapist’s ability to function effectively in clinical contexts.”

## Other Hidden Dangers: The Link Between Shame and Suicide

A major danger of shame-related depression is suicide. In fact, the link between shame and suicide is mentioned specifically in seven chapters—by Potter-Efron (Chapter 9); Rizvi et al. (Chapter 10); Herman (Chapter 11); Gilbert (Chapter 14); Morrison (Chapter 1); Teyber et al. (Chapter 6); and Epstein and Falconier (Chapter 7). As Morrison (Chapter 1) noted, “the relationship of shame to suicide has been grossly underestimated in psychodynamic assessment. . . .” Morrison observed that shame-induced suicide is especially likely when clients feel exposed to public observation and condemnation (e.g., a government official about to be exposed for a scandal) or when clients feel deep despair for their failure to live up to life aspirations and ideals. Under such circumstances, careful assessment of suicide risk is warranted, and efforts to take appropriate action to ensure client safety may be necessary.

Suicidal clients can also elicit shame in the therapist. For example, Gilbert (Chapter 14) described how therapists may experience anticipatory shame when faced with a suicidal client, envisioning the shame of failing as a therapist should the client actually commit suicide and the shame and humiliation of being taken to court for failing to prevent the suicide. He noted that therapists’ anticipation of shame can cloud their professional judgment when dealing with suicidal clients—for example, therapists may take unnecessarily conservative measures, seeking hospital admission even if this is not in the best interest of the client with the aim of avoiding even the remote possibility of being shamed or criticized.

Herman (Chapter 11) described the bidirectional dynamic of shame that can arise between suicidal clients and their therapists when transference reenactments of early childhood experiences take the form of power struggles in which both the patient and the therapist are at risk of humiliation and defeat:

In the extreme case of the suicidal patient who refuses hospitalization, the patient is rendered helpless [i.e., humiliated and shamed] if the therapist hospitalizes her against her will; alternatively, the therapist is helpless [i.e., humiliated and shamed] if he disregards evidence of high risk.” Herman recommends that, in such instances, clinicians explicitly describe the therapeutic dilemma, thus allowing the client to recognize and own both sides of the conflict rather than projecting one side (the role of victim or perpetrator) onto the therapist.

## What to Do: Managing and Treating Client Shame

The master clinicians who contributed to this volume offer a wealth of insights and innovative techniques for managing and treating client shame.

Their ideas are apt to be useful for both beginning and seasoned clinicians. Trained in two quite different clinical programs, on opposite coasts, at different points in time, neither of us (Tangney or Dearing) recalls client shame being a focus of our clinical training (other than questions initiated by Dearing during supervision and coursework as a result of working in the Tangney's shame-focused research lab). We suspect the same is true of many clinicians trained in between us, temporally and geographically. As noted by Brown and coauthors (Chapter 15), few texts on psychotherapy training even mention client shame. Explicit attention to client shame in clinical supervision is equally rare in our experience and that of our colleagues. Yet the foregoing 15 chapters written by experienced, practicing clinicians show remarkable depth and continuity in how they address and transform maladaptive shame.

In an effort to integrate and summarize the authors' many rich observations and suggestions, we found the four domains identified by Greenberg's emotion-focused therapy framework to be a useful organizational scheme. Common themes are described in sections defined by Greenberg's four domains—relational validation, accessing and acknowledging shame, shame regulation, and transformation of shame—followed by a section describing more specific approaches and techniques that we hope will serve as the beginnings of a toolbox for clinicians as they encounter client shame daily.

### *Relational Validation*

The authors were unanimous in emphasizing the importance of developing a supportive, validating, empathic, and affectively attuned relationship. As a sense of safety is established, clients can allow themselves to acknowledge and experience painful feelings of shame. To this end, therapists may find it helpful to state at the outset of treatment that a key goal is to create a safe, collaborative atmosphere in therapy.

Although not explicitly mentioned by our authors, we think the “MI spirit” of motivational interviewing/motivational enhancement therapy (MI/MET) is essentially a shame-reducing approach by virtue of relational validation. In MI/MET, therapists validate and empower clients by working from the client's values (rather than therapist-imposed values, which implicitly suggests there is something wrong with the client's own values and goals). MI/MET therapists also validate (and thereby “de-shame”) clients by emphasizing equality in the relationship (e.g., asking permission to give advice), by eschewing the role of expert, and by providing frequent affirmations.

### *Helping Clients to Access and Acknowledge Shame*

Our clinician–authors were also unanimous in emphasizing the importance of helping clients to recognize and identify shame as a first step in help-



ing clients manage and ultimately resolve or positively transform painful feelings of shame. As both Morrison (Chapter 1) and Greenberg and Iwakabe (Chapter 3) noted, a key to successful treatment is bringing client shame out of hiding and concealment (its natural state). Shapiro and Powers (Chapter 5) further stated,

So, as with any avoidance, that which is most feared most needs to be faced. The most natural response to the experience of shame (i.e., to hide) is the most toxic, whereas the least automatic or natural (i.e., to expose the source of the shame) is the most healing. As the old adage goes, one needs to “let the air get at it.” It is only when shame reaches the light of day that the healing process can begin.

Simply verbalizing shame-inducing events and associated experiences can help reduce the pain of shame. As clients translate into words their preverbal, global shame reaction, they bring to bear a more logical, differentiated thought process that may prompt them to spontaneously reevaluate the global negative self-attributions associated with the experience. In fact, therapists can help clients come to realize that most flaws, setbacks, and transgressions really don’t warrant global feelings of worthlessness or shame.

Efforts to help clients access and acknowledge their underlying feelings of shame can be a tricky business. Greenberg and Iwakabe (Chapter 3) observed that “drawing attention to the shameful experience often only intensifies the impulse to retreat and close down emotionally.” Herman (Chapter 11) underscored the importance of “titrating” shame so that the client will not become overwhelmed, but instead “experiences dignity in the telling”—a process reminiscent of graded exposure. In this regard, it is helpful to reflect and empathize with the client’s discomfort and to normalize the desire to hide. More generally, therapists can help embolden their clients to access and acknowledge painful hidden feelings by normalizing the experience of negative emotions such as shame, guilt, sadness, and anger. Here, too, psychoeducation may be useful in the form of a brief discussion of the functionalist perspective on emotions in lay terms. From this perspective, all emotions evolved for good reason—they are (or were) useful in some contexts but not in others (e.g., Izard, 1977). Shame, in particular, was likely adaptive in more primitive, preverbal, hierarchical societies but is less adaptive than behavior-focused guilt in most modern contexts (Tangney & Salovey, 2010). In the case of shame, normal does not necessarily equate with adaptive.

Therapists need to monitor their own natural tendency to collude with clients in avoiding or prematurely trying to eradicate client shame (Teyber et al., Chapter 6). Potter-Efron (Chapter 9) cautioned that therapists must “accept the client’s shame rather than try to argue it away.” In our rush to “help,” therapists are understandably drawn to try to wipe away clients’

shame—to make them feel better in the moment. (We guess this may be especially true for new therapists in training.) But such well-intentioned efforts are apt to be experienced on some level as invalidating. Therapists need to tolerate, accept, and “hold” clients’ shame in order to provide them with an opportunity to constructively manage and resolve this most unpleasant emotion.

Sometimes clients express anger that serves as a cover for shame. Greenberg and Iwakabe (Chapter 3) suggested that in such instances clients be encouraged to express their reactive anger at being shamed, but interventions should acknowledge such anger as a secondary reaction—a face-saving, coping response—while at the same time highlighting the underlying core experience of shame. For those who are defended by grandiosity and sense of unique specialness (in essence, a reaction formation), Morrison (Chapter 1) suggested that therapists look for cracks in the clients’ defenses to elicit and discuss feelings of underlying shame.

Although painful and fraught with potential pitfalls, the process of helping clients access and acknowledge feelings of shame can be healing in and of itself. Identifying shame in the moment can lead to “an ‘aha!’ experience of recognition and relief that these long-held self-loathing feelings are, perhaps, tolerable and acceptable” (Morrison, Chapter 1). At the same time, it is important to not to encourage clients to unduly persevere on shame. Too much shame is a problem. As Epstein and Falconier (Chapter 7) noted, the goal is not to express shame and persevere but to express shame and resolve it.

Is it necessary to identify shame as such? This is a question we frequently encounter from students and colleagues: Is it necessary to use the term *shame* in session to label such feelings? Our clinician experts’ views on this matter varied widely. Epstein and Falconier (Chapter 7) stated unambiguously that no, it’s not necessary for client or therapist to label shame as *shame*. They can use other, more descriptive terms (e.g., negative self-evaluation and feelings of worthlessness associated with violation of personal standards). In contrast, Rizvi et al. (Chapter 10) suggested that therapy benefits from “direct attention to the shame when it arises, by labeling it as shame and discussing it openly as an obstacle to successful problem-solving efforts.” Brown and coauthors (Chapter 15) were even more adamant that labeling shame as such is essential, stating, “We need to develop the language to talk about shame before we can process our experiences in a meaningful way.” In fact, a substantial portion of the early work in their treatment program is “educational.” They reported that “many clinicians have identified that developing a vocabulary and definition for shame is one of the most transformative components of [the shame resilience] curriculum.”

From our perspective, the use of the term *shame* is a matter of choice depending in part on the needs of a given client and in part on the orientation of the therapist. Some clients may spontaneously offer their own idiosyncratic

descriptions of the shame phenomenon (e.g., “that dark, awful, sinking feeling”). In such cases, Tangney has found it effective to adopt the clients’ personal terminology, with shame work proceeding effectively. Other clients may bristle at the mention of shame, especially shame-prone clients early in treatment. They may benefit initially from alternative, less threatening terms, such as *embarrassment*. We agree, however, that psychoeducation in the emotional realm can be extremely helpful. Expanding clients’ shame-relevant “emotion knowledge” (Denham, 1998) can be a powerful intervention in and of itself, enhancing their ability to reexamine and better regulate the pain of shame. In particular, as discussed below, simply educating clients about the distinction between shame and guilt can result in dramatic positive change.

### *Shame Regulation*

The next task for clients, upon recognizing and acknowledging shame, is learning skills to regulate this often pernicious affective experience. Our authors had many thoughts on how to help clients develop such skills. Some approaches (e.g., Greenberg & Iwakabe, Chapter 3) focused directly on self-soothing or distraction techniques, such as taking a bath or engaging in pleasurable exercise. A number of authors have emphasized meditative practice and self-acceptance, such as that those espoused by acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 1999) and dialectical behavior therapy (DBT; Linehan, 1993). More specifically, both Greenberg and Iwakabe (Chapter 3) and Rizvi and coauthors (Chapter 10) encouraged clients to practice mindful non-judgment. In stepping back and simply observing their thoughts and feelings, clients learn to describe internal and external experiences, “sticking to the facts” rather than engaging in shame-inducing processes of evaluation and judgment. Another key component of acceptance and commitment therapy and DBT, developing tolerance for negative affect, is also advocated (see also Koerner et al., Chapter 4).

We were struck by how many authors identified the development of self-compassion as an especially effective method for regulating shame. Gilbert (Chapter 14), for example, believes that compassion—for the self and for others—is an especially potent antidote for shame. As Gilbert noted, however, because shame-prone (i.e., self-critical) people have had little experience with compassion (from others or toward the self), it is incumbent upon therapists to teach it. A key aim of Gilbert’s compassion focused therapy is to teach clients to become more attentive to and accepting of their feelings and needs. One method for enhancing self-compassion, suggested by Furukawa and Hunt (Chapter 8), is to ask the client to imagine giving advice or comfort to a real or imaginary friend who has a similar shame-inducing problem. Furukawa and Hunt described the advantages of “taking the self” out of the equation, noting

that people are usually much better able to forgive and comfort others than the self.

### *Transformation of Shame*

From Greenberg and Iwakabe's perspective (Chapter 3), the ultimate goal of emotion-focused therapy is to transform problematic emotional experiences into more adaptive, empowering, and meaningful emotions that can then serve as a source of strength, as an internal resource. Our clinician–authors had much to say about ways in which shame can be meaningfully transformed in affective, cognitive, and behavioral terms.

*Cognitive-Affective Transformations.* In our view, the transformation of shame into guilt is one of the most common and effective means of resolving problematic shame, resulting in an enhanced capacity for adaptive moral motivation and behavior. Sometimes all that's needed is to educate clients about the difference between shame and guilt. We have been surprised to find in our clinical work that many clients have not considered the difference between condemning a behavior versus condemning the self. They had not considered the possibility that there might be “good ways” and “bad ways” to feel bad in response to failures and transgressions. People seem to readily understand that it is better to teach a child that he or she did a bad thing than to point a finger and say, “You are a bad kid.” Shame-prone people have a harder time recognizing that during shame experiences, they are essentially pointing the finger at themselves and saying, “You are a bad person.” When this is pointed out and they are given an explicit choice, many spontaneously shift to more adaptive (and less aversive) behavior-focused feelings of guilt.

Some forms of treatment implicitly support the transformation of self-focused shame into behavior-focused guilt. For example, Potter-Efron (Chapter 9) observed that participation in Alcoholics Anonymous can promote such a transformation as members are “encouraged to separate their character flaws from their core selves (Step 4) and to make amends for what they have done wrong during their addictions (Steps 8 and 9),” thus moving from a shame to guilt focus.

From a social cognitive perspective (Maddux & Tangney, 2010), therapists can support the transformation of shame into guilt by encouraging clients to make cognitive reevaluations using key cognitive–behavioral techniques described by, for example, Beck (1983) and Ellis (1962) to challenge internal, stable, and global attributions (i.e., irrational beliefs) that are associated with shame (Tracy & Robins, 2006).

More generally, therapists may find it useful to help clients reexamine cognitions about the nature and degree of self-punishment necessary for violating personal standards by reexamining and modifying perfectionistic stan-

dards (How flexible are they? What are the advantages and disadvantages of living according to such high standards?), by challenging excessive concerns about others' evaluations of the self, and by examining clients' early family experiences concerning shame and expectations.

Potter-Efron (Chapter 9), too, emphasized cognitive–behavioral techniques such as “exploring the exceptions,” (e.g., in response to “I’m a failure” or “I’m not good enough,” acknowledging “Well, I did win an athletic scholarship to the university”). In response to “I’m not good enough,” therapists can ask, “As compared with whom? Some idealized self? An idealized parent, peer, or recovering addict? An idealized version of the self conjured up by a parent or significant other?” We believe it is often extraordinarily useful to guide clients in a reexamination of the advantages and disadvantages of seeking to become a “perfect person.” In addition to underscoring the impossibility of achieving such a goal, it is helpful to appeal to the client’s rationality and good sense, discussing the fact that there’s a point of seriously diminishing returns: The effort required to go from an A to an A+—or from a really, really good person to a perfect person—is enormous (and, quite probably, impossible). One could better use that time and energy to earn three other As—to become really, really good along three other valued dimensions as a person. Not infrequently, clients idealize the therapist himself or herself. Thus, it can be therapeutic for clinicians to allow clients to see therapists as real human beings who have their own frailties and shortcomings. (See the section later in this chapter on the value of therapists acknowledging their own shame.) For some people, addressing spirituality and self-forgiveness (e.g., using symbolic rituals as discussed by Furukawa and Hunt, Chapter 8) in therapy can be a useful tool for moving in a positive direction of personal growth.

When working with clients, Rizvi et al. (Chapter 10) find it useful to explicitly distinguish between justified versus unjustified shame. Rizvi et al. defined *justified shame* as a reaction to behavior that would lead to rejection from important others. Also relevant, we believe, are the answers to questions such as Did you really do it? Did you mean to do it? Is it contrary to your own personal values and code of ethics? Rizvi et al. described strategies for addressing justified shame, including apologizing and repairing the damage, committing to and implementing an effective plan to solve the problem (e.g., anger management therapy), and accepting consequences. Each of these strategies for justified shame involves an emphasis on a shift toward guilt rather than shame-related responses.

In what scenarios is it inappropriate to frame the therapeutic goal as one of shifting from shame to guilt? As emphasized by Rivzi et al., it is important to determine if there’s a rational basis for shame or guilt—that is, to collaboratively determine whether the client actually is responsible for the shame-eliciting (or guilt-eliciting) event(s). If so, many of the suggestions provided

by our authors on cognitively restructuring shame into guilt would be relevant. In cases of justified guilt, the focus can be on reparation (e.g., apology, resolution to do things differently in the future). But in other cases, clients experience shame owing to misplaced responsibility—for example, when someone feels shame for being a victim of physical or sexual abuse or simply for not living up to a significant other's expectations that are at odds with one's own values. What is the therapeutic goal when shame or guilt is an inappropriate response? In our view, when clients feel shame irrationally for some outcome over which they had no responsibility, it is useful to encourage clients to reassess attributions of culpability. Cognitive-behavioral techniques informed by concepts from attribution theory can help guide such interventions. Further guidance is offered within several of the foregoing chapters (e.g., Rizvi et al., Chapter 10; Greenberg & Iwakabe, Chapter 3).

Greenberg and Iwakabe (Chapter 3), for example, noted that survivors of maltreatment and abuse are especially apt to become shame prone, often feeling somehow responsible for the abuse. In such cases, it may be especially healing to help survivors appropriately externalize the blame back onto the abuser—"putting the blame where it belongs," to coin Greenberg and Iwakabe's (Chapter 3) phrase. With this deserved shift in blame often come empowered anger and pride as the client constructs new meaning for long-standing wounds. As Greenberg and Iwakabe observed,

Sadness or anger can be fundamentally growth producing in that they point to adaptive actions appropriate to the situation. For example, sadness can lead to reaching out to connect to others, or anger can lead to asserting one's right to live one's own life without shame.

Here, too, it is important to distinguish adaptive, empowering anger from maladaptive rage born of narcissistic slights and reactions to humiliation. "Maladaptive rage is overly intense, chronic, destructive, and/or inappropriate and is often in reaction to minor insults or failure experiences. . . . The focus of such work is on asserting the self rather than destroying the other" (Greenberg & Iwakabe, Chapter 3).

*Modifying Behavior to Transform Shame.* A unique approach to treating shame endorsed by Rizvi et al. (Chapter 10) centers on the concept of "opposite action," a technique derived from DBT (Linehan, 1993). The notion is to encourage actions that are incompatible with urges that arise from the client's unwanted emotion. In the case of shame, therapists may encourage clients to behave "as if" they are not ashamed, to approach rather than hide, to hold one's head high rather than shrink, to proclaim one's worth rather than communicating shame. The effectiveness of opposite action derives from cognitive dissonance. As Rizvi et al. noted, countless cognitive dissonance studies have shown that "getting people to act contrary to their attitudes (when they

believe they have freely chosen to do so) is a powerful way to change beliefs and attitudes, including low self-esteem.”

Koerner et al. (Chapter 4), too, advocated an action-oriented approach to the treatment of shame. Functional analytic therapists endeavor to create conditions that help clients learn to respond with skill and flexibility to situations that evoke problematic shame—even while feeling intense shame. To this end, therapy often focuses on practical skills (e.g., organization, public speaking) to help clients remedy skills deficits and/or develop new skills and abilities.

### **More Approaches and Techniques: Expanding the Clinician’s Shame-Focused Toolbox**

Our master clinicians offered a number of approaches and techniques that may expand the toolbox of clinicians working with clients who are troubled by maladaptive shame. Among these approaches and techniques are recording of sessions, two-chair dialogue, interpersonal coping, group therapy, and therapists acknowledging their own shame.

#### *Recording Sessions*

One of the most intriguing approaches, suggested independently in two chapters, is the notion of audio- or videotaping sessions so that both client and therapist are able to catch “lightning fast” shame episodes and subject them to more careful scrutiny and analysis (Koerner et al., Chapter 4; Teyber et al., Chapter 6). Episodes of shame are apt to erupt unbidden and unexpectedly. The intricate dynamics of shame intertwined with anger, deflection, and defense can play out within seconds, unnoticed and unprocessed by both clients and therapists in the moment. To make matters worse, while in the midst of a shame experience, clients are apt to be temporarily cognitively impaired—overwhelmed and absent a cool head—and unable to coolly process the emotionally laden and complex shame-provoked processes occurring at both the intrapersonal and interpersonal levels (Lewis, 1971). As Stadter (Chapter 2) noted, when clients are in the midst of a shame experience, “they may be too disrupted to be able to process it.” With the benefit of time to recover and some emotional distance, clients and therapists may be better placed to objectively observe and explore shame-induced behaviors and shame-inducing interactions. Stadter suggested that it may be necessary to revisit such interactions in a subsequent session. Audio- or videotaped records of these subtle but powerful shame triggers and their ensuing effects can be an invaluable tool in this regard. Recordings offer clients (and therapists) a second chance to observe and process such events from a more objective perspective at a time when they are more cognitively able.

### *Two-Chair Dialogue*

Greenberg and Iwakabe (Chapter 3) identified two-chair dialogue as the intervention of choice for clients mired in self-criticism. By encouraging clients to take on the dual roles of condemner and condemned, therapists can help them in capturing

the expressive quality of contempt, specifying the shame-producing cognitions, heightening awareness of agency in the shame-producing process, and countering shame by supporting the emergence of the healthy part of self with feelings of pride. An example of the contempt expressed from the Critic's chair (i.e., the self's critical voice) might be "You're pathetic," and this will evoke shame expressed from the other aspect of self: "I feel so worthless, like curling up into a ball and hiding." In this dialogue people come to see that by denigrating themselves, they are agents in the production of their experience of shame and that they can change how they relate to themselves. People resolve this split as more adaptive feelings such as anger and sadness and later more self-assertion such as "Leave me alone; stop attacking me like that" evolve to counteract the shame. Resolution of the split is seen when the Critic softens into compassion, saying, "I don't want to make you suffer; I do care about you." An integration of the two aspects can then occur, resulting in self-acceptance and a stronger sense of self.

A key insight gained from such two-chair dialogues is that current shame-producing messages are internally generated by the client and therefore amenable to change.

### *Interpersonal Coping*

Although this was implicit in many chapters, Epstein and Falconier (Chapter 7) focused most explicitly on the process of recovering from an experience of shame in-the-moment. Like others, Epstein and Falconier emphasized the importance of sufficient self-awareness so clients can identify their own shame experience. Once recognized, clients have open two major pathways toward managing and resolving the pain of shame: (a) individual coping (e.g., cognitive restructuring or reframing, self-soothing) and (b) reassuring interactions with a partner (or significant other). The latter interpersonal pathway is not much discussed in other chapters, but we imagine it is a strategy that is more common than recognized in well-functioning individuals. Fighting the natural urge to hide, resilient people may be especially adept at seeking out social support from safe others—a supportive spouse, a close friend, a trusted colleague. Epstein and Falconier emphasized that to effectively use the social support pathway, the shamed individual must be aware of the shame experience and willing to share that information "clearly and constructively" with the significant



other. One of the key elements of Brown's shame resilience curriculum (Brown, 2009; Brown et al., Chapter 15) is teaching clients to "speak shame." Specifically, within the context of the therapy group, clients are taught to become more comfortable sharing their shame experiences. Eventually, group participants are encouraged to identify others outside of the group with whom it is safe to talk about occurrences of shame.

For less resilient individuals, the very act of seeking professional help and of struggling to explore shame is a hopeful and important first step toward developing effective interpersonal methods of coping with and alleviating shame. Daring to share one's shame and experiencing its transformation into something more useful in a reassuring therapeutic relationship can then serve as a template from which to generalize. Therapists can explicitly encourage clients to reach out for interpersonal support when experiencing shame in the course of daily life; such behaviors can be reinforced by shame-alleviating client-therapist encounters.

In the context of couples or family therapy, therapist and client can explicitly recruit a partner or other family member more directly to serve as an ally in helping correct unrealistic standards and other shame-inducing cognitions in the course of real life, outside of session. In cases in which partners or family members tend to be less constructive and more inclined to induce client shame, therapists can directly coach such significant others to reexamine beliefs about the advantages of punitiveness. Do people who behave badly deserve to be reminded of it? Do they deserve to be made to feel awful, to be severely punished? Such shame-inducing significant others can be directly coached to express concerns and dissatisfaction in a more constructive way (e.g., requesting a positive change in behavior rather than denigrating the client as a person). In coaching partners or other family members, Potter-Efron's (Chapter 9) Five As of positive interactions may be especially useful:

- Attention: I have time for you.
- Approval: I like what you do.
- Acceptance: It's OK for you to be you.
- Admiration: I can learn from you.
- Affirmation: I celebrate your existence.

In fact, these Five As can be used more generally to coach families, couples, parents, teachers, and even beginning therapists in concrete ways to affirm, not shame, individuals.

### *Group Therapy*

Group treatment is rife with additional sources of shame beyond the many operating in the context of individual therapy. But when facilitated by

a clinician who is sensitive to shame issues, group therapy can be a powerful context for resolving shame-based concerns. In fact, the authors of four chapters (Brown et al., Chapter 15; Herman, Chapter 11; Furukawa & Hunt, Chapter 8; and Shapiro & Powers, Chapter 5) independently suggested that if it is well managed, group therapy can be the optimal environment for treating shame.

First, group therapy can be helpful in normalizing shame experiences by showing that others are facing similar issues (Furukawa & Hunt, Chapter 8). As Shapiro and Powers (Chapter 5) noted, “Universality . . . can mitigate the feeling of aloneness and individual corruptness that often accompanies shame.” Second, even when a group member may not yet be ready to face his or her own feelings of shame directly, the experience of seeing another, less defended member process his or her own shame can help desensitize the reluctant client and provide an indirect learning experience. Third, because of the shame-inducing power imbalance inherent between client and therapist, Herman (Chapter 11) suggested that group psychotherapy may be especially useful for traumatized (and other shame-prone) clients. In group therapy, many clinical interventions come from directly from peers.

#### *Therapists Acknowledging Their Own Shame*

A number of chapters explicitly discussed the power of therapists acknowledging their own shame experiences (e.g., Herman, Chapter 11; Morrison, Chapter 1; Koerner et al., Chapter 4; Potter-Efron, Chapter 9; see also Sanftner and Tantillo’s discussion in Chapter 12 of the utility of supervisors sharing their own shame experiences). As Potter-Efron (Chapter 9) noted, “Clients need to see that their counselors are human.” The notion that it is normal and potentially useful for therapists to experience shame is apt to be reassuring to beginning therapists who fear not being adequate enough. But this raises the sticky issue of how much personal material to reveal and how to do so while still maintaining appropriate boundaries. On this point, Koerner et al. (Chapter 4) offered the following:

There are times when disclosing to clients one’s own thoughts, reactions, and personal experiences regarding shame is helpful to the therapeutic process. A major factor to take into account in making a decision to disclose is whether such disclosure will facilitate clients having greater contact with their shame issues or whether it will take them away from their own focus. . . . Disclosures should be titrated to what the client can handle and should almost always include a discussion of how the client is reacting to the disclosure and why the disclosure was offered.

Supervision can be invaluable for helping to determine when and how much to self-disclose without weakening appropriate client–therapist boundaries.

## Ways Therapists Inadvertently Shame Clients (and What to Do About It)

Despite their very best intentions, therapists can inadvertently induce feelings of shame in the very clients they seek to help. Stadter (Chapter 2) discussed several ways in which clients may feel “objectified,” and thus shamed, by well-meaning therapists. Therapists can unintentionally shame clients by focusing on or reifying a psychiatric diagnosis. Clients may end up feeling that the therapist sees them not as a person but “objectified” as a diagnostic category. Clients are also apt to feel neglected and “not really seen” when therapists use a one-size-fits-all “cookbook” approach to treatment. Or they may feel objectified “as merely the therapist’s 3 p.m. Monday appointment.” (Morrison, in Chapter 1, provided a moving case example of the shame that can arise from such a perception.) To avoid the shame of objectification, Stadter recommended that diagnoses, interventions, and even scheduling of appointments should be done “in a manner that promotes collaboration rather than a situation” totally driven by the “expert therapist.”

In addition, Stadter (Chapter 2) cautioned that clients are apt to feel neglected, “not really seen,” and thus shamed when interpretations are delivered with certainty and are off the mark. Even well-conceived interpretations can be experienced as shaming. Clients may experience the process of interpretation as intrusive, omniscient, and uncovering and as an attack on one’s intrapsychic privacy. Moreover, a therapist’s interpretation may be seen as implying inadequacy and a lack of insight on the part of the client. Stadter recommended that interpretations be

presented in a style conveying lack of certainty but also an invitation to explore . . . (e.g., “I’m not sure of this, but I had a sense that your daughter’s comment hurt you more than you might have thought. Is there anything to that impression of mine?”).

When therapists shame clients, it’s not simply an error; it’s a golden opportunity to process and resolve shame. As Greenberg and Iwakabe (Chapter 3) pointed out, healing such shame-induced ruptures in the client–therapist relationship can be highly therapeutic. A therapist’s unwitting error presents an opportunity for a valuable corrective experience, one that may be generalized to similar shame-inducing misunderstandings outside of the therapy room.

### Sensitivity to Cultural Factors

Furukawa and Hunt (Chapter 8) advised that when working with clients from different cultures, backgrounds, or ethnicities, therapists engage in “an ongoing questioning of our assumptions about other cultures and our own

reactions to them. It requires therapists to be humble.” Perhaps more than any other emotion, culture colors how, when, and why shame is experienced and expressed, thus further complicating an already complicated picture.

As noted by Greenberg and Iwakabe (Chapter 3), in collectivist cultures that emphasize group harmony, social hierarchy, and interdependence, expressions of shame or embarrassment may be used for instrumental purposes—to convey submission or to smooth over social interactions in order to maintain group harmony and to preserve culturally defined hierarchical roles: “Being humble and acting with reserve are considered virtuous and respectful.” Furukawa and Hunt (Chapter 8) suggested being sensitive to such practices by looking to the client for cues regarding direct eye contact, direct questioning, handshakes, and power relations within families.

One implication of such instrumental uses of shame is that Western therapists should guard against overinterpreting initial expressions of shame and embarrassment as necessarily maladaptive or problematic. Alternatively, although some shame may be normative, this is not to suggest that clients from collectivistic cultures are immune to problems with shame (or that their experiences of shame are necessarily adaptive). In fact, Greenberg and Iwakabe (Chapter 3) pointed out that shame plays a prominent role in a variety of mental health problems among individuals from Asian collectivist cultures. They cited, as an example, a class of phobic disorders associated with fear of being publicly shamed. No one, it seems, is immune to maladaptive shame!

Greenberg and Iwakabe (Chapter 3) encouraged therapists working with clients from collectivist cultures to make sure clients understand the rationale for accessing, tolerating, expressing, and understanding shame and other related emotions in therapy: “In particular, they need to know that expression of negative emotions in front of the therapist is not only allowed but also is essential to therapeutic work.” Culturally prescribed “display rules” may dictate that negative emotions such as anger and sadness (and the positive emotion of pride) be inhibited. Clients from such backgrounds may benefit from special permission or invitation to experience and express emotions in the context of therapy (and perhaps in their everyday life).

Furukawa and Hunt (Chapter 8) identified numerous sources of shame that may be overlooked by therapists working with immigrant and refugee clients from culturally diverse backgrounds. Although stigma associated with mental illness persists in the United States, such stigma is more pronounced in many other cultures. Clients from such cultures may feel deeply shamed simply for seeking help for mental health issues. Furukawa and Hunt recommended that, early in treatment, it may be helpful to emphasize how common and acceptable it is in the United States to seek help from psychologists and other mental health professionals.

Clients' shame may be further compounded by difficulty speaking English and by language barriers more generally. Furukawa and Hunt recommended that in such instances, the therapist reassure clients that English is difficult to learn and acknowledge the therapist's own shortcoming in not knowing clients' native language. To further reduce feelings of incompetence and shame, Furukawa and Hunt suggested that therapists request forgiveness when asking clients to repeat themselves and show a willingness to work hard together toward effective communication.

It is useful to bear in mind that when immigrants and refugees seek professional help, the presenting problem is often a more immediate survival issue (e.g., financial problems, children's school-related issues, need for shelter) than a psychological concern:

Practical survival problems may be associated with feelings of incompetence, worthlessness, and shame and cannot be ignored. The challenge for the therapist is to deal with these external but serious case management problems that clients face while being aware of and addressing underlying psychological issues. (Furukawa & Hunt, Chapter 8)

An intriguing approach suggested by Furukawa and Hunt to ease the burden of shame is the use of culturally relevant rituals. They cited, as an example, sweeping rituals common in many cultures of Central and South America that can be drawn upon to help clients resolve shame related to past traumatic events. Alternatively, intense shame and guilt associated with deceased loved ones can be alleviated through traditional mourning rituals, as described by Furukawa and Hunt. With an open mind and a sincere effort to understand the nuances of the client's cultural background, therapists can creatively adapt treatment strategies to help clients regulate and transform difficult experiences of shame.

### **Therapists Experience Shame, Too**

Shame is not solely the domain of clients. Therapists experience shame, too. As both Morrison (Chapter 1) and Herman (Chapter 11) independently observed, shame is contagious—therapists can catch it from their clients. Herman emphasized the bidirectional dynamic of shame in the therapeutic relationship. Shame-prone clients are apt to inadvertently shame therapists (projecting their own shame onto the therapist), and (as noted earlier) therapists can inadvertently shame clients. Stadter (Chapter 2), too, observed that therapists are vulnerable to shaming and being shamed by clients. The former is especially problematic in that it is so inconsistent with the ideal therapist role of empathic, caring helper.

In fact, as discussed by Sanftner and Tantillo (Chapter 12) and by Ladany and coauthors (Chapter 13), therapists often struggle with fears about adequacy and competence. This may be especially the case for therapists in training, who are apt to “worry whether they are doing things correctly, understanding the client sensitively, formulating accurately, and intervening appropriately. Shame may be a major reason that important material is not disclosed during supervision” (Gilbert, Chapter 14). But even seasoned therapists are not immune. Chapters by Morrison (Chapter 1) and by Koerner et al. (Chapter 4) identified numerous sources of therapist shame, including identification with a client whose shame issues are similar to those of the therapist, mistakes made in session, unsuccessful treatment outcomes, and unfavorable comparisons with colleagues, to name a few. Moreover, because shame is incongruous with the role of therapist, we think that mental health workers may be further vulnerable to the double whammy of “metashame”—feeling ashamed of being ashamed!

Group therapists may be especially vulnerable to being shamed in the therapy hour because group members may be emboldened by numbers. Shapiro and Powers (Chapter 5) observed that group therapy members not infrequently disparage and devalue the group leader. Disparagement of the leader may represent an effort to distract the group from more difficult material, or it may arise from projections of unacceptable parts of the self. Regardless, such encounters should be anticipated, and group leaders need to have a pretty hardy level of professional esteem to weather the shame that these attacks are apt to induce.

Shapiro and Powers also remarked that therapists are at times devalued (shamed) by other professionals. They noted that in the “pecking order” of the mental health professions, group therapy has been perceived for many years as occupying a lower position despite empirical evidence supporting the efficacy of group therapy. Morrison (Chapter 1), too, referred to one-upmanship in the institutional hierarchy as a source of therapist shame.

The impact of therapist shame on the therapy process can be dramatic. Koerner et al. (Chapter 4) cited shame as the potential culprit when therapists avoid dealing with problematic client behaviors (e.g., chronic lateness, not paying therapy bills) and when they do not observe limits and boundaries (e.g., answering client phone calls late at night). Koerner et al. advocated supervision in such instances, asserting that “seeking consultation from a trusted colleague when one’s own shame issues interfere with treatment is both courageous and ethical.”

Numerous authors in this volume stressed the importance of therapists being aware of areas of vulnerability, recognizing (and managing) shame quickly when it arises in session, and dealing with shame issues and shame vulnerability in the therapists’ own personal therapy. Similarly, Brown et al.

(Chapter 15) advocated that therapists “do their own shame resilience work before they can ethically and effectively do shame work with clients . . . ‘we need to do the work before we do the work. . . .’”

### **Importance of Supervision**

In addition to personal therapy, supervision is an ideal setting in which to “do the work.” Our guess, however, is that most supervision, as currently practiced, does not address shame—either on the part of clients or on the part of supervised therapists. Tangney, for example, has had some outstanding supervisors over the years, yet she cannot recall a single instance in which client shame or her own shame was broached in supervision. (In retrospect, she certainly can recall multiple instances of shame—both client and therapist shame—in the therapy room!)

Because shame can be profoundly unsettling and, at the same time, hidden or disguised, Shapiro and Powers (Chapter 5) strongly advised professional or peer supervision when shame issues arise. They noted that supervision is invaluable not just in instances of already perceived shame experiences but also when therapists find themselves feeling confused, stymied, or ineffective: “It is useful to suspect shame as the culprit and valuable to allow another set of eyes to ferret out the potential manifestations of shame and the defenses aroused in response to its presence” (Shapiro & Powers, Chapter 5).

Ladany et al. (Chapter 13) advocated that supervisors adopt a collaborative approach from the outset, negotiating the goals of supervision and the manner in which things will be discussed. For supervisee shame experiences to be fully understood, the supervisor must facilitate exploration, deepening the supervisee’s understanding of his or her reactions and exploring possible links to previous shame events in the supervisee’s life (i.e., countertransference). Because shame events are apt to affect the therapist’s sense of professional self, efforts are needed to reinforce or rebuild the supervisee’s self-efficacy. It is also helpful to normalize the supervisee’s experience, underscoring that therapists are human and that mistakes, even significant ones, are bound to happen.

Sanftner and Tantillo (Chapter 12) observed that because supervisees have less power in the supervisory relationship (and less experience), they are especially vulnerable to shame. Supervisors can enhance effectiveness by “[reframing] vulnerability to emphasize nonjudgmental awareness, curiosity, and self-empathy” and by presenting “uncertainty and vulnerability as opportunities for growth.” There is also use in reexamining perfectionistic and unrealistic images of what a therapist should be. By encouraging novice therapists to abandon perfectionistic standards and by helping them develop self-compassion, episodes of shame can be viewed as a unique opportunity for non-judgmental inquiry and professional growth.

Finally, we think it is useful to consider clinicians' irritation with clients (or subtle denigration when talking about clients during supervision) as a possible sign of therapist shame. Research consistently shows a link between shame and hostility or anger (for reviews, see Tangney & Dearing, 2002; Tangney, Stuewig, & Mashek, 2007). On occasion, therapists find themselves irritated or annoyed with clients—an inevitable, if occasional, human response to the difficult work of helping others who do not always respond immediately to treatment efforts. When a therapist finds himself or herself feeling uncharacteristically aggravated, exasperated, or even scornful toward a difficult client, the possibility of unrecognized shame should be considered, and peer or professional supervision can be invaluable.

### **Is Shame Ever Adaptive?**

In line with empirical research (for reviews, see Tangney & Dearing, 2002; Tangney et al., 2007), clinicians' sense of the psychological and social implications of shame is grim. Shame is uniformly portrayed in the chapters in this volume as the root of multiple forms of psychopathology and as the source of disruptions to the psychotherapeutic process. The question arises: Is shame ever adaptive? Why in the world do humans have the culturally universal capacity to experience this painful, often devastating emotion?

Contributing clinician–authors were mixed in this regard. Epstein and Falconier (Chapter 7) believed that mild to moderate (but not intense) shame can motivate people to make positive changes. The theory underlying emotion-focused therapy (Greenberg & Iwakabe, Chapter 3) explicitly acknowledges an adaptive form of shame. *Primary adaptive shame* is conceptualized as a direct, initial, rapid reaction to a situation. Similar to the functions of self-esteem in Leary's (2005) sociometer theory, shame can serve as a source of adaptive information, informing us that we are too exposed and that other people will not support our actions. From an emotion-focused therapy perspective, shame can inform us that we have violated important standards or values. Moreover, displays of shame can function to reduce the likelihood of others' retaliatory aggression, evoking instead affiliative responses, such as sympathy and forgiveness from others (Greenberg & Iwakabe, Chapter 3; Gilbert, Chapter 14).

More broadly, Koerner et al. (Chapter 4) posited that access to vital resources depends on membership in groups and on one's rank within the group. Feelings of shame aid us by alerting us when our behavior is apt to result in a demotion in status or exclusion from the group. It prompts us (sharply) to inhibit offending behaviors and to strive to correct them. Shame signals us to shift behavior in order to reduce the threat of rejection.

In contrast, Morrison's (Chapter 1) answer to the question "In what ways can shame be adaptive?" is unambiguous: None. Morrison wrote, "I find it dif-



difficult to find any redeeming qualities in shame per se, in contrast with the clear benefits of self-awareness. Rather, I believe that what can be useful about shame lies only in its resolution.”

From our perspective, shame is a relatively primitive emotion that served adaptive “appeasement” functions in the distant past among ancestors whose cognitive processes were less sophisticated and in the context of much simpler societies. This sociobiological approach taken by Gilbert (1997) and others (de Waal, 1996; Fessler, 2007; Keltner, 1995; Leary, Britt, Cutlip, & Templeton, 1992; Leary, Landel & Patton, 1996) emphasizes the appeasement functions of shame that reaffirm the relative rank in a dominance hierarchy and minimize harmful intragroup aggression. In short, shame evolved as an important damage limitation strategy in contexts in which the likelihood of aggression was high and the consequences often life threatening.

Humankind, however, has evolved not only in terms of physical characteristics but also in terms of emotional, cognitive, and social complexity. With increasingly complex perspective-taking and attributional abilities, modern human beings have the capacity to distinguish between self and behavior, to take another person’s perspective, and to empathize with others’ distress. Whereas early moral goals centered on reducing potentially lethal aggression, clarifying social rank, and enhancing conformity to social norms, modern morality centers on the ability to acknowledge one’s wrongdoing, accept responsibility, and take reparative action (Tangney & Salovey, 2010). In this sense, guilt is today the moral emotion of choice.

#### EMPIRICALLY SUPPORTED TREATMENTS TARGETING SHAME: STATE OF THE FIELD AND FUTURE DIRECTIONS

No doubt about it: Shame is ubiquitous in the therapy room. Clients frequently present with shame-related issues. The process of therapy often provokes experiences of shame. And therapists are by no means immune to the dark pain of shame.

This volume represents a first compendium of master clinicians’ approaches and techniques for addressing shame in the context of mental health treatment. The vast majority of contributors work from theoretical perspectives that do not explicitly consider shame as a focus of treatment. Yet whether cognitive-behavioral, psychodynamic, or humanistic in orientation, these clinicians had much to say about managing and treating shame in the therapy hour.

At present, there exist only a few explicitly shame-focused therapies: Gilbert’s compassion focused therapy (Chapter 14), Rizvi et al.’s shame-enhanced DBT for the treatment of borderline personality disorder

(Chapter 10), and Brown's Connections curriculum for shame resilience (Chapter 15). In addition, Greenberg and colleagues' emotion-focused therapy addresses shame as one of several emotions of particular clinical relevance (Chapter 3).

The field is in its infancy in terms of empirical validation of shame-focused therapies. In a pilot study of five women with BPD, Rizvi and Linehan (2005) evaluated an 8- to 10-week manualized shame-enhanced DBT, a cognitive-behavioral intervention based on an expansion of the DBT principle of opposite action (Linehan, 1993) for shame. Results indicated that the intervention reduced shame about a specific event for some of the clients. An unanticipated but clinically significant finding was the high level of client motivation, as indicated by the absence of treatment dropouts and unplanned missed sessions and by the high compliance with homework assignments—both unusual in the treatment of individuals with BPD. As noted by Rizvi et al. (Chapter 10), the sample size was small; future research is needed on a larger scale to replicate the promising findings.

Several nonexperimental evaluations have been conducted on Gilbert's (2010) compassion focused therapy with promising results. In a small study of people with chronic mental health problems, compassion training was associated with reduced shame, self-criticism, depression, and anxiety (Gilbert & Procter, 2006). Compassion training appears helpful for people who hear psychotic voices (Mayhew & Gilbert, 2008). And group-based CFT with 19 clients in a high-security psychiatric setting was associated with decreases in shame, depression, and general psychopathology and increases in self-esteem (Laithwaite et al., 2009).

Brown's (2009) Connections, a psychoeducational shame resilience curriculum, has yet to be empirically evaluated, but it is manualized and ready for empirical study.

Together, these shame-focused therapies break important new ground. We hope that in the coming years, the many rich ideas presented in this volume will provide the basis for additional treatment development in this important but long-neglected area. What's needed next is much more scientifically informed outcome research using randomized experimental designs to clearly document treatment the efficacy and effectiveness of shame-focused interventions. Once efficacy has been demonstrated, efforts to "decompose" treatments to identify their most "active ingredients" will further our understanding of optimal strategies for managing and treating maladaptive shame.

Research indicates that the propensity to experience shame is associated with a broad range of psychological disorders (for reviews, see Tangney & Dearing, 2002; Tangney et al., 2007). It may be necessary to develop shame-focused interventions tailored to the specific needs of particular disorders and/or populations. Rizvi and Linehan's (2005) shame-enhanced DBT for the treatment of

borderline personality disorder may serve as a model for other disorder-specific treatment approaches. We can imagine the utility of shame-focused treatment for individuals suffering from eating disorders, from depression, from post-traumatic stress disorder, from social anxiety, from sexual dysfunction, and from substance use disorders, to name but a few. As Rizvi et al. (Chapter 10) observed, “The treatment of maladaptive shame has been largely overlooked in treatment models and manuals across all disorders.”

Classes of clients not addressed in this volume include those who present with conduct disorder, antisocial personality disorder, and psychopathy. Virtually no research has been conducted on shame among children with conduct disorder to guide clinicians who work with such difficult clients, and systematic research on the dynamics of shame in adult antisocial personality is in its infancy. In our own research with adult felony offenders (Tangney, Mashek, & Stuewig, 2007), we have begun to explore the moral affective characteristics associated with antisocial personality and its more serious variant, psychopathy. In a study of 550 jail inmates (Tangney, Stuewig, Mashek, & Hastings, 2010), we found that antisocial personality disorder, as assessed by the Personality Assessment Inventory (Morey, 1991), was negatively correlated with guilt proneness but positively correlated with shame proneness. Psychopathy, as assessed by the Psychopathy Checklist: Screening Version (Hart, Cox, & Hare, 1995), was negatively correlated with guilt proneness but unrelated to shame proneness. These findings suggest that although some psychopathic individuals may be truly absent the capacity for both “moral emotions,” some psychopaths (and many individuals with antisocial personality) are vulnerable to shame. Our guess is that such individuals do not necessarily experience shame for their crimes against society, but instead may be vulnerable to shame in connection with personal failures and shortcomings, with substance abuse (a prevalent comorbid condition), and with other stigmatizing personal characteristics. Much research remains to be done to help guide clinicians and others committed to the rehabilitation of individuals with antisocial spectrum disorders.

Finally, an exciting avenue for future clinically relevant research concerns the role of shame (in both client and therapist) in shaping the therapeutic process, including its impact on the therapeutic alliance. Helen Block Lewis (1971) identified this as an area ripe for empirical study nearly 40 years ago, and it remains so today. We hope the current volume will also stimulate clinically relevant research on effective strategies for addressing shame in the context of clinical training and supervision.

In editing this volume, we have been struck by how much we can learn from each other about optimal clinical intervention once the veil of silence is lifted from shame. We are forever indebted to Helen Block Lewis for paving the way.

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